



Shared Decision-Making in Patient Care: Advantages, Barriers and Potential Solutions

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Abstract

Shared Decision-Making (SDM) is a collaborative process where physicians integrate scientific evidence with patients' goals, preferences, and values to make healthcare decisions. This approach contrasts with traditional methods, enhancing patient involvement and understanding. The BRAN questions (Benefits, Risks, Alternatives, Nothing) effectively facilitate SDM across various clinical settings, promoting patient safety. While time constraints and low health literacy pose barriers, strategies like visual aids, extended appointments, and cognitive assessments can mitigate these challenges. Training for physicians in SDM skills has been shown to improve patient outcomes and satisfaction, underscoring the importance of personalized care in outpatient and inpatient contexts.

BACKGROUND

Shared Decision-Making (SDM) is an interactive, collaborative process where physicians focus on the best scientific evidence and patients' goals, preferences, and values to make healthcare decisions.^{1,2} Multiple viable options can complicate medical and surgical decision-making in numerous clinical scenarios. Through SDM, physicians assist patients in analyzing potential risks, benefits, and outcomes to reach medical decisions that are not only evidence-based but also aligned with the patient's values and preferences. The traditional approach, where the physician unilaterally makes decisions and presents them to the patient, may limit patient involvement to mere consent without a detailed discussion and understanding of their preferences or adherence to recommendations.¹ Our patients have the right to be well-informed and actively engaged in their care decisions, with a comprehensive understanding of potential benefits, risks, and alternatives. Most patients prefer an active role in medical decision-making but perceive physicians often make decisions contrary to their preferences.² SDM enables patients to make informed treatment decisions based on their preferences and circumstances, with physicians providing relevant evidence and guidance.

BRAN questions, the UK SDM tool, is an excellent tool for practicing shared decision-making in clinical practice.³

B - What are the **B**enefits?

R - What are the **R**isks?

A - What are the **A**lternatives?

N - What if I do **N**othing?

The BRAN tool's adaptability to various health decision settings, including diagnostic tests, treatments, and procedures, increases its potential to enhance patient safety.³ SDM reminds us that a "one size fits all" approach does not work in medicine because of patients' unique values, preferences, and circumstances. For instance, different patients might choose different screening tests based on their circumstances, views, and preferences about each option's potential risks, benefits, and costs. Similarly, some patients may prefer to continue treatment despite a limited response rate for their malignancy. In contrast, others may choose not to continue treatment based on their social and financial situations. Unless physicians are willing to understand patients' situations and priorities, patient care will not be optimized accordingly.

ADVANTAGES OF SHARED DECISION-MAKING

The primary care context is the root of shared decision-making (SDM) as it is the first point of contact in the healthcare infrastructure that addresses various health needs. Physicians are at the forefront of any healthcare system and need training to enhance their SDM skills. Both live and online training programs for physicians improve patient and observer-reported SDM skills, promoting overall health and well-being.⁴ During inpatient rounds on medicine and pediatrics services, the most frequently observed SDM behaviors included explaining the clinical issue and matching medical language to the patient's level of understanding.⁵ In contrast, the least frequently observed SDM behaviors were checking the pa-

tient's understanding, examining barriers to follow-through, and asking if the patient had any questions during bedside rounds.⁵ Team size, number of learners, patient census, and the type of decision being made did not affect SDM, suggesting that even large, busy inpatient services can perform SDM effectively with proper training.⁵

There is often no perfect treatment choice. Nearly all treatment options involve some uncertainty and side effects. Informed clinical decisions require judicious application of diagnostic testing, overcoming biases, and customizing evidence-based practices to suit individual patients' needs. SDM increases patient satisfaction, which in turn correlates with improved treatment adherence.⁶ Facilitating SDM has shown positive associations with improved quality of life and patient outcomes. It reduces decisional conflict and increases patient knowledge.⁷ Clinical prediction scores, such as Pulmonary Embolism Severity Index (PESI), can provide valuable insights into patient outcomes and risk categories. However, these clinical tools cannot replace physicians' clinical judgment and the importance of shared decision-making. For example, the American Society of Hematology guidelines recommend discharge with direct oral anticoagulation for patients with a low risk of complications from pulmonary embolism. However, SDM remains essential for engaging patients and caregivers in discussions about the risks and benefits of anticoagulation, as well as assessing their comfort level and willingness to be discharged on the same day. SDM empowers physicians, allowing them to view patients as unique individuals, which is crucial for safe and exceptional patient-centered care.

BARRIERS TO IMPLEMENTING SHARED DECISION-MAKING AND POTENTIAL SOLUTIONS

Several obstacles can hinder SDM in clinical encounters. Time constraints are frequently identified as a significant barrier to implementing SDM in clinical practice. The limited duration of a typical physician's office visit may not allow sufficient time to address all concerns of sick, complex patients and guide them in making well-informed decisions that align with their preferences. To improve patient understanding and communication, use tools like visual aids, and simplified language. Sitting at the patient's level can contribute to a positive tone and improved communication during the visit. Schedule longer appointment times for SDM discussions for pa-

tients with complex needs or arrange close follow-up visits. Quality and quantity of time are crucial in cultivating strong patient-physician relationships to promote patient satisfaction. Low health literacy is another common issue contributing to suboptimal SDM discussions and emphasizing the need for simple and patient-friendly language during patient encounters. Optimal treatments for individual diseases may not be suitable for elderly patients with multimorbidity. In discussions involving elderly patients and their caregivers, physicians should focus on preferred health outcomes to guide treatment choices rather than addressing each medical condition in isolation. Undiagnosed cognitive impairment impedes effective communication and decision-making. Additionally, disabling hearing impairment affects many elderly patients, potentially leading to misunderstandings, as hearing loss might be mistaken for cognitive impairment. Resources like the Mini-Cog, which can quickly assess cognitive impairment, are valuable in such cases. Addressing these barriers with potential solutions can foster an environment that encourages open communication and SDM between patients, their families and physicians.

CONCLUSION

Shared Decision-Making (SDM) is a cornerstone of patient-centered care and emphasizes integrating patients' needs, values, and goals into their treatment plans. Physicians can provide personalized, effective care by actively involving patients and caregivers in the decision-making process and considering their unique preferences and circumstances. This evidence-based approach ultimately leads to enhanced patient satisfaction, better adherence to treatment, and improved health outcomes in both outpatient and inpatient settings.

Disclosures/Conflicts of Interest

None

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