Shared Decision-Making and Self-Management in Health Care

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There is increasing interest in shared decision-making (SDM) by patients, health care professionals and policy-makers. Woolf reports that "patients increasingly seek more active participation in health care decisions and many groups have called for a shift toward more meaningful dialogue between patients and physicians."¹ However, although shared decision-making is advocated as the preferred form of health care decision making, it is rarely observed in practice.²³

Shared (also described as informed) decision-making demands that patients have a clear understanding of their health care issues, the various treatments that are available, what the expected outcomes of treatment should be, and the ability to adequately frame their expectations in terms of their own personal value system. This places a huge obligation on patients to be able to interpret vast amounts of clinical information, including a significant measure of inherent uncertainty. It is no wonder that many patients relinquish their decision-making autonomy to a strong, paternalistic health care professional.

This becomes particularly confusing and complicated when decisions are preference-sensitive. Some health care professionals, including medical physicians and doctors of chiropractic, have been known to recommend patients follow treatment options that are opposed to the patient’s preferred choice, often leading to patient dissatisfaction and complaints lodged against the practitioner.⁴

Battersby’s research group proposed 12 evidence-based principles for implementing self-management support in primary care that were associated with improved patient self-management and health outcomes:⁵

- A brief, targeted initial assessment
- Evidence-based information that guides shared decision-making
- A non-judgmental approach in patient interactions
- Collaborative priority and goal-setting
- Collaborative problem-solving
- Self-management support delivered by a diverse group of providers
- Self-management interventions delivered in various formats
• Encouraged patient self-efficacy
• Active follow-up
• Case management that adheres to recent evidence-based clinical practice guidelines
• Links to evidence-based community programs
• Multifaceted interventions

Recent research suggests that 47 percent of all preventative and therapeutic interventions are of unknown or undetermined effectiveness, and a further 7 percent possess conflicting information with regard to harm or benefit. An essential component of a truly informed decision between patient and health professional is a thorough discussion of the many and varied uncertainties that accompany a clinical decision. Yet few clinicians adequately address uncertainty in the evidence when asking for patient consent.

*JAMA* reported an analysis of 1,057 clinical encounters by primary care physicians and surgeons that revealed the following: "Only 16% to 18% of discussions met the minimum criteria for an informed decision. Discussion of uncertainty about risks and benefits of treatment was done only 1% of the time for basic decisions, 6% for intermediate decisions and 16.6% for complex decisions."

There will always be multiple sources of uncertainty around most health care decisions because scientific evidence is prone to error and misinterpretation. A partial list includes flaws in study design (randomized controlled trial versus observational or case studies), sample size, population selected, appropriateness of outcome measures, blinding, control of confounders in design and/or analysis, duration and dosage of treatment and follow-up. If any or a combination of these flaws is identified in a study, its validity is compromised and the research results will be criticized for being biased at best or even worse, labeled useless.

Decision analysts define *clinical uncertainty* in terms of ambiguity and vagueness; in other words, the reliability, credibility or adequacy of risk information. To patients and clinicians alike, this translates into an understanding that when ambiguity or vagueness is high, the risk information that is trying to be communicated is unreliable, conflicting, incomplete, unknown, unknowable or contested.

Patient-centered care relies on applying the best research evidence that a patient’s values, preferences, concerns, needs and wishes bring to bear on an informed decision. Sandman and Munthe have proposed models that may be used to guide decisions that take into account patient values, autonomy, compliance and adherence. However, they suggest that if the doctor and patient cannot agree, a default compromise driven
by the professional is necessary to protect the patient’s best interest while still preserving the continuing care relationship.\textsuperscript{10}

Shared decision-making is a good policy for doctors of chiropractic to follow because it has the potential to reduce the overuse of options that are not in the patient’s best interest; reduce useless health care practices; enhance sustainability of the health care system; and encourage patients to get involved in decisions that affect their health.\textsuperscript{11}

References


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