Teaching shared decision making

An essential competency

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The goal of health care is to improve patients' outcomes. To achieve this, it is important to foster in learners the ability to provide patient-centred care. Promoting health care that is relevant to patients, using tools like shared decision making (SDM), can lead to positive outcomes.[1] As teachers and clinicians, physicians need to learn to shift the focus from disease-oriented outcomes to patient-oriented outcomes, toward care that matters. First and foremost, health decisions must make sense for the patient.

Shared decision making is "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences."[2] It requires not only sharing information, but also guiding patients in their efforts to make sense of the meaning of that information. It is important to master the ability to elicit patients' values and preferences and share information in a meaningful way, particularly when there is a fine balance between benefits and harms.

Shared decision making is linked to evidence-based health care (EBHC) and minimally disruptive medicine (MDM). Minimally disruptive medicine is the concept of "professionals work[ing] with patients and caregivers to design care that advances patient goals with the smallest possible healthcare footprint on their lives."[3] Teaching SDM relates to these concepts. In fact, the fourth step of EBHC—to apply evidence in practice—has always been thought of in the spirit of SDM. More than 10 years ago, this step was described as containing different tasks: individualizing evidence; explaining options; eliciting preferences; and considering management tasks.[4] In fact, SDM and MDM are tools to achieve true evidence-based care.

These concepts should be the new standard of care. Unfortunately, this is not yet a reality, but we need not wait before teaching SDM. It is an inherent part of the communicator role of the CanMEDS competency framework.[5]

Evidence and best practices

In teaching SDM, like any other domain in health care, physicians have to pay attention to knowledge, attitudes, and skills. While the focus is often on skills, the others are also important.

Teaching has to foster knowledge of the goal and principles of SDM. Some learners are not aware of SDM and practise as if they should ultimately make every decision. While this might be true in some aspects of care (eg, in some urgent circumstances), many other aspects of care should involve SDM. These include screening decisions, decisions about prophylactic medications, decisions on nonurgent care, and decisions regarding different approaches that have different potential benefits and potential harms (eg, menopausal symptoms can be treated with exercise, natural products, or different medications). Consistently highlighting opportunities for SDM will help learners recognize the practical value of that approach.

There is no best way of teaching SDM. The core competencies required for SDM include skills in risk communication, eliciting patient preferences, and clarifying patient values. The use of specific decision aids is likely to increase the adoption of SDM in practice[6]; therefore, teaching how to use these tools should be part of the curriculum.

One of the known barriers to SDM is the belief that *the patients want me to decide for them*. To address this, physicians should regularly discuss with learners issues surrounding patients' self-determination. This can be embedded into any presentation about any topic. For example, having reviewed the investigation and treatment of a patient with diabetes, you can offer a straightforward clinical case and ask your students to provide a plan. You then gradually make your learners aware of specific aspects of the life of this patient (eg, wife is in palliative care, patient just lost his job, etc). Subsequently, ask the students to reflect on how the *evidence* can now be seen in light of the new information. The ultimate goal is for the students to acknowledge the importance of the patient's values and preferences in decision making (**Box 1**).[7]

The other often-cited barrier is that SDM takes time. In fact, the median effect on the length of the consultation is just an additional 2.5 minutes.[8] Role-play is very interesting and formative in teaching SDM in that it helps learners develop the necessary skills. When using role-play scenarios, do not hesitate to time the discussions and let your learners realize that the interaction was meaningful and not so long.

Shared decision making should be part of an EBHC curriculum. Every EBHC session should finish with a discussion about what the information might mean to patients and how to explain this to the next patient with a similar problem (this step of an EBHC approach is often forgotten). A simple exercise is to have learners make a conversation aid and then reflect on how they prioritized and framed information they chose to put in their tool.

Box 1. Example of a potential conclusion to a diabetes talk: *This framework can be used for various talks on different topics.*

Conclude with ...
So, you have learned about the different medications we can offer a patient with diabetes but ...

Ask them ...
What do you think should drive the choice of medications?

Learners might bring up the following points; if not, make sure you talk about them
Evidence of efficacy
- Try to stimulate reflective learning: Efficacy for what health outcome?
- Bring forward the concept of patient-oriented outcomes and that various outcomes might be weighted differently by different patients

Drug coverage or other aspects of accessibility
- Make them reflect: Financial cost is one issue, but can there be others?
- Give examples if they are not forthcoming (eg, physical, geographical, or cultural barriers in accessing care)
- Make the link with the notion of burden of care (see minimally disruptive medicine)

Values and preferences
- Give them an example by showing a decision aid to help make an informed decision about which diabetes medication should be next (eg, Mayo Clinic decision aid[7])
- Depending on the time, the size of your class, and the level of the learners, have them role-play a discussion about a diabetes medication choice
  -One fun way of doing this is giving the mock patients a scenario with specific issues
  -You can then guide the learners to reflect on how people can make different choices depending on their life circumstances

Shared decision making involves different steps (**Box 2**).[9-11] As a teaching aid, some teachers have used reminder cards that learners can carry with them. Others have used these steps to provide structured feedback.

Conclusion

Shared decision making is a teachable skill.[12,13] In order for it to become integrated into practice, it needs to be an essential part of all teaching, not just a stand-alone curriculum. Similar to any other topic, using multimodal activities is likely more efficient for learning. **Box 3** lists different ideas for possible activities.[14]

Box 2. Steps of shared decision making

1. Acknowledge there is a decision to be made
2. Present options and alternatives:
   - avoid framing effect*
   - avoid applying your own values
   - use appropriate decision aids
3. Discuss potential risks and potential benefits of each option:
   - use absolute risk numbers
   - use similar denominators for potential benefits and potential harms
   - use natural numbers (eg, 1 out of 100 people instead of 1%)
4. Discuss patient values and preferences in light of that information
5. Discuss the effects of different options on the patient's daily life and goals
6. Offer information on specific issues that might still be needed to help the patient reflect
7. Ascertain the patient's concerns and clarify understanding
8. Make a plan and organize follow-up if needed

*Framing involves presenting information in a manner that can influence perceptions of the value of different alternatives or of the benefit and harms.
Inspired by the Agency for Healthcare Research and Quality,[9] Mincer et al,[10] and Wexler.[11]

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Competing interests
None declared

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Box 3. Specific activities for teaching SDM

Role-play
- Pair 2 learners, one being the patient, the other the clinician
- Group 3 learners, with one learner as an observer; this person could be given specific points to report on

Practise the use of decision aids
- Use a role-play scenario or as a presentation to a group
- Potentially ask different groups to use different tools

Practise values clarification
- Have learners elicit values and preferences, starting from a specific scenario
- Use a written exercise or a role-play scenario, or be the patient and have learners ask you different questions
- Foster a reflection on what questions were more useful and why
- Discuss the difficulty of accepting a decision that might not reflect our own values

Have learners make a conversation tool or a decision aid
- Use an empty tool (eg, an empty drug fact box) and give learners information they need (eg, an RxFiles table)
- Discuss what they have highlighted in their tool and why
- Provide structured feedback using some of the criteria from the International Patient Decision Aids Standards Collaboration[14]

Discuss the framing effect
- Make learners play with different ways of presenting information (percentages, number needed to treat, relative risk, etc) and foster reflection

Use videos
- Highlighting the steps of EBM from a video example.
- Watch a video of a learner's interaction with a specific patient

Use the steps of SDM in a structured way to give feedback
- Embed these steps in your daily or weekly learners' feedback forms

Tackle the formal teaching
- Ask that information be presented in absolute risks in the different activities
- Aim to include some reflection on what the information discussed might mean to patients at the end of many (if not most) lectures

EBM—evidence-based medicine, SDM—shared decision making.

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Tools and resources

Canadian Family Physician Prevention in Practice series: **www.cfp.ca/content/by/section/Prevention%20in%20Practice**

Ottawa Hospital Research Institute's "Ottawa Decision Support Tutorial": **https://decisionaid.ohri.ca/ODST**

Association of American Medical Colleges "Shared Decision-Making Toolkit: Train-the-Trainer Tools for Teaching SDM in the Classroom and Clinic": **www.mededportal.org/publication/9413**

Ottawa Hospital Research Institute's patient decision aids: **https://decisionaid.ohri.ca**

O'Connor, Stacey, and Jacobsen. Ottawa Hospital Research Institute & University of Ottawa. "Ottawa personal decision guide for people making health or social decisions": **https://decisionaid.ohri.ca/docs/das/OPDG.pdf**

Canadian Task Force on Preventive Health Care: **https://canadiantaskforce.ca**

International Patient Decision Aids Standards Collaboration *Criteria for Judging the Quality of Patient Decision Aids*: **http://ipdas.ohri.ca/IPDAS_checklist.pdf**

Teaching tips

▸ Some myths and barriers need to be addressed in order for learners to embrace shared decision making (SDM) in practice. Make specific messages part of formal and informal teaching.

▸ Using role-play will help learners feel confident in their SDM abilities. It is an unavoidable part of SDM teaching, but there are also other tools.

▸ Ask learners to advise you when they will see a patient with whom they will discuss a specific issue (eg, screening or preventive medication). Specifically listen to them and give them structured feedback using the SDM steps.

▸ Try not to limit your teaching to knowledge of specific illness issues. While this will always be important, make sure to embed SDM in case discussions.

Teaching Moment is a quarterly series in *Canadian Family Physician*, coordinated by the Section of Teachers of the College of Family Physicians of Canada. The focus is on practical topics for all teachers in family medicine, with an emphasis on evidence and best practice. Please send any ideas, requests, or submissions to **Dr Viola Antao,** Teaching Moment Coordinator, at **viola.antao@utoronto.ca.**