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Twelve myths about shared decision making

France Légaré [a,b,*], Philippe Thompson-Leduc [a]

[a] Research Centre of the CHU of Québec, St-François d'Assise Hospital, Québec, Canada
[b] Department of Family Medicine and Emergency Medicine, Laval University, Québec, Canada

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ABSTRACT

Objective: As shared decision makes increasing headway in healthcare policy, it is under more scrutiny. We sought to identify and dispel the most prevalent myths about shared decision making.
Methods: In 20 years in the shared decision making field one of the author has repeatedly heard mention of the same barriers to scaling up shared decision making across the healthcare spectrum. We conducted a selective literature review relating to shared decision making to further investigate these commonly perceived barriers and to seek evidence supporting their existence or not.
Results: Beliefs about barriers to scaling up shared decision making represent a wide range of historical, cultural, financial and scientific concerns. We found little evidence to support twelve of the most common beliefs about barriers to scaling up shared decision making, and indeed found evidence to the contrary.
Conclusion: Our selective review of the literature suggests that twelve of the most commonly perceived barriers to scaling up shared decision making across the healthcare spectrum should be termed myths as they can be dispelled by evidence.
Practice implications: Our review confirms that the current debate about shared decision making must not deter policy makers and clinicians from pursuing its scaling up across the healthcare continuum.

1. Introduction

Shared decision making, a process whereby health professionals and patients work together to make healthcare choices, is fundamental to informed consent and patient-centered care [1,2]. In recent years, the number of shared decision making publications in scientific journals has surged. In 2000, 95 publications were indexed with these key words, 203 publications in 2006, and 581 in 2013, or an increase of 611% over a ten-year period, with this journal (*Patient Education and Counseling*) having published the most [3]. Thus, it is no surprise that shared decision making has been making headway in healthcare policy. In 2011, Härter and colleagues inventoried policy-related activities in 13 countries designed to foster shared decision making across the healthcare continuum [4]. In the United States, for example, policy driven initiatives such as the patient-centered medical home and the Affordable Care Act have reinforced the importance of implementing shared decision making across the health care continuum [5]. In the United Kingdom, health authorities have engaged clinical champions and patient representatives in national initiatives for shared decision making and embarked on a process of widely disseminating patient decision aids [6]. In Germany, patient information and shared decision making are embedded in social health insurance programs, since it is the insurers' responsibility to maintain their healthy members in good health as well as treat their members' illnesses [7]. In the Netherlands, the government has emphasized patient experience in its health care programs on a collective level [8].

Notwithstanding these developments, arguments against the scaling up of shared decision making across the healthcare continuum abound. Given its high profile, shared decision making has gained supporters as well as critics. In this paper, we discuss some of the most commonly encountered myths about shared decision making and review the evidence most relevant to these myths.

In preparation for a keynote presentation at the 2013 International Conference in Communication in Health, we selected some of the perceived barriers to scaling up shared decision making found in common arguments, popular beliefs, or anecdotes. We further investigated these perceived barriers by conducting a selective review of the literature that included

* Corresponding author at: CHU of Québec, St-François d'Assise Hospital, 10, rue Espinay, Québec, Québec, Canada. Tel.: +1 418 525 4437; fax: +1 418 525 4194.
E-mail address: france.legare@mfa.ulaval.ca (F. Légaré).

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several systematic reviews on shared decision making related topics in which the first author (FL) was either involved or with which she was familiar [9–17]. Together, these reviews covered over 400 original studies published between 1982 [9] and 2013 [17]. If we found insufficient supporting evidence for the arguments, popular beliefs and anecdotes, we labeled them myths. We thus labeled twelve of the commonly perceived barriers as myths.

2. Twelve myths

2.1. Myth #1: Shared decision making is a fad – it will pass

Shared decision making has been around for a long time. Involving patients was described as one of the dimensions of being a "modern doctor" as early as 1959 in a study by Menzel and colleagues [18]. These authors studied an equal relationship between doctors and patients as an independent variable in the context of the diffusion of innovation such as new drugs. Doctors who were found to exhibit a more positive attitude toward an equal and active role for the patient in his/her relationship with the doctor were more likely to adopt new clinical practices than those who were not. One interview included a particularly forceful expression of a stand in favor of the patient's equality: "The doctor should not be mystical. He should consider the patient as an equal partner—as intelligent as himself—and give the patient a chance to help the doctor by trying to figure out problems together. The patient should have the freedom and the chance to say what he thinks about a certain therapeutic approach." Interestingly, among several types of innovating behavior examined, acceptance of a more equal doctor–patient relationship was the only behavior associated with greater general satisfaction with modern developments in medical practice by the participating doctors.

By 1982, a more equal doctor–patient relationship had moved to being a primary research target (i.e. dependent variable of interest). A US Presidential Commission on medical decision-making ethics recommended shared decision making as the "appropriate ideal for patient–professional relationships that a sound doctrine of informed consent should support" [19]. The Commission's survey revealed that 56% of physicians and 64% of the public felt that increasing the involvement of patients would improve the quality of care, with physicians citing compliance and cooperativeness as the main reasons. Embedded in a shift toward patient involvement and advocacy, shared decision making is increasingly prevalent in health literature [20]. In light of the current trend in patient-centered care and the potential systemic advantages exposed by current shared decision making research, more and more countries are deciding to orient their policy decisions around the patient [4]. The history, relevance and general tendency of patient-centered care and shared decision making clearly demonstrate that shared decision making is not a passing fad, and will play an increasingly important role in the way we think about our health and our relationship with care.

2.2. Myth #2: In shared decision making, patients are left to make decisions alone

The myth that the patient is left alone to make the treatment decision is not supported by the extensive systematic reviews on models of shared decision making and contradicts its core elements [9,10]. Shared decision making is an interpersonal, interdependent process in which the health care provider and the patient relate to and influence each other as they collaborate in making decisions about the patient's health care [21]. The idea of balance and respect between the two partners is fundamental to shared decision making and one of its main purposes is to take advantage of both parties' expertise [22,23]. The degree to which the decision is shared (i.e. whose expertise was explored the most in the medical encounter) varies widely in terms of the condition, the treatment options and the sheer personality of the actors involved, with self-efficacy systematically being a high predictor of engagement in shared decision making [24]. A widely-recognized review of 161 conceptual definitions of shared decision making has identified that clinicians' recommendations and knowledge were essential to shared decision making [9]. The clinician is involved in every step of the decision-making process, from identifying that a decision needs to be made, presenting the evidence and counseling the patient to implementing a strategy with which both parties feel comfortable. Furthermore, an increasing number of studies highlight the important role of the patient's family members (or other companions) when making a health decision and these findings impact the way we measure and conceptualize shared decision making [25,26]. Shared decision making is not, in fact, abandoning patients to make decisions alone, but is rather striving to optimize their expertise in the most supportive environment possible.

2.3. Myth #3: Not everyone wants shared decision making

The preferred and assumed role of patients in the decision making process is often assessed in shared decision making studies and varies according to patients' characteristics and the clinical situation. However, the evidence suggests a clear desire on the part of patients for more information about their health condition [27]. In a systematic review of optimal matches of client preferences about information, decision making, and interpersonal behavior, findings from 14 studies showed that a substantial number of clients (26–95%, with a median of 52%) were dissatisfied with the information given, and would have preferred a more active role in decisions concerning their health, especially when they understood the expectations attached to this role [27]. Moreover, a time trend is observed: the majority of respondents preferred sharing decision roles in 71% of studies dated 2000 and later, compared to only 50% of studies dated before 2000 [28].

This argument may stem from the fact that assuming an active role in the decision-making process remains particularly difficult for vulnerable patient populations [27]. Although such vulnerable patients systematically report less interest in shared decision making, they are the ones who may stand to benefit most from it. If we do not want to exacerbate inequities when implementing shared decision making—that is, only improve outcomes for those who can most easily share decisions, such as the more educated—the process should be at least recommended for all patients, with adaptations to suit individual ability and interest [29,30]. Indeed, a number of studies have shown that even among patients who prefer a more passive role, those who are actively involved in decision making derive the most clinical benefits [27,31,32]. In fact, patients' reluctance to engage in the decision-making process may not reflect a true lack of desire to be involved, but rather a lack of self-efficacy [33]. Therefore, it may be possible to develop tailored interventions to foster shared decision making with vulnerable populations [34]. Ethical and moral principles require that we search for new ways to engage these reluctant patients in shared decision making rather than abandoning the attempt.

2.4. Myth #4: Not everyone is good at shared decision making

Shared decision making is not an inborn talent but consists of specific behaviors that can be taught. It is useful to describe the behaviors expected by both patients and clinicians, notably during a shared decision making encounter [35]. Using socio-cognitive theories, interventions that act on the determinants of shared