Some disproven misconceptions about shared decision-making

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Shared decision-making (SDM) consists of identifying a decision to be made, discussing the available options (with their associated benefits, harms and practical considerations) and eliciting patient values to arrive at a collaborative decision.[1] Despite the ethical[2] and empiric[3] benefits of SDM, uptake of this approach remains low.[4] Pharmacists are well positioned to help address such shortcomings, given their medication expertise and ever-expanding scope of practice. However, based on our experiences and empirical findings,[5] several persisting misconceptions may serve as barriers to successful SDM implementation. The objective of this commentary is to discuss and disprove these misconceptions to facilitate SDM adoption.

Misconception 1: SDM is a "nice to have, not a need to have"

It is often implied in the way that SDM is presented (e.g., minimal integration into clinical practice guidelines,[6,7] usually only with a brief section touting its importance) that it may be a commendable act, but no one should be faulted if they refrain from routinely incorporating SDM into their practice. However, this overlooks that patient autonomy is the primary principle guiding the provision of ethical care.[8] SDM affirms a patient's right to self-determination by providing them with information about options and associated trade-offs, while ensuring their values play a key role in the decision-making process. Without engaging in these deliberations, clinicians are depriving patients of the opportunity to decide what is in their own best interest. Outside of cases where SDM is not appropriate[9] (e.g., the patient does not want an active decisional role or is experiencing an acute emergency), it is a serious ethical failure when SDM is not integrated into care.

This does not mean that individual pharmacists are to blame when SDM is not incorporated. There are restraints put on pharmacists due to the systems in which they operate,[10] and lapses in ethical care occur despite individuals' best efforts. Just as we should not jump to blaming the emergency department staff for extensive wait times, we should not assume failures to engage in SDM are always the fault of individuals. It is nonetheless important to realize that failures to incorporate SDM are ethically serious and solutions are needed at both the individual and system levels.

Misconception 2: SDM is the same as informed consent

Informed consent requires that a patient (or their representative) be provided information on an intervention's benefits, harms and inconveniences, along with alternative options, prior to them agreeing to a decision.[11] SDM goes further by also encouraging the patient to reflect on and convey their values prior to reaching a decision.[1] This creates a 2-way dialogue that guides the decision towards the choice most consistent with the patient's informed values.

To illustrate these differences, consider a pharmacist explaining to a patient with heart failure with reduced ejection fraction that changing from ramipril to sacubitril-valsartan will reduce their risk of death and heart failure hospitalization, increase their risk of light-headedness and possibly entail an increased cost, thereby (at least partially) fulfilling their responsibility to obtain informed consent. To elevate this to include SDM, it would be necessary for the pharmacist to elicit the patient's values (e.g., how much do these benefits matter to you and are they worth the cost and potential adverse events?) prior to reaching a collaborative decision. While informed consent provides patients with a veto, SDM goes a step further and embeds the patient into the decision-making process.

Misconception 3: SDM is done only when deliberating a new intervention

Changing circumstances often present opportunities for revisiting prior decisions with SDM. Examples where it may

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be necessary to revisit a previous decision include changes in prognosis (e.g., a patient may initially decline statin therapy, but their preferences may change if their predicted risk increases after developing diabetes), changes in ability to pay (e.g., loss of job benefits) or the onset of adverse effects. This is especially relevant as pharmacists may not always be present during the initial encounter but may nonetheless be able to identify changing circumstances that warrant such re-evaluation during follow-up.

There is also evidence that patient preferences may shift following an acute event (e.g., hospitalization for heart failure).[12] Therefore, a SDM intervention reviewing their options may be most valuable once the patient is more prepared for dialogue during outpatient follow-up (e.g., at their community pharmacy).

Misconception 4: Most patients do not want SDM, so there is no need to offer it

The proportion of patients preferring an active role in decision-making ranges across studies from 22% to 81%.[13] It also depends on what "SDM" entails, as 1 study found that 96% of people agreed with the statement "I prefer that my doctor offers me choices and asks my opinion" yet were more divided on making decisions, with 52% agreeing with the statement "I prefer to leave decisions about my medical care up to my doctor."[14] The interpretation of such results is further complicated by those who report reluctance to participate due to low self-efficacy.[15]

Regardless, even if most patients do not want to participate in SDM, there is still an obligation to allow patients to choose their preferred decisional role. Even if a patient chooses to play a passive role, the offer was not a "waste of time" because the patient was able to choose that role through their own volition. Furthermore, even if only 1 in 5 patients wants to play an active role (the most pessimistic reported finding), these patients should not be deprived of an opportunity for involvement just because they are in the minority.

Misconception 5: Few decisions require SDM

Preference sensitivity (i.e., different patients will make different choices when presented with the same options) is a key marker that a decision is amenable to SDM. There is an abundance of evidence that preference sensitivity is widespread among common medication-related decisions, such as in initiation of statin therapy,[16] atrial fibrillation stroke prophylaxis,[17] type 2 diabetes mellitus,[18,19] hypertension,[20] depression[21] and insomnia.[22] This incomplete list is illustrative that decisions amenable to SDM are not rare—and could possibly represent the majority of chronic disease management decisions.

What pharmacists can do

- Identify at least 3 conditions that you commonly see in your practice and search either 1) the A to Z Inventory of Decision Aids (https://decisionaid.ohri.ca/AZinvent.php) to identify a relevant decision aid or 2) My Studies (https://mystudies.org) to identify the most important benefits and harms of the relevant medication(s).
- Offer patients opportunities to share in decisions related to these conditions, using the previously identified tools/information to inform the discussion.

Misconception 6: SDM is not necessary to determine what a patient wants

It could be reasoned that if clinicians and patients came to the same conclusions anyway, then SDM might be unnecessary. However, such an approach is in tension with empirical findings demonstrating that clinician and patient preferences rarely overlap.[23]

Alternatively, it might be thought that clinicians could use their intuition as a heuristic for determining patient preferences. However, even if clinical intuition of patient preference was 80% sensitive and specific (an optimistic assumption given the difficulties of psychological inferences), this would still result in 20% of patients being misclassified regarding their preferences. Using intuition in this manner may also unintentionally introduce bias and discrimination into the decision-making process. Consequently, the only safe way to know what a patient wants is to have a discussion regarding their values.

Conclusion

SDM is a key approach to the provision of ethical care, but misconceptions may preclude its proper implementation. As such, this commentary has addressed several misconceptions surrounding what SDM is, why it should be adopted and when it is appropriate. In doing so, we are hopeful pharmacists can continue to better incorporate patients into the decision-making process. ■

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