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Review Article

Shared decision making and the internist

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ABSTRACT

In this narrative review, we locate within the tradition of great diagnosticians in internal medicine, a fundamental development in patient-centered care: shared decision making (SDM). In this way, we present SDM as a core component of the clinical method, one in which diagnosis of the situation and of the actions that resolve it is essential toward the practice of evidence-based medicine.

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1. Shared decision making in the context of evidence-based practice

Evidence-based medicine is the practice of medicine that is informed by the pertinent body of research evidence, which is judiciously adapted to the care of individual patients in their particular situation [1]. Much of the work of evidence-based medicine has focused on issues of evidence: how we know what we know, the problems of error, bias, and spin (in the use of composite endpoints, surrogate markers, and subgroup analyses), and selective dissemination of evidence [2]. Using the best evidence to guide the care of patients has received less attention. Shared decision making offers a way of helping clinicians advance the particular situation of each patient.

In this article, we will focus on the role shared decision making plays in the work of the internist, particularly in the care of patients with chronic conditions. The high and increasing prevalence of chronic conditions at younger ages [3] makes the patient with one or more chronic conditions the most common patient an internist is likely to see, and the internist the most valuable clinician for such patients. Internists see patients in other contexts, e.g., patients admitted to the intensive care unit or to hospice. Shared decision making has particular complexities in these and other settings, complexities deserving of their own attention, one they will not get here.

2. Shared decision making as a process of diagnosis and deliberation

A first step in shared decision making is developing a shared understanding between patient and clinician as to what problem requires attention today. This shared understanding is the result primarily of conversations between patients and clinicians. Investigating the patient situation is often easier in the setting of an ongoing relationship of care. This may indeed be one of the key benefits of continuity of care. A relationship of care sets the stage for partnerships between patients and their clinicians with the objective of figuring out what is the situation that demands medical intervention, and what is the action that the situation demands. Indeed, partnership may be a pre-condition toward shared decision making, particularly in the care of patients with chronic conditions [4]. Because shared decision making is about advancing the situation and solving the problems of each patient in respectful conversations with each patient, shared decision making is a hallmark of patient-centered care [5,6].

The process of deliberation that ends with arriving at the best course of action to address the patient situation takes place also in conversation. In this conversation, also known as collaborative deliberation [7,8], patients and clinicians consider alternative options, pertinent evidence-based pros and cons of each and practical considerations that may favor one over the other in terms of their burden to the patient. Some key approaches that make a difference in this process are:

1. Start by making the patient aware that the discussion has as its goal selecting a course of action that is best for the patient. This step, sometimes called choice awareness [9], explains to the patient why options are being discussed and why their attention and involvement are necessary. This step may require a statement that no technically correct answer exists and that the best answers depend on patient values, preferences and context, issues about which the patient is the expert. Also it may prevent the premature closure of the deliberation conversation via a recommendation without patient involvement or discussion.

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2. When presenting options:

   a. Start with issues that distinguish among the options, not with the options. Usually, we would list the options and present for each of them all the relevant attributes. Yet, this presentation is often long, it requires the patient to hold attention through all of it, and to remember relevant attributes to then compare them across options. This is a nearly impossible cognitive task. We have learned [10] that it is better to present issues that distinguish the options and then ask patients to identify the issue that is most salient to them. Then how the options fare on that issue is discussed. If an option emerges as the best, then that option can be explored further in terms of a second issue of relevance. This is reflected in our design of the Depression Medication cards (Fig. 1) [11,12].
   b. When it is important to discuss risk, present the baseline risk for the event of interest and how that risk will change with use of the treatment options. Risks of relevant outcomes to be compared (across options, or between favorable and unfavorable outcomes) should be presented using the same denominator (12 in 100 and 10 in 100 rather than 12 in 100 and 1 in 10). Ideally, risks should be offered graphically and verbally paying attention to present not only the event sufferers but also those that will remain event free (12 in 100 will have an event, 88 in 100 will not) [13]. An example is in Fig. 2.
   c. Highlight uncertainty in your language. Uncertainty often exists around the estimates of benefit and harm. Uncertainties may exist in relation to the credibility of the evidence base, to the precision of the estimates, and to the applicability to the individual patient (am I one of the 12 in 100 that will suffer this event or one of the 88 that will not?). The latter in our view is the biggest uncertainty by far (whether a patient will suffer or not the event of interest or whether they will benefit or not from treatment to prevent that event) and is usually the only one that is worth highlighting ("We cannot tell whether you are one of the 12 or one of the 88").

3. Think out loud together while deliberating. In this process, the patient and the clinician consider the options and how they would impact the patient's life routines and health. This can be thought as trying the options on like one tries clothing on for size and fit at a store. The patient can see to what extent the option will fit their situation and how well it fits compared to the alternatives [14]. As hypotheses get tested using the method of conversation, patients and clinicians persist until they find the option that best responds to the situation and moves it toward resolution [15]. As important as reaching this point, is the journey to it, during which clinicians and patients can deepen their partnership, while they pay close

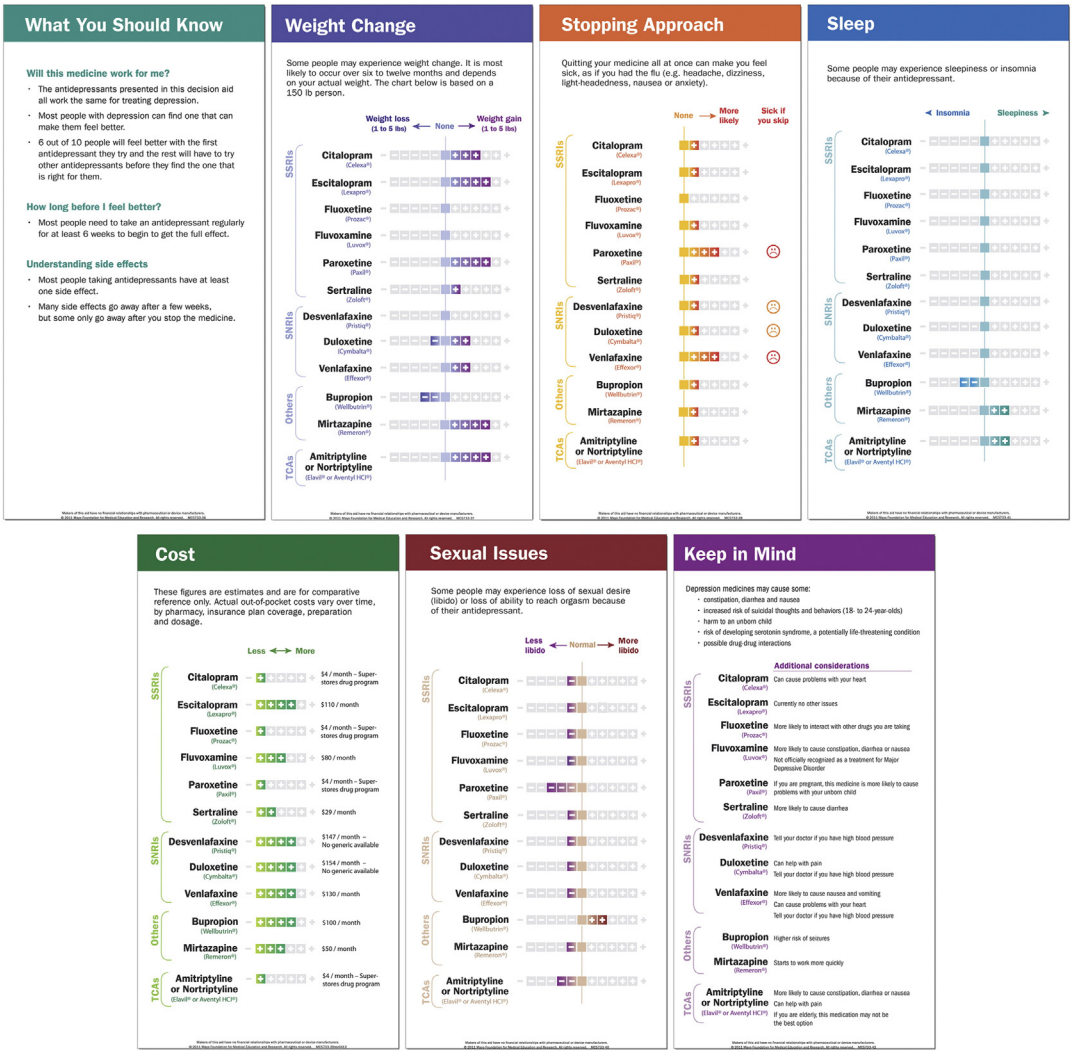

Fig. 1. The Depression Medication cards. An example of issue cards to facilitate shared decision making during the consultation.

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