

## CORRESPONDENCE

### Outcome-Relevant Effects of Shared Decision Making—A Systematic Review

by Katarina Hauser, MSc, Dr. phil. Armin Koerfer, Dipl.-Stat. Kathrin Kuhr, Prof. Dr. med. Christian Albus, and Prof. Dr. med. Stefan Herzig, PD Dr. med. Jan Matthes in issue 40/2015

#### Shortcomings in Education and Training

Perhaps we are nowadays more rationally thinking “physicians” than “real doctors”, almost pure natural scientists. Perhaps we only think about the diagnosis and the latest treatment trials and no longer about the patients’ understanding, wishes, or self-determination? The article by Katarina Hauser and colleagues, who likely had the good intention of opening the eyes and hearts of physicians to the need of involving patients in the diagnostic and therapeutic decisions, is rather difficult to read and ultimately is of low yield (1).

The unsatisfactory conclusions of this contribution are not surprising. There are after all different types of patients. Some prefer a detailed explanation and may raise many personal objections—which can be based on highly competent and justifiable concerns, or on less important reasons. Others do not want any part in shared decision making. They need confidence and are unsettled by information sheets, signatures, or detailed verbal advice. Therefore, physicians should simply develop a sense for this. This can and should begin during their studies—in lecture halls, during internships, and at bedsides—and should be transmitted to the assistants by the chief and senior physician visits, with constant reinforcement.

Intensive courses that teach the necessity of involving patients in patient-relevant decisions are, in my view, second choice at best (2). On the other hand, this probably can be taken as an admission of shortcomings in the education and training of young doctors—not only in their curriculum, but also in the personal role models displayed by many chief and senior physicians.

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#### REFERENCES

1. Hauser K, Koerfer A, Kuhr K, Albus C, Herzig S, Matthes J: Outcome-relevant effects of shared decision making—a systematic review. *Dtsch Arztebl Int* 2015; 112: 665–71.
2. Härter M, Buchholz A, Nicolai J, et al.: Shared decision making and the use of decision aids—a cluster-randomized study on the efficacy of a training in an oncology setting. *Dtsch Arztebl Int* 2015; 112: 672–9.

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#### Consensus About Objectives

I do not agree with the authors (1) that shared decision making (SDM) should primarily be used to improve patient-relevant, disease-related endpoints. According

to international consensus, the aim of SDM is to reach “informed decisions”—that is, decisions based on complete information about all alternatives, including doing nothing, which reflect the subjective preferences of patients (2, 3).

The authors consider surrogate endpoints, the validity of which is either not, or not consistently given, as relevant for patients; this includes for instance HbA<sub>1c</sub> in type 2 diabetes mellitus, total cholesterol and LDL cholesterol after acute coronary syndrome, adherence of patients with bronchial asthma, or blood pressure in arterial hypertension. In particular, only increasing adherence or compliance cannot be, in my view, the purpose of SDM.

It is unclear why, of all terms, the MeSH term “shared decision making” was not considered in the literature search. Likewise, it is unclear why “decision aids” (or “patient decision support technologies”) were excluded (for instance, see [4]).

I completely agree with the authors, however, that the theoretical concept of SDM should be clarified, and that a consensus about the objectives (and objectives criteria) should be reached.

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#### REFERENCES

1. Hauser K, Koerfer A, Kuhr K, Albus C, Herzig S, Matthes J: Outcome-relevant effects of shared decision making—a systematic review. *Dtsch Arztebl Int* 2015; 112: 665–71.
2. Marteau TM, Dormandy E, Michie S: A measure of informed choice. *Health Expect* 2001; 4: 99–108.
3. Sepucha KR, Borkhoff CM, Lally J, et al.: Establishing the effectiveness of patient decision aids: key constructs and measurement instruments. *BMC Med Inform Decis Mak* 2013; 13: 12.
4. Stacey D, Legare F, Col NF, et al.: Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2014; 1: CD001431.

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#### In Reply:

We thank the authors for their comments. As rightly pointed out, it becomes more and more difficult to cope with both the growth of increasingly complex scientific findings and the need for (and the right to) comprehensible and useful information for patients. It is hoped that the upcoming generation of doctors will be (even better) prepared for these challenges, as the necessary skills have recently been described in the catalogue of National Competency-based Learning Objectives for Undergraduate Medical Education (*Nationaler Kompetenzbasierter Lernzielkatalog Medizin*, NKLM; see [www.nklm.de](http://www.nklm.de)) and approved by the German Medical Faculty Association (*Medizinischer Fakultätentag*) (1).

The criticized “low yield” from reading our article may reflect expectations typical for physicians, i.e. primarily “science-focused” and thus not (well) suited for our topic. Similar to research in medical education, it is particularly difficult to generate clear, undistorted and transferable results in clinical research on communication, approaches, and attitudes; however, such results are essential to complement, and perhaps confirm or revise, experience-based practices in everyday clinical settings.

We agree with the view that it is not the primary aim of shared decision making to be “therapeutic”. However, there is strong evidence—as also shown in our review—that shared decision making not “only” meets the needs of patients for participation and enables them to make informed decisions, but also optimizes (or even permits) therapeutic success. The discussion initiated here about the validity (among other issues) of surrogate parameters needs to be continued in a critical manner, which is however beyond the scope of this reply.

In our article, we described how we selected the endpoints that we considered (2). Here, we would like to “defend” only the consideration of adherence. Firstly, adherence has been associated with improved therapeutic success (and even with decreased mortality). Secondly, adherence is significantly affected by physician–patient communication (3–4).

We have already justified not using the MeSH term “shared decision making”, this can however be seen as a limitation of our study.

We would like to clarify, that studies in which decision aids were examined were only excluded if their

use was the only difference between control and intervention groups. It is not called into question the effectiveness of decision aids.

The reactions of readers of *Deutsches Ärzteblatt International* shows that having a reasonable and scientifically-based patient participation is an issue of concern not only for us. A critical discussion—even beyond “solid evidence”—is an essential part of this process.

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## REFERENCES

1. Fischer MR, Bauer D, Mohn K: Endlich fertig! Nationale Kompetenz-basierte Lernzielkataloge Medizin (NKLM) und Zahnmedizin (NKLZ) gehen in die Erprobung. *GMS Z Med Ausbild* 2015; 32: Doc35.
2. Hauser K, Koerfer A, Kuhr K, Albus C, Herzig S, Matthes J: Outcome-relevant effects of shared decision making—a systematic review. *Dtsch Arztebl Int* 2015; 112: 665–71.
3. Matthes J, Albus C: Improving adherence with medication: a selective literature review based on the example of hypertension treatment. *Dtsch Arztebl Int* 2014; 111: 41–7.
4. Simpson SH, Eurich DT, Majumdar SR, et al.: A meta-analysis of the association between adherence to drug therapy and mortality. *BMJ* 2006; 333: 15.
5. Martin LR: Barriers and keys to treatment adherence and health behavior change. In: Martin LR, DiMatteo MR (eds.): *The Oxford handbook of health communication, behavior change, and treatment adherence*. Oxford: Oxford University Press 2014; 9–20.

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## Conflict of interest statement

The authors of all contributions declare that no conflict of interest exists.