Shared perioperative decision making: a shift in the doctor–patient paradigm

ABSTRACT

The high-risk surgical patient only constitutes approximately 4% of the elective non-cardiac surgical population but contributes to the vast majority of in-hospital deaths following surgery. This, in conjunction with a high morbidity rate, can lead to a perioperative pathway fraught with challenges. It is incredibly difficult to anticipate which complications may arise and the risks involved before surgery. It is for this reason that patients need to be engaged in the decision-making processes regarding their perioperative care involved before major surgery.

A combination of good medical practice, medicolegal influences and a governmental drive have begun to result in a shift away from paternalistic medicine to a shared decision-making approach. This article defines shared decision making, explores its benefits and limitations and addresses the relevant legal literature.

As surgical ambition continues to grow, patients who would previously have been deemed unsuitable or too 'high risk' for surgery are now undergoing potentially life-saving operations, challenging current models of care.

The high-risk surgical patient is often elderly and multimorbid, with the perioperative risk further influenced by the nature of the planned surgery. As clinicians attempt to create a new perioperative pathway to support this specific cohort, surgical complications continue to occur with varying severity. Despite the use of various risk scoring systems and vast amounts of clinical experience, it remains very difficult to predict how a high-risk patient will perform perioperatively. As a result, counselling this population reliably before surgery is becoming increasingly important.

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If a patient's beliefs and wishes are not clearly ascertained before surgery, it can be difficult to establish what is in the patient's best interests postoperatively, particularly if complications ensue. A paternalistic approach also risks having patients feeling pressured into making decisions without being able to appreciate their full implications. Particularly if complications should occur, this lack of autonomy may commit patients to a potentially traumatic postoperative pathway. As a result, a shift is being seen away from the 'doctor knows best' paradigm to a more patient-centric one, involving patients in the decision-making process while attempting to ensure a successful perioperative outcome. This concept of shared decision making is fraught with challenges as it involves a delicate balance between incorporating patient wishes and ensuring best clinical practice.

What do we mean by shared decision making?

Shared decision making is a stark contrast to the assumed paternalistic approach to clinical decision making. Traditionally, clinicians were seen as the only competent decision makers given their expertise, with decisions being made on the patient's behalf (Coulter and Collins, 2011). Although some health-care professionals think they are sharing decisions already, data from patient experience surveys indicate that this is not generally the case (Coulter, 2010; Zikmud-Fisher et al, 2010). After patients gave signed consent in a preoperative clinic a survey demonstrated that 13% of clinicians failed to provide informed consent, with a further 33% exhibiting other types of deficits such as not addressing patient values, preferences and goals. Non-English speaking and poorly educated patients were at higher risk of insufficient communication (Ankudu et al, 2014). Similarly, a study by Cooper et al (2016) showed that 15% of 882 patients had deficits in knowledge about their diagnosis and/or procedure, with elderly patients being foremost in that group. Both studies concluded that interventions for identifying these patients are needed to ensure careful shared decision making is undertaken (Ankuda et al, 2014).

Shared decision making is an 'approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences' (Coulter, 2010; Elwyn et al, 2010). It recognizes the need to support patient autonomy while aiming to achieve care that patients value. This is achieved by discussing treatment options, available choices and exploring the risks and benefits (National Institute for

Health and Care Excellence, 2016). Clinicians and patients must commit to sharing expertise during the decision-making process and respect each other's viewpoint.

In many clinical settings, clinicians will naturally use guidelines to support their decision making. However, most guidelines are aimed at clinicians, not patients. Thus, while providing extensive, clear and unbiased evidence-based information to patients should be the utmost priority, doing so verbally in a busy clinic can be overwhelming and challenging for both parties.

Risk

One of the hardest aspects with any preoperative consultation is ascertaining and interpreting risk. Any procedure is aligned with inherent risk and conveying this to the patient so that he/she can interpret it in a meaningful way to aid his/her decision making is incredibly difficult. Despite a variety of risk stratification tools developed to predict morbidity and mortality, it is impossible to predict how or when either will present (Royal College of Anaesthetists, 2019). Furthermore, some complications are wholly unacceptable to the patient and others less so. Invariably, predicting risk is a combination of clinical experience, use of scoring systems and some form of assessment with regards to physiological fitness. However, consistency in clinical prediction of outcome can vary, hindering patient education.

There is also a potential boundary when a patient interprets risk, which can become a minefield when trying to discuss surgical outcomes. A mortality risk of 4% for a hernia repair may seem high to the clinically minded but not to the layperson, and understandably so. It is for this reason that, while risk stratification tools such as P-POSSUM (Moonesinghe et al, 2013) are useful aids for clinicians, reciting the results to patients does not necessarily confer the magnitude of risk. Poor literacy skills may further confound this as some patients are unable to understand percentage risks and other mathematical expressions. For example, a study conducted by Smith et al (2014) found that 46% of people did not know whether a risk of 1 in 100, 1 in 10 or 1 in 1000 resulted in an increased chance of developing a disease (Coulter and Collins, 2011).

Health literacy refers to a patient's motivation, coupled with his/her ability to access, understand and use information in a way which enables good health (Rowlands and Nutbeam, 2013). Low health literacy is associated with higher mortality and poorer health (DeWalt et al, 2004). There are also clear issues surrounding access, with the least literate patients having the least amount of access to relevant information (Rowlands et al, 2015). Interdisciplinary approaches can identify these patients and enable appropriate interventions. Public health strategies to tackle this include building population skills through education, improving the communication skills of health-care professionals, and providing improved education aids (Protheroe et al, 2017).

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Legal influences

In the medicolegal arena, there have been several instances where a failure to explain all options to the patient has led to judicial decisions in favour of the claimant. This has been highlighted in Birch *v* University College Hospitals NHS Trust [2008], and more recently with Montgomery *vs* Lanarkshire Health Board (Scotland) [2015].

The Patients Association (2011) paper 'We've been Listening, have you been learning' explains how the sharing of information should be extended to family and carers when appropriate (Rainey et al, 2013). The case of R (Tracey) v Cambridge University Hospitals NHS Foundation Trust [2014] further highlights the importance of informing patients and families of key decisions, in this case a do not attempt resuscitation order.

The elephant in the room

Although the courts are keen to maintain patient autonomy, they will often look to support clinical acumen in the first instance. Clinicians are not legally obliged to provide treatment against their better judgement or when it is not in the best interests of a patient. This is a fundamental flaw in the shared decision-making process, where a clinician can enter dialogue with a patient on uneven terms.

If the physician feels that a therapy is not merited, then clearly the final decision is no longer 'shared'. However, the shared decision-making approach still results in a lower level of patient dissatisfaction and litigation. It also enables a process of patient education and understanding as to why a specific clinical decision has been reached. Although this dialogue could be viewed as one-sided, it remains as good clinical practice and provides an opportunity for the patient to air his/her concerns and wishes. It is important that this aspect of the doctor–patient paradigm exists to ensure that clinicians are not compelled to simply fulfil patient instructions against their clinical judgement.

Limitations of shared decision making

Some health-care professionals express doubts about shared decision making (Elwyn et al, 2012). Within modern medical training, the concept of establishing patient values and expectations to enable planning is not unfamiliar and is already actively encouraged. However, consultation times, NHS targets and disjointed pathways have made the concept of shared decision making appear idealistic. Shared decision making need not be time-consuming. Several studies demonstrate that physicians trained in shared decision making take less time for a consult than non-trained physicians (O'Connor et al, 2009). Even if the initial meeting takes longer, future discussions are more efficient (Edwards et al, 2002). Nonetheless, it is

KEY POINTS

- Shared decision making is a stark contrast to the traditional paternalistic approach to clinical decision making.
- More multimorbid, often elderly patients, who were previously deemed 'too high risk' for surgery are now regularly undergoing major operations.
- By engaging patients in shared decision making, physicians can attempt to create a bespoke perioperative pathway for their patients.
- Despite some limitations of shared decision making, the overall benefits of empowering patients during the perioperative period and supporting their autonomy highlight the need for shared decision making to become cemented in our normal practice.

difficult to ignore that NHS strains and inefficiencies can dilute any potential benefits from shared decision making. Finally, there is a lack of consensus around which outcome measures constitute success. Without defined goals, practising shared decision making becomes less attractive (Crossingham, 2013).

Furthermore, not all patients want to be involved in the decision-making process. They may recognize limitations in their understanding and be fearful of making 'bad' decisions (Coulter, 2010). Although every attempt should be made to involve patients, some patients prefer a more paternalistic approach and if clearly indicated, the physician should not force shared decision making.

The reasonable patient

The obvious difficulty when attempting to discuss risk with a patient is 'how much information is too much information'? A knee-jerk reaction to cases such as Montgomery is to provide as much information as possible. However, the patient ends up being overloaded with statistics and data. In particular, where there are issues of health literacy to consider, it is clear that the balance between providing sufficient information while ensuring that it is interpretable is a delicate one.

There has been an evolution in the medicolegal literature with respect to consenting patients before interventions. In 1957 Judge McNair claimed that 'a doctor cannot be criticised if he does not stress the dangers' to a patient. Lord Woolf felt the emphasis should be placed on 'significant risk' with regards to the consent process (Jackson, 2016). However, it is unclear whether this refers to a significant risk of an event happening, or whether its consequences are significant. Nonetheless, it is now universally accepted that relying on the 'reasonable doctor's test' does not protect a patient's right to self-determination. There has been a move to a compromise between the prudent (reasonable) patient test and the subjective standard. Unfortunately, both are still fraught with limitations. It is almost impossible to anticipate what a patient would consider significant. The reasonable patient test also does not necessarily maintain patient autonomy. The subjective standard relies on health professionals entering an 'informational exchange' with patients, identifying their priorities and concerns. However, patients are still reliant on doctors to make judgements about factors that are likely to be important to them.

The ambiguity within the medicolegal literature perhaps highlights that tort law is not designed to provide medical guidance. Instead, there should be a reliance on the principles of good clinical practice advocated by institutions such as the General Medical Council as opposed to defensive based practice.

Governmental drive

Despite some negativity towards shared decision making, there is compelling evidence that patients who are actively encouraged to participate in managing their health have better outcomes, elect for more conservative options and have an improved patient experience (Santhirapala et al, 2016). Shared decision making is an ethical imperative which expects clinicians to work in partnership with patients. Patients are able to make choices in line with their own needs, values and circumstances and get 'the care they need and no less, the care they want and no more'. Shared decision making helps to achieve the right intervention rate and reduce unwarranted practice variation, thus reducing litigation costs (O'Connor et al, 2009).

As a result, governmental and other regulating bodies have advocated that shared decision making become the 'norm' within the NHS. Much of this is supported by the paper *Making Shared Decision-Making A Reality* (Coulter and Collins, 2011), which stresses the importance of shared decision making becoming embedded within the NHS. Furthermore, the NHS and clinical commissioning groups have a legal duty to involve patients in decisions about their care, with the NHS constitution making a commitment to support a patient's ability to make choices about his/her health care while providing information to support his/her choices. The patient experience framework describes communication and engagement strategies as key in shared decision making, with clinical commissioning groups committed to shared decision making as part of their local Quality Innovation of Productivity and Prevention plans. The Commissioning for Quality and Innovation national goals also look towards shared decision making to 'improve responsiveness to the personal needs of patients'. The shared decision making programme is working with the NHS to get decision aids embedded into the system, support patients with a decision coaching service and stimulate a 'patient movement' to drive consumer expectations of shared decision making (Santhirapala et al, 2016).

Conclusions

It is clear that shared decision making is evolving and is a vital area for quality improvement. It requires communication skills beyond those which are traditionally taught (Coulter and Collins, 2011) and the evidence supporting its use over the traditional paternalistic approach to decision making is overwhelming. The vast number of regulating bodies and patient groups endorsing shared decision making

highlight the shift in what patients need and want. Healthcare professionals must ensure that shared decision making becomes a cemented 'norm' in their practice. **BJHM**

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