PERSPECTIVE

Shared Decision Making: A Win-Win Situation for Both Patients and Physicians

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INTRODUCTION

Shared decision making (SDM) is a bidirectional, interactive approach that provides a structured pathway for physicians to collaborate with patients to arrive at healthcare decisions based on their goals, preferences, and values.[1] In many clinical situations, the decision-making process is not always straightforward, as there are multiple reasonable options from which to choose. Even for experienced clinicians, determining the most appropriate medical or surgical treatment to optimize outcomes can be complex. The traditional approach of decision making is unidirectional, in which the clinician makes the final decision and presents it to the patient. Even if patients are well-informed, their involvement may be limited to providing consent, which may or may not necessarily involve adhering to the recommendations. Most patients prefer active involvement in their medical decision making. Indeed, many patients perceive that physicians make the decisions more often than they prefer.[1] By collaborating with patients to analyze the potential benefits, risks, alternatives, and outcomes, physicians can empower patients to make evidence-based and value-congruent medical decisions.

BENEFITS OF SHARED DECISION MAKING

SDM is an invaluable tool that allows physicians to understand patients as individuals first to provide safe patient-centered care. According to a study published in *JAMA*, SDM has been associated with high patient satisfaction and treatment adherence.[2] The patients engaged in SDM rated their physicians more positively and were less likely to find them liable for any adverse outcomes compared to those who did not participate in SDM.[3] SDM is crucial in situations where patients need to weigh the benefits and risks of treatment and make an informed decision about whether to pursue treatment. For instance, a patient with atrial fibrillation may face the decision of starting anticoagulation when they have a high risk of bleeding but also a high CHA2DS2-VASc score. SDM helps to elicit the patient's and family members' preferences and weigh the risks of bleeding and thromboembolic stroke

to make an informed treatment decision. This interactive approach allows physicians to better understand the patient's preferences and values, leading to improved communication, trust, and ultimately better health outcomes.[2,4] One study showed that discussing healthcare priorities and goals with older adults can lead to a better professional relationship between physicians and patients.[5] By taking the time to engage in SDM, clinicians can strengthen their relationships with their patients' families as well. Further, research has demonstrated that facilitating SDM can lead to improved patient outcomes and quality of life.[4,7] A meta-analysis found that SDM has a remarkable impact on increasing patient knowledge and reducing decisional conflict.[6,7]

POTENTIAL CHALLENGES TO PRACTICING SHARED DECISION MAKING

In clinical practice, time constraints are often the major obstacle to executing SDM. [8] Primary care physicians (PCPs) were estimated to invest 26.7 h/day to provide guideline-recommended care, 14.1 h/day for preventive care, 7.2 h/day for chronic disease care, 2.2 h/day for acute care, and 3.2 h/day for documentation and inbox management.[7,9] It is challenging to listen to patients, address all their needs and emotional concerns, and help them make informed decisions that align with their core values and preferences within a 15- to 20-minute visit. In contrast, some patients may perceive SDM as time-consuming and prioritize other aspects of their appointments. Patients may not feel comfortable asking many questions. The presence of undiagnosed cognitive impairment in elderly patients can be an obstacle for SDM during clinical encounters. Disabling hearing impairment can sometimes be mistaken for cognitive impairment. Clinicians may perceive advanced age as a barrier to patient participation and understanding of SDM, inadvertently adopting a paternalistic approach in clinical practice. Additionally, low health literacy is highly prevalent among older adults, which can impede SDM discussions. There are very few clinical trials so far that have included geriatric patients. Our elderly patient population is diverse, ranging from highly independent individuals to those with multimorbidity who require significant assistance from others for daily activities. SDM is crucial for the geriatric population with multiple chronic conditions because the optimal treatment for each disease may not be the best approach for the elderly patient. Therefore, conversations between elderly patients with multimorbidity, their caregivers, and medical teams should not solely focus on treating each medical condition. Rather, SDM should emphasize preferred health outcomes, patient preferences, and values to guide discussions and treatment options.

CONCLUSION

Shared decision making has been shown to provide remarkable advantages for patient satisfaction, quality of life, and outcomes. Clinicians should consciously integrate it into their clinical practice. SDM reflects patient-centered care, which is a fundamental principle of our healthcare system to deliver evidence-based management to patients.

Notes
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