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Shared Decision-Making towards a Higher Quality of Care: Is This the Norm?

George Athanasiou and Chris Bachtsetzis

Abstract

Patient-doctor relationship has traditionally been paternalistic, in which the doctor decided on behalf of the patient. It focused mainly between the patient who called for help and the doctor whose decisions had to be silently observed and followed by the patient. In this paternalistic model, the physician used his skills to choose the necessary interventions and treatments that were likely to restore the health of the patient. All the information given to the patient was selected to encourage them to consent to the doctor's decisions. This definition of the asymmetric or unbalanced interaction between physicians and patients has begun to be questioned over the last 20 years. There has been a shift from this direction to one where the patient is more informed, empowered, and independent - a move from a "paternalistic" to a more "complementary" relationship. Critics suggested a more active, autonomous patient-centered role which supports greater patient control, reduced doctors' dominance, and a more mutual participation. This approach has been described as one where the doctor attempts to enter the patient's world to see the disease with the eyes of the patient and is becoming the predominant model in clinical practice today.

Keywords: Shared Decision-Making, Doctor-Patient Relationship, Informed Decision, Patient involvement, Measuring shared decision-making

1. Introduction

The relationship between the patients and the doctors has been dependent through the centuries on the medical situation and the social scene. This relationship was predominantly between a patient seeking help for an illness or symptom and a doctor whose decisions were silently complied with by the patient. The patient-doctor relationship has traditionally been paternalistic, in which the doctor took all decisions on behalf of the patient. Nevertheless, there has been a shift from this direction to one where the patient is more informed, empowered and independent - a move from a "paternalistic" to a more "complementary" relationship. In this 'mutualistic' relationship, the patient is more empowered, informed, and autonomous [1].

This paternalistic doctor-patient relationship focused mainly on the patient, who called for help, and the doctor, whose decisions had to be silently observed and followed by the patient. In this paternalistic model, the physician used his skills

to choose the necessary interventions and treatments that were likely to restore the health of the patient. All the information given to the patient was selected to encourage them to consent to the doctor's decisions. This definition of an asymmetric or unbalanced interaction between physician and patient has begun to be questioned over the last 20 years. The critics suggested a more active, autonomous and, therefore, a more patient-centered role which supports greater patient control, reduced doctors' dominance, and a more mutual participation. This patient-centered approach has been described as one where the doctor attempts to enter the patient's world to see the disease with the eyes of the patient and has become the predominant model in clinical practice today [2].

2. Historic pathway

In Ancient Egypt, the doctor-patient relationship was that of a priest-suppliant relationship, retaining the ideology of a parent-figure to manipulate events on behalf of the patient [3]. Such healers used rationality, theology, magic, and mysticism in their care of external and visible disorders. This type of relationship may be defined as activity-passivity type of relationship. This relationship was not changed for years, as there were no technical advances or the appropriate social circumstances to require such a change. During the Greek enlightenment in the 5th century BC, medicine shifted to a naturalistic observation with the elements of trial and error. Based on the Hippocratic Oath, the doctor provided regimen which had to be to the benefit of the patient, irrespective of gender and age. The needs, the well-being and the best interest of the patient were above the doctor's self-interest, respecting confidentiality. This doctor-patient relationship under the Hippocratic approach was based on a guidance-cooperation and mutual participation. During the Medieval times, the doctor, was in a glorious, high ranking position in society, filled with magical powers. The patient was regarded as helpless infants. The relationship between doctor and patient weakened and deteriorated and resembled the activity-passivity model of the ancient times, with the era of witch hunting and incarcerating the mentally ill [2].

The social and cultural changes brought in the transition period of the Renaissance movement and the period towards the French Revolution encompassed innovative flowering of an increased demand for equality, liberalism, and dignity. This, inevitably, led to changes in the doctor-patient relationship from the activity-passivity model to a more guidance-co-operation model [2, 4].

In the 18th century, Medicine was based on symptoms and thus the model of illness was developed. Hospitals emerged to treat ill patients following the foundation of professional nursing by Florence Nightingale. With the development of microbiology and surgery, Medicine focused, not on the symptom but the biomedical model of diagnosis. The expert clinical and anatomical knowledge, the knowledge of the patient's body and the necessity of physically examining the patient, evolved the doctor as an active participant, with the patient becoming more dependent as a result. The relationship resulted in a dominant doctor and a passive patient, i.e. an activity-passivity (paternalistic) model [2].

3. Doctor-patient relationship: the models

There are three models of the doctor-patient relationship as proposed by [4]:

The model of activity-passivity: A paternalistic model with limited interaction, as the patient is unable to actively contribute, as they are regarded as helpless

requiring the doctor's expert knowledge. Treatment is commenced "irrespective of the patient's contribution and regardless of the outcome". This doctor-patient relationship focused mainly between the patient who called for help and the doctor whose decisions had to be silently observed and followed by the patient. In this paternalistic model of doctor-patient relationship, the physician uses his skills to choose the necessary interventions and treatments that are likely to restore the health of the patient. All the information given to the patient is selected to encourage them to consent to the doctor's decisions.

The model of guidance-co-operation: This takes into account that, despite the fact that the patient is ill, they are conscious and thus have feelings and aspirations of their own. The patient is, therefore, ready, and willing to "cooperate" and obey to their guidance without question.

The model of mutual participation: This model, also advocated by [5], considers that the doctor does not know exactly what is best for the patient. It is argued that there is an equal interaction between the doctor and the patient, having equal power, mutual independence, and equal satisfaction with mutual participation between this relationship. This model has elements of mutual and equal partnership, without power or control of any member of this relationship upon the other. This gives a greater emphasis on patient-centered medicine.

4. Patient-centeredness

As suggested by [6] the patient-centered medicine is a "two-person medicine" with both the doctor and the patient having their integral part in this relationship, and cannot be considered separately, as they are influencing each other all the time. Mead and Bower [7] underline that a large number of variables can potentially influence the patient-centeredness. The so-called "shapers", these variables may impact this relationship. Such variables include cultural norms, socioeconomic background, and societal expectations, such as norms relating to gender, the medical training of doctors, etc. For example, it is more socially acceptable for females to discuss feelings and emotions than males. On the other hand, ethnic differences, presence of third parties, workload pressures or time-limitations may create barriers to effective communication and limit possibilities for full negotiation in this doctor-patient relationship.

5. Shared decision-making process

In recent days, there is a shift of interest and additional research on this new doctor-patient relationship. This new alliance is based on co-operation rather than confrontation, in which the doctor must "understand the patient as a unique human being" [8]. Thus, patient-centered care has replaced the one-sided, doctor-dominated relationship in which the exercise of power distorts the decision-making process for both parties. This decision-making is based on a two-way process in which both the patient and the doctor share the information and the responsibility for decision-making. It applies to most visits, as the majority of treatment decisions include several options, even if one of the options is a no-action or non-treatment. The shared decision-making (SDM) process has begun to be at the center of health-care. Coulter and Collins [9] define SMD as *a process in which clinicians and patients work together [...] sharing information about options [...] with the aim of reaching mutual agreement on the best course of action.*

SDM includes at least one patient and one healthcare provider. Both parties take steps to actively participate in the decision-making process, share information and

personal values, and together they come to a shared responsibility decision [10, 11]. This process is indicated when there are multiple possible treatments and the alternatives have different and uncertain results, as is the case of most chronic diseases or if the outcome of the treatment is considered to be subjectively significant [12]. Furthermore, it might help the patient and the healthcare professional to conclude to a mutual agreement on treatment or other long-term decisions [13]. Chwening et al. [14] argue that greater patient involvement in management decisions is associated with fewer conflicting decisions, which can be considered moderate to patient satisfaction. SDM is associated with feelings of autonomy, control, and individual capacity from the patient. Actions for the implementation of SDM are becoming increasingly important and their results should be evaluated and measured.

5.1 The stages of SDM

Elwyn et al. [15] define SDM with the following steps:

1. Definition/explanation of the problem in simple terms
2. Presentation and explanation of the different possible management options - this should include all possible choices, including no decision-making or watchful waiting. The patient should know an equipoise or equilibrium position where there is no right or wrong decision, only a preferred option.
3. Discussion of the benefits/disadvantages (benefits/risks/costs) - these should be explained along with all possibilities (if known), so as the patient can weigh their options.
4. Clarification of patient preferences - the attitudes, concerns and expectations of each individual should be explored.
5. Discussion of the patient's capacity - the patient should be aware that he/she does not need to make the decision on his/her own, but that family members or friends are invited to participate, as appropriate. The doctor should support the decision-making process so that the patient does not feel destitute.
6. Presentation of the data (what is known) and recommendations - the physician should present the available data through his/her clinical experience and advise the patient in the joint decision-making process.
7. Clarification and checking the understanding of the patients - the patient should have the opportunity to ask questions or ask for more information if necessary.
8. Discussion about possible postponement of the decision - Some patients will make the decision at this time. For others, it may be better to make a decision at a later stage until all possible options are considered without time pressure. It should be possible to re-examine the problem at a later stage (e.g. at the next appointment).

5.2 The pros and cons

The perceived potential benefits when applying SDM are multiple and include the improvement of patient's knowledge and self-esteem, even though not all of

them are conclusively proven. It also improves patient's risk perception and reduces their anxiety. It is worth noting that the main drawbacks cited are usually based on clinicians' perceptions rather than an evidence base. Not all patients request it and not all consultations are suited to such approach as it takes more time and requires special training from the doctor's side [16].

A recent systematic review by [17] looked into the barriers and facilitators of SDM in clinical practice. It was found that the most commonly identified facilitators were positive impact on the clinical process, provider motivation, and positive impact on patient important outcomes. On the other side, common barriers were time constraints, lack of applicability due to the characteristics of the population, and the clinical situation.

6. Is shared decision-making the norm nowadays?

If the benefits of SDM are not conclusively proven, with not all patients wanting it and being potentially time consuming, why are doctors encouraged through the health systems to engage in such a practice? Whether research findings are conclusive or not, there are some other convincing reasons. In the UK, practicing SDM is supported and encouraged by the General Medical Council, General Dental Council, and government policy. It is considered as an ethical and legal imperative and underpins government legislation [18]. The National Health System (NHS) of the UK, has recognized the importance of patient involvement in treatment decision and adopted SDM into the redesigned health-system through a recent Health and Social Care Act. The government has provided the legislation for SDM to become the norm. With the mantra 'no decision about me without me', SDM is now a statutory requirement for the commissioning board of the NHS and local clinical commissioning groups [19, 20].

In order to support developments in this area, a Shared Decision-Making Collaborative has been established in 2015. It comprises members from the statutory sector, patient and voluntary sector organizations and academia committed to thinking collectively about the role of SDM in UK health systems [21]. Throughout Europe there is an increasing awareness that patients should be allowed to play a crucial role in decision-making and care management. WHO is encouraging SDM practices as innovative strategies to support patient-centered health services and promote patient rights [22]. WHO indicates that most research on SDM in Europe has occurred in Northern European countries, however, the SDM approach may fit also the Mediterranean region with different socioeconomic and cultural factors and lower degree of patient empowerment and communication.

SDM is of international importance and is currently promoted in many health systems. The reasons for these changes include the expansion of patients' knowledge on different conditions and treatments through the internet and mass media and the increasing number of therapeutic options available. The increased preference for more active patient involvement, by both, the patient and the physician is also a key factor [23]. According to [24] SDM requires collaboration between patients and healthcare professionals who work together to select the appropriate management, treatment and support, based on patient preferences and needs, physician experience and evidence-based data. It can improve patient involvement in healthcare and help provide effective services.

One recent study by [25] on SDM in mental health services, reveals that this application is a continuous, dynamic, and difficult process that requires every mental health professional to internalize his characteristics, facilitate patient involvement, and create a culture of trust in the management process of treatment.

It is reported that SDM balances the power and responsibility for creating safe care. This balance requires continuous thinking and evaluation of patient resources, constraints and need for assistance to give them the power (patient empowerment) and responsibility to be able to manage the different needs during various phases of illness and management. The patient's functionality may change over time, so, in order to ensure safe care, mental health professionals must always compensate for the strength and responsibility that the patient cannot maintain.

The main provisions for the implementation of SDM are that health professionals recognize that different medical situations require different approaches, as well as accepting SDMs as a key element of good practice [26]. It is understandable that healthcare professionals know that facilitating patient participation is important, as many patients either do not want to, or, are unable to participate in the recovery process. Grol et al. [27] report that patients need flexible services to accommodate their changing needs. It was argued that when patients have severe symptoms, they need care and less responsibility. When they have fewer symptoms, there is a growing need for empowerment, active participation, and more responsibility for decision-making. Most patients want to be more informed about their health status, investigation, and management options than they are routinely given by health professionals, and many would like a greater share in the process of making decisions about how they will be treated. Bastiaens et al. [28] have shown that, patients are dissatisfied when they are not being properly informed about their condition and the options for treating it. However, not all patients want to share in making the decisions. For example, older people or those with life-threatening conditions tend to be more likely to prefer to delegate decision-making to the doctor as described by [29].

As suggested, different cultures or settings may influence the degree of patient involvement in decision making. A survey [29] showed that a more paternalistic view of the doctor-patient relationship prevailed in Poland and Spain than Germany, Italy, Slovenia, Spain, Sweden, Switzerland and the United Kingdom. 91% of Swiss and 87% of Germans felt that the patient should have a key role in their management decision, either by sharing responsibility with the doctor or by being the primary decision-maker. This percentage was much lower in Polish and Spanish patients - 59% and 44% respectively.

Clinicians should always try to find patient preferences through effective communication. Stevenson et al. [30] highlighted that they need to encourage patients if they are to play an active role in decisions about their care. As a result of this encouragement, patients become more involved, their knowledge improves, their anxiety lessens, and they feel more satisfied. Encouraging patients to play an active role in decisions regarding their healthcare can ensure better compliance to their treatment and management appropriately tailored to the individual.

6.1 How to evaluate the process of shared decision-making

SDM can be categorized and evaluated at its various stages, namely, before the decision (e.g. role preferences), during the decision-making process (e.g. observed or perceived physician behavior) or the outcome of decisions (e.g. conflict of decisions, satisfaction). The process may also be evaluated by an external observer, the patient, or the physician. Measuring SDM using observational tools is laborious, costly and not conducive to rapid data feedback.

The OPTION instrument ("Observing Patient Involvement in Decision Making") is an important tool for assessing the extent to which clinicians actively involve patients in decision-making [31]. Barr et al. [32] emphasize that this is the most frequently used instrument for measuring patient involvement from an observer's viewpoint. It has been developed to evaluate shared decision making specifically in

the context of general practice, but it is intended to be generic enough for use in all types of consultations in clinical practice. The OPTION scale is designed to assess the overall shared decision-making process. In summary, it examines whether problems are well defined, whether options are formulated, information provided, patient understanding, and role preference evaluated, and decisions examined from both the professional and patient perspectives [33]. Recently it has, been revised in a shorter form, which evaluates the SDM process from its observer's viewpoint to just five OPTION-5 elements. Another way to measure and evaluate SMD is the CollaboRATE scale [34]. This is a fast and frugal a three-item patient-reported measure of SDM. It is applicable to a wide range of clinical settings, especially in the primary care setting where varied and unanticipated decisions are made [35, 36].

However, there are only two ways to evaluate the perceptions of both the patient and the doctor using the same process and these are (a) the dyadic OPTION [37] and the SDM-Q-9 [38, 13]; the latter is a 9-point decision-making evaluation questionnaire was developed on a case-by-case basis and measures the extent to which patients are involved in the decision-making process: from the view of the patient (SDM-Q-9) and from the physician's perspective (SDM-Q-Doc). These two tools have been developed for use, both, in research and every-day clinical practice. Both versions can be applied equally for purposes of assessing and improving quality in healthcare.

7. Conclusion

SDM enables the voice of the patient to be heard and considered that his views are significant even at various different stages of the condition. Through this, the patient becomes more autonomous with an active role in his management. By participating in this two-way relationship, the healthcare professionals may interact better with the patient in different situations, with different levels of involvement. By recognizing the importance of patient's involvement process, the healthcare professional confirms that the patient is an important role-player in the process, ie that he is autonomous and equal, transferring the respect and dignity necessary for the balance between power and responsibility. When a healthcare professional encourages their patient's involvement and recognizes the importance of the patient's involvement process, then they are more likely to engage them positively in their own care. Creating a culture of trust is essential to enable the therapeutic environment as a whole to balance the power and responsibility for creating safe care. SDM is considered both, as a philosophy and a process that leads to better-quality care, ensuring that patients receive the 'care they need and no less, and the care they want and no more'. It is believed that many clinicians are already informally engaging patients in SDM without formally recognizing the name or details of the process.

However, more research and evidence are required to ensure that SDM is being routinely used in either primary care or hospital consultations, despite the fact that healthcare professionals believe they are engaging patients in their treatment decisions. Research suggests that SDM does influence the way patients consider treatment decisions and may have a positive impact on outcomes, as it improves compliance and adherence. It is imperative to involve patients as equal partners in healthcare, as part of healthcare professionals' legal and ethical obligation.

Acknowledgements

We would like to help Mr. Sozomenos Hadjivassiliou for his contribution and editing in this work.

Conflict of interest

The authors declare no conflict of interest.

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