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REVIEW

Effective communication and shared decision making: Theoretical approach from the doctor-patient relationship approach

Comunicación efectiva y toma de decisiones compartidas: Aproximación teórica desde el enfoque de la relación médico-paciente

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ABSTRACT

Introduction: shared decision making is understood as a communicational model in which health personnel collaborate with the patient or caregiver in making optimal health decisions, encouraging patients, family members and physicians to evaluate clinical information and compare risk-benefit in order to select the most appropriate treatment option.
Objective: to characterize shared decision making as a model of patient-physician communication.
Development: the method has gained acceptance among the medical community in recent years; despite having an approach in line with current medicine due to benefits such as a decrease in medical errors, being associated with a better overall quality of decisions and less decisional conflict, its use is controversial due to weaknesses such as lack of practical guidelines for its use, lack of training for the parties involved, lack of time and applicability due to the patient's characteristics. Shared decision support tools provide information about the options and potentially expected outcomes for a person's health status, and are different from traditional educational materials.
Conclusions: shared decision making emerges as a method of patient-physician communication centered on the participation of the patient in his or her medical therapy and is credited with reducing decisional uncertainty. The scientific evidence is insufficient to recommend its use over traditional methods, although its application has gained acceptance among the international community in recent years.

Keywords: Shared Decision Making; Decision Support Techniques; Decision Tools; Decision Modeling.

RESUMEN

Introducción: se entiende por toma de decisiones compartidas al modelo comunicacional en que el personal de salud colabora con el paciente o persona a cargo del mismo en la toma de decisiones de salud óptimas, el mismo alienta a los pacientes, familiares y médicos a evaluar información clínica y comparar riesgo-beneficio para seleccionar la opción de tratamiento más apropiada.
Objetivo: caracterizar la toma de decisiones compartidas como modelo de comunicación médico paciente.
Desarrollo: el método ha ganado aceptación entre la comunidad médica en los últimos años; a pesar de tener un enfoque acorde a la medicina actual por beneficios como disminución de errores médicos, estar asociado con una mejor calidad general de las decisiones y menor conflicto decisional, su uso se torna controversial al prestar atención a debilidades como falta de guías prácticas para su uso, de capacitación a las partes involucradas, de tiempo y aplicabilidad debido a las características del paciente. Las herramientas de ayuda para toma de decisiones compartidas permiten proporcionar información acerca de las opciones y los resultados potencialmente esperados sobre el estado de salud de una persona, siendo diferentes de los materiales educativos tradicionales.

Conclusiones: la toma de decisiones compartida surge como un método de comunicación médico paciente centrado en la participación de este en su terapia médica y se le atribuye una disminución de la incertidumbre decisional. La evidencia científica es insuficiente para recomendar su uso sobre métodos tradicionales, aunque su aplicación ha ganado aceptación entre la comunidad internacional en los últimos años.

Palabras clave: Toma de Decisiones Compartidas; Técnicas de Apoyo a la Decisión; Herramientas de Decisión; Modelación de Decisiones.

INTRODUCTION

In 1956, Szasz and Hollender[1] published an article where they proposed a new model of the physician-patient relationship, characterized by mutual participation; later, in 1972,[2] Veatch used the term "shared decision making" for the first time, but it was not until 1997 when this denomination gained popularity and became a paradigm of health communication.[3]

Although there is no fully agreed-upon definition, shared decision making (SDM) or Shared Making Decisions is understood as a model in which healthcare personnel establish a communication process with the patient or caregiver to collaborate in making optimal healthcare decisions that are aligned with what is most important and in the best interest of the patient.[4]

It emerges as a clinical decision-making model different from the paternalistic one because of the bioethical aspects of beneficence, nonmaleficence, patient autonomy, and justice it provides.[3]

DBT has gained acceptance in the medical community in recent years; the literature shows that it is a standardized procedure in countries such as the United States, Germany, Canada, the Netherlands,[5] China,[6] Spain.[7] In Latin America, conversely, the degree of acceptance of the method has yet to be discovered in the literature.[8]

The 2017 Cochrane systematic review by Stacey et al.[9] supports the above; it included 105 randomized controlled trials from 2012 to April 2015 with more than 31 thousand participants, proved that DBT reduced the number of undecided participants and proved to have a positive effect on patient-physician communication.

Despite having an approach in line with current medicine, many healthcare entities consider its implementation in consultations and parts of medical evolution as they claim some factors undermine the integrity of this method, including the complexity of medical decision-making, the perceived discomfort of many physicians in giving up some of the "control," difficulty in integrating patient beliefs with multiple treatment options and time constraints.[10]

With the continued increase in treatment options, DBT encourages patients, families, and physicians to evaluate clinical information and compare risk-benefit to select the most appropriate treatment option.[10]

In light of the above, the present research was conducted to characterize DBT as a model of patient-physician communication.

DEVELOPMENT

The essential elements of DBT are oriented around the patient's wishes. To be effective, it requires at least 2 participants; both parties must share information related to the decision to be made and follow the necessary steps to reach a consensus on the treatment to be chosen. It is considered successful when an agreement is reached between the patient and the physician.[10]

It is from the appearance of this concept that the role of patients in clinical decision-making becomes more critical, with the consequent active participation of patients in decisions about their health, generating an advance in addition to informed consent in terms of patient autonomy and control about the authority of the clinician.[11]

Ortis Llácer considers that a crucial aspect of DBT on the part of the physician is the diligent and prudent search for and offer of options; without options, there is no decision. A physician (or other healthcare professional) should be obliged to educate and involve people in DBT.[12]

John Lantos, in his 2018 book The Ethics of Shared Decision Making,[13] offers concepts and rationale related to DBT; of note is his visualization of the method to effect person-centered care, one of the dimensions of quality of care.

For his part, Cantón et al.[4] defines person-centered care in fundamental concepts:

Care provision from a biopsychosocial perspective, the conception of the patient as a human being, therapeutic alliance, valuing the professional as a person, the distribution of power and responsibility between providers and users of the health system

In this sense, questions arise in the authorship, such as: Would the use of DBT apply to all levels of health care? Does the patient's protagonism in choosing a therapy positively or negatively influence its results? Should

the use of DBT be considered as opposed to other traditional methods of communication?

Although DBT constitutes a revolutionary practice, the value of its application to different levels of health care, as well as its peculiarities, is still a subject of research; many studies analyze the benefits and risks of its application to specialties such as oncology,[11] pediatrics,[14] neurology,[15] psychiatry,[5] to cite a few examples. There is no reliable source of information that would allow us to infer the degree of popularity of DBT in the different specialties; moreover, according to the availability of research reports, its use could be less valued in third-world countries.

Benefits

Some of the factors behind the rise of DBT are related to a rapid expansion of medical information and improved access to health information for patients, with a consequent evolution in the patient's role in the decision-making process and their increased desire to actively participate in their health care. Thus, an increasing percentage of patients have gone from being mere passive spectators of their health to actively participating in the clinical decision-making process that concerns them.[11]

It is believed that patient participation in their therapeutic behavior can help prevent errors and adverse medical outcomes, mainly due to medication errors and lack of treatment adherence.[3]

Steffensen et al.[16] posit that DBT is associated with better overall quality of decisions. Hugues et al.[17] note that poor DBT techniques were associated with worse patient health outcomes, decreased established quality indicators, and increased use of specialized medical care.[10]

A case-control study conducted by Sandergard in which patients were consulted with both the paternalistic and the DBT approach indicates that participants seen by the DBT-trained physician reported less decisional conflict than the control group.[3,18]

Based on this approach, they agree with Pietersen et al.[3], which discusses the importance of patients being attended by personnel trained in presenting options to guarantee decision-making by clarifying personal values and interests that benefit the patient.

Weaknesses

Conceptual barriers are described in the literature, such as the persistence of paternalistic positions that perpetuate the debate between the promotion of respect for autonomy and the supposed best interest of the patient, the erroneous belief that families do not wish to participate in decision making and the lack of practical guidelines with demonstrated evidence. One of the most critical challenges in implementing person-centered care lies in humanizing the dialogue and generating a connection that, from a compassionate viewpoint, recognizes the subjectivities with which each family goes through the different experiences associated with health care.[4]

Some of the commonly cited barriers are lack of time, disconnection between the information provided to patients and their verbal risk-benefit connection of therapies, ten lack of applicability due to patient characteristics (age, cognitive abilities), and because of the clinical situation (such as emergency settings, psychiatric patients).[12]

Padilla Garrido et al., in their study on knowledge and evaluation of shared decision-making in oncological practice from the medical point of view, point out that 82,3 % of their participants had no training in DBT and only 33,8 % acknowledged knowing enough and using it in their usual practice. In addition, 60 % acknowledged that they made most of their medical decisions alone.[7]

Metz et al., in their randomized case-control clinical trial on mental health care, propose follow-up by clinical outcome consultation as an alternative to provide patients with access to quality information that makes the DBT process effective and thus reduces decisional conflict, using a control group with a paternalistic model and an intervention group with DBT; their results show no significant differences between the two groups.[19,20]

It should be borne in mind that the lack of significant differences in the use of one method or the other does not detract from the validity of DBT versus traditional communication since the study results show that both were associated with good clinical outcomes.

Xuejing Li et al., in their systematic review of DBT in health care in mainland China, include 60 studies and point out among their main findings the lack of comprehensive understanding of the concepts related to DBT; furthermore, they emphasize the need to create uniform standards to develop DBT in the country adequately.[6]

Müller et al., based on the evidence, recommend the need to establish international guidelines that include a basic set of expected outcomes to measure the quality of DBT.[10]

DBT Support Tools

Much of the work developed concerning DBT involves developing procedures and instruments that serve as decision-support resources and initiate a conversation about available options between clinicians and patients.

These instruments, termed Helping Tools for Shared Decision Making (HATDC), emerge as a complementary measure to the counseling provided by healthcare professionals and are defined as interventions designed to assist individuals in making specific and deliberate choices among various diagnostic or therapeutic options by providing information about the options and potentially expected outcomes for an individual's health status.[11]

They are different from standard health education materials because they deal in a more detailed and specific way with the options and outcomes of those options (benefits, risks, and uncertainties) based on a careful review of the evidence. The options can be presented through a variety of media and formats (brochures, written text, videos, computer applications), often using visual aids such as smiley faces or other pictograms.[21]

They can be grouped into three main categories. Those used by clinicians in face-to-face interviews show information in short sentences and graphics and assist the physician in communication but cannot be used by the patient independently. Those that can be used by the patient outside the clinical consultation ensure that they arrive prepared for the medical interview. Finally, there are the tools mediated by social networks, whose validity is subject to doubt due to the uncertainty about the source of information used.[21,22]

The International Patient Decision Aids Standards (IPDAS) is a list of criteria currently used to assess the quality of publicly available HATDC. The IPDAS has been developed to be applied by HATDC designers, patients, healthcare professionals, insurance companies, healthcare managers, and researchers who wish to assess and compare the quality of different HATDCs in the same area of interest.[11]

More than a few authors advocate in their articles the need to develop and globalize standards to assess the quality of HATDC to provide feedback on the training of those involved in its use. Criteria as to what should be considered quality DBT are heterogeneous.

In Spain, the Working Group of the Methodological Manual for the Application of the Clinical Practice Guidelines to Shared Decision-Making recommendations was created in 2022, and these professionals propose recommendations for writing that facilitate the CDT process. Among them is simple, clear language that generates easy reading and short sentences, preventing the use of abbreviations, symbols, and passive voice; their preparation should be based on incorporating the values and preferences of the patient to whom they are addressed. Using adequately designed visual aids is advisable, avoiding excess information and misleading representations, such as truncated graphics, which can confuse the recipient. The communication impact of the uncertainty inherent in medical processes must be clarified.[23,24,25]

Based on these aspects, the need for studies with solid methodological support to help clarify the diversity of positions and considerations currently existing on CDT is highlighted.

CONCLUSIONS

Shared decision-making has emerged as a method of physician-patient communication centered on the patient's participation in his or her medical therapy and is credited with reducing decisional uncertainty. There needs to be more scientific evidence to recommend its use over traditional methods, although its application has gained acceptance among the international community in recent years.

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