Z. Evid. Fortbild. Qual. Gesundh. wesen (ZEFQ) 123-124 (2017) 91–94

Contents lists available at ScienceDirect

Z. Evid. Fortbild. Qual. Gesundh. wesen (ZEFQ)

journal homepage: http://www.elsevier.com/locate/zefq

Special Issue / Schwerpunkt

Shared decision making in preventive care in Switzerland: From theory to action

Partizipative Entscheidungsfindung in der Vorsorge in der Schweiz: von der Theorie zur Praxis

Kevin Selby [1,2,*], Reto Auer [1,3], Jacques Cornuz [1]

[1] *Department of Ambulatory Care and Community Medicine, University of Lausanne, Switzerland*
[2] *Kaiser Permanente Division of Research, Oakland, California, USA*
[3] *Institute of Primary Health Care (BIHAM), University of Bern, Switzerland*

ARTICLE INFO

Article History:
Available online: 18 May 2017

Keywords:
Switzerland
shared decision making
decision aids

ABSTRACT

Switzerland with its decentralized, liberal health system and its tradition of direct democracy may be an ideal place for shared decision making (SDM) to take root organically, rather than using top-down regulations seen in other countries. There are now multiple directives and programmes in place to encourage SDM, with the creation of several decision aids and specific training programs in the five Swiss medical schools. There has been an emphasis on preventive care, with the integration of patient preference into an organized colorectal cancer screening program, clear recommendations for prostate cancer screening, and inroads into the primary prevention of cardiovascular disease. Focusing on the experience of the University of Lausanne, we describe multiple approaches being taken to teaching SDM and the local development of decision aids, drawing on international experience but tailored to local needs. Efforts are being made to further involve patients in not only SDM, but also associated research and quality improvement projects.

ARTIKEL INFO

Artikel-Historie:
Online gestellt: 18. Mai 2017

Schlüsselwörter:
Schweiz
partizipative Entscheidungsfindung
Entscheidungshilfen

ZUSAMMENFASSUNG

Die Schweiz ist mit ihrem dezentralisierten, liberalen Gesundheitssystem und ihrer Tradition der direkten Demokratie möglicherweise der ideale Ort, um partizipative Entscheidungsfindung (PEF) zu etablieren anstelle einer Top-down-Regulierung wie in anderen Ländern. Es gibt bereits mehrere Richtlinien und Programme in den fünf Schweizer Universitätskliniken, die PEF fördern und neue Entscheidungshilfen und Trainingsprogramme entwickeln. PEF hält auch in die Gesundheitsvorsorge Einzug und findet im Darm- und Prostatakrebs-Screening sowie neuerdings auch beim Brust- und Lungenkrebsscreening Anwendung. Anhand der Erfahrungen in Lausanne beschreiben wir mehrere Herangehensweisen, PEF zu vermitteln und geeignete, für hiesige Verhältnisse maßgeschneiderte Entscheidungshilfen zu entwickeln. Weitere Bestrebungen sind im Gange, PEF vermehrt anzuwenden und Patienten in die damit verbundenen Forschungs- und Qualitätsverbesserungsprojekte einzubeziehen.

We have spent a staggering amount of time and energy over the past several decades developing, discussing, and debating guidelines. . .It seems that it would be much more productive to devote such energy to educating screening candidates about the harms and benefits of screening and to engaging in shared decision making.

Stefanek ME, 2011 [1]

Background

In healthcare contexts where more than one reasonable choice exists, patient and physician preferences become the determining factors in choosing treatments [2]. Physicians have an ethical responsibility to 'diagnose' the values and preferences of their patients. Patients trust their physicians to individualize decisions to their unique situation and have a recognized right to autonomy. Swiss healthcare has a long history of patient-centred care stemming not from strict, central governance, but from a decentralized healthcare system that offers a high degree of choice, transparency, and direct access to all levels of care [3,4]. Patients can choose

* Corresponding author: Kevin Selby, M.D., Kaiser Permanente Division of Research, 2000 Broadway, Oakland, CA, USA, 94612.
E-mail: kevin.selby@hospvd.ch (K. Selby).

http://dx.doi.org/10.1016/j.zefq.2017.05.008
1865-9217/

their own physicians, and physicians have had considerable latitude, within a fee-for-service system, to tailor care to meet patient expectations. Further, a unique combination of flexible time-based billing by physicians and a high proportion of medical costs being paid directly out-of-pocket by patients has made for a responsive primary care system [5]. These factors may help explain why, in a recent survey involving 11 developed nations, Switzerland ranked second overall in patient-centred care and Swiss patients were the most likely to report that their physicians discuss their goals with them, tell them about treatment choices, and give clear instructions about when to seek further care [6].

Since the last description of SDM in Switzerland in 2011 [7], considerable progress has been made in promoting evidence-based SDM by providing tools and training to foster the underlying current of patient-centeredness in Swiss primary care. The *Health2020 report*, released in 2013, underlined the need for patient involvement and patient rights to autonomy and equality with their care givers [8]. In 2015, the *Swiss Medical Association (FMH)* released a directive outlining SDM as the 'ideal model', detailing patient involvement as crucial in all medical decisions and that patient preferences should be incorporated into clinical guidelines [9]. SDM has been featured in a National Research Program launched by the *Swiss National Science Foundation* in late 2015, "Smarter Health care", that focuses on innovative research into health care services and calls specifically for tools that "support decision making for patients" [10]. Within the last years, the five Swiss medical schools (Basel, Bern, Geneva, Lausanne and Zürich) have formally integrated SDM into their pregraduate training program, as well as their postgraduate training in general internal medicine. Most of these programs are embedded in the doctor-patient communication skills or preventive care curricula. Beyond noting these national trends, we focus primarily on efforts made by the *Department of Ambulatory Care and Community Medicine* in Lausanne to encourage SDM. Having not done a comprehensive review of all activities in Switzerland, omission of other work does not imply a lack of activity at other centres.

Preventive care

One focus of SDM implementation has been the integration of SDM into routine preventive care. Preventive care has recently been the source of considerable controversy in Switzerland. In a much publicized announcement in 2013, the *Swiss Medical Board (SMB)* recommended that "no new systematic mammography screening programs be introduced and that a time limit be placed on existing programs." [11] The SMB had previously pronounced itself against prostate cancer screening; the practice of both screenings remains widespread. SDM has been proposed as a possible compromise amidst differing opinions, especially given strong differences in health cultures between cantons. In 2014 the *Smarter Medicine campaign* of the *Swiss Society for General Internal Medicine* included systematically discussing the benefits and harms of prostate cancer screening before ordering a PSA test in its Top 5 list [12].

The so-called *EviPrev programme (for Evidence-based Preventive Medicine)*, which brings together members of all five academic ambulatory general internal medicine centres in Switzerland, has created unified recommendations for preventive care, taking into account the Swiss context and encouraging the integration of the patient's perspective [13]. The implementation of the EviPrev recommendations focuses on an interactive table that integrates all of its recommendations, providing levels of evidence and links to patient and provider materials [14]. An extension of this work has been the creation of decision aids (DAs) for preventive care, including the use of statins in primary prevention [15], cancer screening [16,17] and smoking cessation. In a separate development, the "Health Coaching" programme developed at the University of Zürich and adopted by the *Swiss College of Primary Care Medicine*, also explicitly integrates SDM into behaviour change with patient-centred choice of the area of action and shared responsibility between general practitioners (GPs) and their patients [18]. These initiatives promote SDM in guidelines and provide decision aids. The hope is to create an environment where SDM is the norm, without closely measuring the implementation of SDM at the individual level. The effectiveness of these changes on the experience of individual patients is unknown [19].

SDM has been formally integrated at every stage of development of the first large-scale, systematic screening program for colorectal cancer (CRC) in Switzerland in the *Canton of Vaud* (the largest French speaking state of Switzerland) [16]. Instead of presuming all eligible persons should be screened, the Vaud program helps them make an informed choice about: (a) whether to be screened for CRC and, (b) which method of screening (fecal immunochemical test or colonoscopy) is best for them [16]. Over the next 5 years, all 170'000 eligible citizens of Vaud will be invited to discuss their choices for CRC screening with their GPs, in a 15 to 30-minute, deductible-free, shared decision making (SDM) visit. We believe the Vaud program is the first to shift the paradigm from "uninformed compliance" to "informed choice" [20]. In informed choice programs, the outcome shifts from the percentage of the population screened to the percentage of the population that makes an informed decision about screening. Invitation to the program is with a mailed DA that aims at meeting *International Patient Decision Aid Standards (IPDAS)* criteria and a list of 10 recommendations to improve risk communication material [21]. The DA outlines the decision to undergo screening and the choice of fecal immunochemical testing (FIT) or screening colonoscopy. A training program was designed for GPs that exposed them to variations in care between physicians in the offering of FIT and colonoscopy as the default screening choice and an example consultation with a patient using a grid comparing the two choices and her reasons for preferring FIT [22]. After the training program GPs reported being more likely to prescribe FIT and colonoscopy in equal proportions to their patients [22]. A project currently aims at testing the effect of a training intervention in general practitioner quality circles in a cluster randomized controlled trial. Beyond training of GPs in SDM, SDM is now integrated into multiple levels of medical training, with unique objectives and strategies at each stage (Table 1).

Development of decision aids

Four DAs have now been developed for preventive care decisions made in primary care. Each has been developed for a different clinical scenario and has brought its own lessons in DA development (Table 2). The two DAs for cancer screening are stand-alone brochures designed to be read by persons alone in preparation for a consultation with his or her GP. Both contain standard DA components explaining the underlying disease process with and without screening, and potential advantages and risks [16,17]. The other two DAs are shorter and intended for use during a consultation; emphasis is on rapid comparisons between options and information is limited to that which patients found most directly relevant during the development and pilot testing of the DA.

In some situations the most efficient path to having high quality, evidence-based DAs in non-English countries is to adapt existing DAs that are made freely available internationally. If external DAs contain balanced evidence presented in a way that reflects Swiss guidelines and practice, the use of existing figures and language can avoid the need for extensive local work conducting systematic literature reviews and weighing which statistics to include. For our statin DA, a partnership was made with the *Mayo Clinic Shared Decision Making National Resource Center* to translate the content of their *Statin Choice Decision Aid* [23] and integrate a cardiac risk tool