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AUA White Paper on Implementation of Shared Decision Making into Urological Practice

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Abstract

Introduction: Shared decision making is a collaborative approach to care that seeks to improve the quality of medical decisions by helping patients choose options concordant with their values and in accordance with the best available scientific evidence.

Methods: A literature review was performed targeting publications between 2003 and 2014 on the topic of shared decision making and decision aids for urological conditions. An expert panel was convened to evaluate this information and create this white paper with the purpose of educating the urological community on these issues.

Results: Shared decision making represents the state of the art in patient counseling. Patients who have engaged in shared decision making have greater knowledge and satisfaction as well as greater engagement with care. Numerous organizations make available free resources for shared decision making including decision aids and tools to evaluate the quality of shared decision making.

Conclusions: Shared decision making is an important component of high quality health care delivery and future reimbursement models. In appropriate circumstances urologists should adopt shared decision making into routine clinical practice.

Key Words: decision making, decision support techniques, urology

Abbreviations and Acronyms

ACA = Patient Protection and Affordable Care Act

AHRQ = Agency for Healthcare Research and Quality

AUA = American Urological Association

DA = decision aid

IPDAS = International Patient Decision Aid Standards

OHRI = Ottawa Hospital Research Institute

PSA = prostate specific antigen

SDM = shared decision making

Scientists studying medical decisions recommend shared decision making for patients and physicians. SDM is associated with increased patient knowledge and satisfaction, greater patient engagement with care and possible reduction of medical costs.[1−3] Additionally, SDM is at the core of several delivery system reforms outlined in the ACA. In

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keeping with the state of the art, American Urological Association guidelines on complex urological topics suggest, either explicitly (http://www.auanet.org/education/guidelines/prostate-cancer-detection.cfm and http://www.auanet.org/education/guidelines/radiation-after-prostatectomy.cfm) or implicitly (http://www.auanet.org/education/guidelines/renal-cancer-follow-up.cfm), the necessity of SDM in optimizing urological care for patients. However, physicians have a limited understanding of SDM and how to implement it in clinical practice.[2] To improve the quality of care for urological patients the AUA Quality Improvement and Patient Safety Committee reviews the literature in the field of urological SDM and makes suggestions for how best to implement it in practice.

Shared Decision Making

SDM is a collaborative process between patients and their health care providers for medical decisions for which multiple options are considered clinically acceptable. This approach is relevant in health conditions in which the ratio of benefits-to-harms is uncertain, equivalent or "preference sensitive" (eg dependent on the value that a patient may assign them).[4] SDM aims to improve the quality of medical decisions by helping patients choose options concordant with their values and the best available scientific evidence. Randomized controlled trials of SDM vs routine care have demonstrated that patients engaged in SDM are more knowledgeable, have more realistic expectations, participate more in the care process and frequently arrive at decisions aligned with their personal preferences.[5]

One challenge of implementing SDM is the lack of a universally accepted definition. In a systematic review of the shared decision making literature Makoul and Clayman found that fewer than 40% (161 of 418, 38.5%) of articles included a conceptual definition of SDM.[6] Although 31 concepts were used to explicate SDM, the only categories that appeared in more than half of the 161 definitions were "patient values/preferences" (in 67.1%) and "options" (in 50.9%). The authors concluded that defining SDM is necessary for operationalizing SDM in further research. Charles et al provided the most widely accepted SDM model, defining its key characteristics as 1) involvement of doctor and patient in the decision making process, 2) both parties sharing information with each other, 3) both sharing in the process of building consensus through the expression of preferences, and 4) doctor and patient agreeing on the decision to implement.[7]

Benefits of SDM

SDM requires a partnership between the doctor and the patient, and sometimes the patient's family. Ideally it includes a balanced presentation of options and outcomes tailored to the individual patient's risk. Equally important is active engagement with the patient to help clarify his or her values and preferences, and communicate them to the clinician. The benefits of SDM result from a relationship of trust and mutual respect between patient and physician.[8] Patients who perceive that they have participated in their health care decisions more often report feeling informed or empowered and having a better quality of life, and are more likely to express higher satisfaction with their medical care. They are less likely to have decisional regret and more likely to adhere to the agreed-upon medical regimen.[9,10] Such empowerment may be important for long-term, anxiety provoking decisions.

Numerous studies suggest that people presented with the benefits and harms of difficult health care choices are capable of coming to reasonable decisions, often different from those they might have made without SDM. Balanced presentation of prostate cancer natural history, diagnosis and treatment options led to decreased interest in prostate cancer screening in 6 of 9 studies,[11] and increased preference for watchful waiting for low risk disease.[12] Only a quarter of patients with high risk prostate cancer considering surgery elected a nerve sparing approach when participating in SDM to explain the risks and benefits of nerve sparing prostatectomy.[13] With physician assistance, patients and families can prioritize their values and make rational choices with more realistic expectations, less decisional conflict and increased long-term satisfaction.[5]

Use of SDM in Clinical Practice

Despite the prevalence of preference sensitive urological conditions, few studies have documented the prevalence of SDM use in the community. A large, cross-specialty physician survey suggested that more than 70% of physicians identify SDM as their preferred style of clinical decision making over paternalism or consumerism.[14] However, actual use has been as low as 10% in certain settings.[8,15] Despite wanting to have a more active role in their health care decision making, many patients report not being sufficiently involved in the decision process.

Studies consistently demonstrate a gap between ideal and actual practice. Among men undergoing PSA screening only 42% to 51% discussed its advantages with their physicians, while only 7% to 20% reported discussing the disadvantages[16,17] and only 15% discussed its associated uncertainties. These disparities could affect clinical practice as men never having received PSA counseling were less likely to undergo PSA screening in spite of the known limitations of PSA.[18]