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Dr Dr David Timbrell, ST6 Anaesthetics, Guy's and St Thomas' NHS Foundation Trust, London, UK

Dr Ramai Santhirapala, Consultant Anaesthetist[1] & Clinical Lead, Choosing Wisely UK

025

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Shared Decision-Making in Perioperative Medicine

Key Points

- In addition to improving patient reported outcomes, shared decision-making can significantly reduce overdiagnosis and overtreatment
- Many of the barriers to shared decision-making relate to misconceptions that it is something we already do and that there is not sufficient time or resources to do any better
- Embedding shared decision-making in usual care will require a cultural change necessitating engagement from organisational leaders, clinicians and patients alike
- Effective shared decision-making requires strong communication and clinicians must be supported in learning how to structure these conversations

MCQ

True or False:

1. Patients who have been through a shared decision-making process are more likely to:
    a. Demonstrate better reported communication with clinicians
    b. Have reduced adherence to treatment
    c. Undergo a greater number of investigations
    d. Undergo non-operative management
2. Performing shared decision-making may mean:
    a. Consultations take more time
    b. Increased costs for the health service
    c. Doctors have improved job satisfaction
    d. A loss of professional autonomy for doctors

Dr Dr David Timbrell, ST6 Anaesthetics, Guy's and St Thomas' NHS Foundation Trust, London, UK

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3. The shared decision-making process:
    a. Can only really be done by doctors
    b. Should not require much investment from local organisations
    c. Requires specialist training to be effective
    d. Is best conducted by the same clinician
4. Decision aids:
    a. Have not been shown to be beneficial in a recent meta-analysis
    b. Have been shown to help patients prioritise
    c. Are not approved by NICE
    d. Guarantee patients continue with the decision they make

Answers: 1 .TFFT, 2. TFTF, 3. FFTF, 4. FTFF. (See notes at end of article)

Introduction

Since the King's Fund publication '*No decision about me, without me*', improving shared decision making has become a national priority (Coulter and Collins, 2011; Ross et al, 2018). One survey of 500 doctors found 82% admitted to prescribing treatments they consider unnecessary (Academy of Medical Royal Colleges, 2016), whilst over 30% of patients wish to have more involvement in decisions about their care (NHS England, 2018). The Montgomery ruling means there is now a legal imperative to discuss 'material risks' with patients. However, what really is 'shared decision-making' (or '*SDM*' as it is commonly known)? Is it worth it? And don't we already do it?

This article will address these questions and provide a framework for how to perform shared decision making in practice. We will also discuss the future for shared decision making including the development of effective training programmes and how to implement the process so as to embed it into usual care.

Dr Dr David Timbrell, ST6 Anaesthetics, Guy's and St Thomas' NHS Foundation Trust, London, UK

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What is shared decision-making?

SDM is a collaborative process between clinicians and patients, which aims to select the most suitable management option based on both best available evidence and patient preferences. Effective SDM is the cornerstone of the *Choosing Wisely UK* initiative (Academy of Medical Royal Colleges, 2016). Launched in 2016, *Choosing Wisely UK* is endorsed by the Royal Colleges of Anaesthetists and Surgeons (Eng). It encourages patients to ensure four key questions ('BRAN') are addressed when elective surgery is considered:

- What are the Benefits?
- What are the Risks?
- What are the Alternatives?
- What if I do Nothing?

While doctors are the experts in medical evidence, the patient is the expert regarding their values and personal circumstances. For example, as medical professionals we might know which treatment option offers the greatest chance of curing the patient's cancer. However, only the patient can know whether a six month recovery from a major laparotomy and its associated morbidity/mortality risk suits their personal goals. SDM seeks to bridge varying viewpoints and achieve a consensus decision on the best way forward. This may mean that for some patients surgery is not always the answer.

Benefits

When performed effectively, SDM can have a significant impact on the overall safety and efficacy of personalised care. Patients who are effectively involved in making decisions about their care have fewer regrets about treatment, better reported communication with clinicians, improved treatment adherence and an overall better experience with improved satisfaction (NHS England, 2018).

Furthermore, improving SDM will likely reduce both overdiagnosis and overtreatment. This may well mean a reduction in operative procedures (Stacey et al, 2017). Interestingly, it is suggested that professionals who participate in SDM may have improved job satisfaction.

Dr Dr David Timbrell, ST6 Anaesthetics, Guy's and St Thomas' NHS Foundation Trust, London, UK

Dr Ramai Santhirapala, Consultant Anaesthetist[1] & Clinical Lead, Choosing Wisely UK

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Challenges

While doctors are generally in agreement that shared decision-making is beneficial, there are a number of practical and logistical challenges which result in inconsistent application of the process. The MAGIC (Making Good Decisions in Collaboration) programme, established by the Health Foundation, produced a report in 2017 which addressed five key challenges (Joseph-Williams et al, 2017):

- We do it already
- We don't have the right tools
- Patient don't want shared decision-making
- How can we measure it?
- We have too many other demands and priorities

The greatest challenge is almost certainly the misconception that SDM is something we already do. This perception-reality gap is exacerbated by a misunderstanding of what SDM actually is and consequently contributes to a lack of skill among practitioners in performing SDM effectively. Investment in training and education is crucial if clinicians are to have sufficient access to high quality evidence and be adequately skilled to undertake these conversations.

It is often suggested that patients frequently do not wish to engage in the decision making process. While shared decision making should not be forced on anyone, it is important to be aware that the level of involvement patients want in the process can vary significantly and there are often a number of reasons for this. Some patients may simply expect a paternalistic approach and some may feel it antagonises the clinician's role to question decisions about their healthcare (Frosch et al, 2011) (Say et al, 2006). It is therefore important that patients are primed to expect to be involved in making decisions about their care and are supported throughout the process.

Limited resources, time constraints and other work pressures are often cited as barriers to performing SDM. It is true that going through all the options and having the discussion may

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take some time at the outset. However, effective SDM should mean that this time is recouped down the line. Clinical pathways may need to be reorganised in order to support the process but doctors should not be solely responsible as SDM can be shared out amongst members of the multidisciplinary team. eg. the surgeon describes the options and a clinical nurse specialist explores the patient's preferences (Joseph-Williams et al, 2017).

Practitioners often report concerns that SDM will mean the loss of professional autonomy. However shared decision making requires clinicians to utilise professional expertise including careful consideration of options which are appropriate for each individual patient. Indeed, effective SDM enables patients to make more meaningful decisions between potential treatment options which are felt to be medically appropriate.

Implementing Shared Decision Making

The reality is that funding, time and resources are at a premium in the modern day healthcare sector.

Embedding shared decision making in usual care requires a cultural change necessitating engagement of stakeholders at all levels – national, regional and local organisations. Organisation leaders must be engaged in order to ensure the necessary support to enable redevelopment of care pathways that support the SDM process. Patients and their relatives must be involved throughout as it is they who can advise best on whether the SDM process works for them.

Training clinicians in SDM is crucial if staff are to be appropriately equipped with the requisite skills to perform this complex intervention effectively. This process has already begun. In conjunction with The Health Foundation's 'MAGIC' programme, The Royal College of Anaesthetists and Academy of Medical Royal Colleges 'Choosing Wisely' initiative developed a collaborative series of workshops. Using a train-the-trainers approach, this programme sought to train a core group of 60 perioperative clinicians in the SDM process who might in turn train colleagues at a regional/local level (The Health Foundation, 2013). In addition, the Academy of Medical Royal Colleges has partnered with the Winton Centre for Risk and Evidence Communication and Australian Commission for Safety and Quality in Healthcare to produce e-learning modules in shared decision making. These are available at https://moodle.wintoncentre.uk.

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Structure of the Shared Decision Making Process

Shared decision making can be a challenging concept for clinicians as it can feel as though the balance of power in the consultation is shifted from more traditional approaches. However, it should be remembered that at its core, the SDM process is a collaboration of two important sets of expertise:

- The clinician's experience and knowledge of the options
- The patient's preferences based on their individual circumstances, values and goals

In order for an effective discussion, clinicians should be trained to understand and effectively perform the key elements of the SDM process. In 2012, Elwyn and colleagues published 'the three-talk' model for shared decision making (Elwyn et al, 2012). This was revised in 2017 and provides a basic framework for clinicians to learn from when training in shared decision making (Elwyn et al, 2017). The three-talk model is shown in Figure 1.

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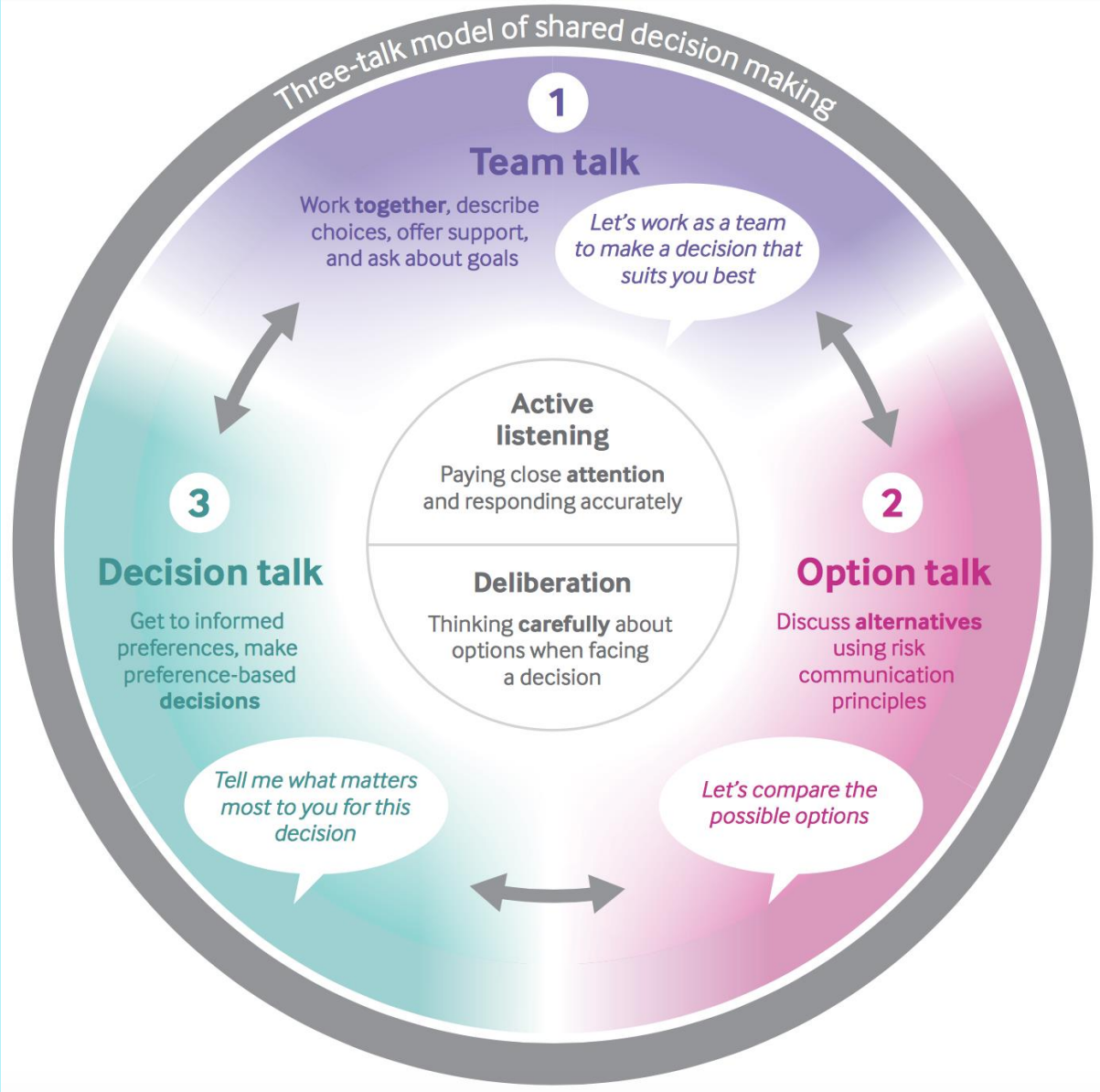

Figure 1. The three-talk model (Elwyn et al, 2017)

The model consists of three key 'talks'. These 'talks' should be considered as fluid phases of the discussion process rather than discrete discussions to be had in isolation. It is not

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necessary for an individual clinician to undertake the whole process with the patient by themselves. For example, in a surgical outpatient setting it would be quite reasonable for a clinical nurse specialist to see the patient at the 'Team talk' stage, a surgeon to conduct the 'Option talk' and, following some time to deliberate, the patient to complete the process with the clinical nurse specialist at the 'Decision talk'.

'Team talk': During this phase the patient is introduced to the SDM process. They should be made aware that a choice exists and their goals in relation to their health issue are explored. This step is key to the development of a supportive partnership between the patient and the multidisciplinary team.

'Option talk': The possible options are explored and compared with each other in the context of their risk to the patient. At this stage it can be useful to make use of 'decision aids' to help illustrate risk in the context of the other options available.

'Decision talk': The aim of this phase of the process is to come to a preference-based decision. The patient and clinician work together to identify the best choice on offer in the context of the patient's own goals.

Decision Aids

Deciding to undergo surgery (or not) can be a challenging decision for patients. Making complex health decisions is further compounded due to poor health literacy. 43% of English adults do not understand health information – and this rises to 61% if there is a numerical component to the information (NHS England, 2018).

In 2017, a Cochrane review of 105 studies demonstrated that people who use decision aids are more knowledgeable about their health issues, have a better appreciation of risk and play a more active role in decision-making about their health (Stacey et al, 2017).

Decision aids come in many forms including leaflets, videos and online or app-based tools. They are available from a variety of sources including Ottawa Hospital Decision Aids (https://decisionaid.ohri.ca), Patient.info, NHS England and NICE.

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Conclusion

Compelling moral, legal and economic imperatives exist for improving shared decision-making in the perioperative period despite the challenges of this complex intervention.

MCQ Answers

1.
   (a) T
   (b) F
   (c) F
   (d) T

2.
   (a) T
   (b) F – Initial consultations may take longer but this should be recouped
   (c) T
   (d) F

3.
   (a) F
   (b) F – The main investment is leadership support to initiate culture change
   (c) T
   (d) F – Can be shared between a multidisciplinary team

4.
   (a) F
   (b) T
   (c) F – A number are published by NICE
   (d) F – Unclear, further research is needed on this

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Dr Dr David Timbrell, ST6 Anaesthetics, Guy's and St Thomas' NHS Foundation Trust, London, UK

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