

COMPREHENSIVE

The Whys and Hows of Shared Decision Making

BY ANNIE STUART, CONTRIBUTING WRITER
INTERVIEWING LAURA K. GREEN, MD, RICHARD A. HARPER, MD,
ANDREAS K. LAUER, MD, AND LAURA L. WAYMAN, MD

Many years ago, the medical model began evolving from an authoritarian, top-down style of communication to a new paradigm of shared decision making, whereby both physicians and patients share information, discuss treatment preferences, and agree on a treatment plan.¹

This cultural shift actively involves the patient in decision making and is tailored to individual patients, said Laura K. Green, MD, at LifeBridge Health Krieger Eye Institute in Baltimore. “Patient centeredness has been reflected in respecting the patients’ autonomy and ability to make decisions as opposed to just following edicts delivered by the physician.”

To illustrate the implications of that individuality, Dr. Green gives the example of two patients—with very different visual needs—who are considering cataract surgery. One is 60 years old, is actively working, and needs to read on a computer and drive at night. The other is an infirm 90-year-old who is content to watch television all day.

Deciding the best course of action, said Dr. Green, “requires a conversation to determine each patient’s needs and expectations—not a one-way flow of communication, where the doctor diagnoses the problem and tells the patient what to do.”

Andreas K. Lauer, MD, at the Casey Eye Institute in Portland, Ore., agreed. “The dynamic of the physician-patient relationship, as with other healthy

relationships, is a two-way street,” he said. “If we presume too much with a patient, we risk losing the therapeutic relationship.”

What are the challenges and benefits of shared decision making, and how can ophthalmologists improve its use in their practices? Four ophthalmologists offer some insights.

Pros and Cons

The Information Age has no doubt helped prime the pump of shared decision making.

“Thanks largely to the Internet, access to medical information is no longer exclusive to the physician,” said Dr. Green. “Anyone can use ‘Dr. Google,’ and they do. This can put physicians on the defensive and can be a bit frustrating, but it just comes with the territory of practicing medicine these days.”

Drawbacks. Physicians may perceive shared decision making as a drawback if the patient makes a decision the physician doesn’t agree with, said Laura L. Wayman, MD, at Vanderbilt University Medical Center, Nashville, Tenn.

Time can also be an obstacle, especially if the patient has hearing or cognitive limitations that require repeating information. “This can slow things down,” she said. “Still, it’s important not to rush through questions.”

Benefits. Patients who are better informed also tend to ask more questions when it comes time for a procedure or treatment, said Dr. Wayman. “However, if the patient is knowledgeable

The Value of Discussion



When physicians and patients talk through decisions together, the benefits are numerous. One example: Patients tend to be more adherent to complicated medication regimens.

about the disease process, treatment options, and potential outcomes—good or bad—and if they help make the decision,” she said, “no matter how things go, there will be less of a feeling of ‘I was forced into this.’”

And with that perception comes a medicolegal benefit for the physician, said Dr. Wayman. “It can’t be at the forefront of your mind, but neither can you ignore it.”

Shared decision making has other benefits as well. For example, said Dr. Green, patient adherence with a complicated medication regimen is much better if patients clearly understand what’s going on with their disease and why, for example, they need to take glaucoma drops. In addition,

being in agreement with physicians about the nature of the treatment and need for follow-up strongly correlates with patients' recovery.²

The Process

Dr. Lauer said that as a physician-surgeon, he feels that his job is to let patients know what the options are, including the standard of care and what most patients choose. But he makes it clear: The choice is yours. "I try not to come on strong," he said, "unless the patient clearly has an emergent life-threatening or sight-threatening situation."

The role of questions. After presenting options, it's time to receive feedback from the patient, said Richard A. Harper, MD, at the University of Arkansas for Medical Sciences in Little Rock. It helps to give patients a format in which to express their questions—it might even be in the form of a survey you send out before the appointment. "This helps patients structure their thoughts," said Dr. Harper, "and it helps the physician or technician to address concerns in a more timely way."

Dr. Green agreed, saying that answering the patient's questions helps direct your exam very quickly to what you need to focus on and avoids extraneous tangents.

The discussion. Next, ask which treatment the patient is most comfortable with. If you think a different option would be better for the patient, you can say, "I understand what you're saying, but here's why I would recommend a different approach," said Dr. Harper.

Be sure to communicate the plan as a partnership by saying something like this: "We're going to keep working on this." That is a way of saying, "I'm here with you." But never say, "we're going to fix this," which risks promising too much, Dr. Harper said.

Dr. Lauer said that patients usually respond well when he tells them that he's giving his professional recommendation for what is safest and most beneficial. "As long as patients and I have discussed the decision together," he said, "they feel as though they've been

Ideas, Concerns, Expectations (ICE)

The physician can enhance shared decision making through the ICE approach—it quickly gets to the heart of the patient's beliefs, fears, and desires with these three simple questions: 1) What is your idea about what is going on? 2) What are you most concerned about? 3) What are you expecting that I can do?¹

Ideas. Asking patients what they believe is happening with their vision will give you an idea of how much they already know and how much they want to learn.² The patient will tell you why he or she is there, and the reason isn't always what the referring physician or family member has told you, said Dr. Lauer. "If the physician doesn't attend to the reason the patient is there, the rest of the conversation or therapeutic advice won't be that relevant."

Concerns. Use an open-ended question such as, "What concerns you most?" said Dr. Green. It's important to reflect back what you've heard, she said. Use language like, "I understand that you have a concern about" This validates the patient's concerns and ensures that you understand correctly.

"This kind of language and tone is really important, even if you end up disagreeing and refuting everything the patient says," said Dr. Green. "When people know they've been heard, they tend to present with less anxiety and antagonism in the doctor-patient relationship. It builds trust."

Expectations. After creating a connection, ask about the patient's expectations of you, probing with more questions, as necessary, said Dr. Harper. Then it's time to lay out your findings and recommendations, following up with more questions: "How do you feel about this treatment plan? Are you on board with this? What concerns you about it?"

1 Matthys J et al. *Br J Gen Pract.* 2009;59(558):29-36.

2 Ha FJ et al. *Ochsner J.* 2010;10(1):38-43.

listened to and looked after. Regardless of whether we do surgery, medication, or observe, the patients feel they have somebody on their side."

When the patient doesn't agree.

However, disagreements will inevitably arise. "Be open to the patient getting a second opinion. If the patient does not agree with you and decides to go elsewhere, be sure not to communicate, 'It's my way or the highway.' Maintain the relationship as much as possible," said Dr. Lauer.

Patients' discomfort with making decisions. Many patients of the older generation aren't comfortable being involved in the decision-making process, said Dr. Green. "They might say, 'I don't know, doc—you tell me what to do.' I just explain, 'It's your eyes and your vision. I couldn't possibly know how you are experiencing the world and how it is affecting you. I need you to communicate how you're affected in your activities of daily living.'" That information can then help guide the

patient's decision-making process. ■

1 Ha FJ et al. *Ochsner J.* 2010;10(1):38-43.

2 Stewart M et al. *J Fam Pract.* 2000;49(9):796-804.

Laura K. Green, MD, is an ophthalmologist at LifeBridge Health Krieger Eye Institute in Baltimore. Financial disclosure: None.

Richard A. Harper, MD, is professor of ophthalmology at the University of Arkansas for Medical Sciences in Little Rock. Financial disclosure: None.

Andreas K. Lauer, MD, is professor of ophthalmology at the Casey Eye Institute at Oregon Health & Science University in Portland. Financial disclosure: None.

Laura L. Wayman, MD, is associate professor of ophthalmology and visual sciences at Vanderbilt University Medical Center in Nashville, Tenn. Financial disclosure: None.

PATIENT EDUCATION. The Academy has updated its patient education brochures so that they are easier for the average person to understand. Learn more at www.aaopt.org/store.