Shared Decision Making and Effective Physician-Patient Communication: The Quintessence of Patient-Centered Care

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"The good physician treats the disease; the great physician treats the patient who has the disease."

—Sir William Osler

The Institute of Medicine's (IOM) 2001 landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, identified patient-centeredness as one of the fundamental attributes of quality health care, alongside safety, effectiveness, timeliness, efficiency, and equity.[1] The IOM defined patient-centeredness as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."[1] This concept of patient-centered care represents a paradigm shift from the traditional disease-oriented and physician-centered care, grounding health care in the subjective experience of illness and the needs and preferences of individual patients rather than the evaluation and treatment of diseases which emphasizes on leveraging clinical expertise and evidence derived from population-based studies.

A multiyear research conducted by the Picker Commonwealth Program for Patient-Centered Care (now the Picker Institute), which coined the term "patient-centered care" in 1987, revealed that patient-centered care encompasses seven dimensions from the patient perspective: (1) respect for patients' values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support and alleviation of fear and anxiety; (6) involvement of family and friends; and (7) transition and continuity of care.[2] This conceptual framework transcends the earlier interpretations of patient-centeredness as a way of how physicians should interact and communicate with patients at the interpersonal level, expanding the concept to the health care system level.[3] Since the inception of the patient-centered care concept, a plethora of studies have repeatedly shown that orienting health care around the needs and preferences of patients holds promise for improved health care quality, patient satisfaction, and health outcomes.[4-8]

At the pinnacle of patient-centered care is shared decision making, a process by which clinicians and patients participate jointly in making health decisions for a preference-sensitive condition—a condition where more than one screening, diagnosis, intervention, or support strategy is clinically appropriate.[9,10] Shared decision making goes beyond the discussion of risks and benefits involved in the informed consent process.[11] It also helps identify and takes into consideration the patient's circumstances, values, and informed preferences for the risks, benefits, and uncertainties associated with each alternative. This is in sharp contrast to the traditional decision-making approach, in which clinicians make decisions *for* rather than *with* patients. Shared decision making recognizes that both clinicians and patients bring different but equally important forms of expertise to the table. The extent to which a clinician or a patient takes responsibility for the decision-making process varies in different circumstances along a continuum between two extremes: clinician-driven decision making and patient-driven decision making.[12]

Shared decision making is only attainable in the presence of effective physician-patient communication. In fact, quality communication within the physician-patient dyad is the single most important enabler of quality health care, without which the delivery of patient-centered care would not be possible.[13] Clear, respectful, and empathic communication between health care professionals and patients enables and supports information exchange, shared decision making, management of uncertainties and emotions, patient self-management, and meaningful clinician-patient relationship.[14] Successful integration of these functions leads to increased access to care, greater patient knowledge and shared understanding, enhanced therapeutic alliances, better management of emotions, improved family and social support, enhanced patient empowerment and agency, and higher quality health decisions, which, in turn, improve patient satisfaction, treatment adherence, physical and emotional well-being, and health outcomes.[14-18] In contrast, gaps or lapses in physician-patient communication can lead to medical errors and undesirable outcomes.[19,20]

The experience articles by DiSalvo in this issue of *International Journal of Medical Students* (IJMS) present the perspectives and experiences of a medical student with regard to patient-centered care as he engaged in the care process of patients as part of his clinical training. The first article explores the importance of patient-centered communication and shared decision making through his experience with a chronic liver failure patient.[21] The patient was loaded with physical and emotional discomforts

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owing to lapses in physician-patient communication, a deficient coordination and transition of care, and a lack of attention to the patient's physical and emotional needs. The second article discusses the significance of treating patients as individuals and incorporating patients' values and preferences into clinical practice through his reflection on the meaning of the "First, do no harm" aphorism as he followed up a critically injured patient who was unable to decide for himself.[22] In both cases, paternalistic physicians made health decisions for the patients without adequate communication with the patients or their families and friends.

DiSalvo's experiences add to the growing body of evidence that there is inadequate physician-patient communication and little shared decision making taking place in clinical practice, despite the universal recognition of patient-centered care as the desideratum of health care. Many physicians feel that they actively engage patients in the decision-making process and communicate effectively with their patients, but evidence suggests a perception-reality gap and a discrepancy between patient's and physicians' impressions about the care received or provided.[23,24] As a consequence, decades after the publication of the first compelling evidence to support patient-centered care,[25] paternalism continues to dominate health decision making, and the primacy of patients' preferences and expressed needs remains to be appreciated in most clinical encounters.[26-28]

A number of reasons may account for the limited adoption of shared decision making in clinical practice. Most clinicians cite time constraints, lack of applicability due to patient characteristics, and lack of applicability due to the clinical situation as the most important barriers to engaging patients in the decision-making process.[29] These perceived barriers likely represent misconceptions about shared decision making.[30] Current evidence indicates that implementation of shared decision making does not result in a systematic increase in consultation duration.[31] Additionally, regardless of their education and functional health literacy, all patients want to be involved in health decision making, albeit with different levels of engagement.[32] Therefore, even the most vulnerable patients should not be systematically excluded from shared decision making. Other misconceptions which hamper the implementation of shared decision making include misconceptions about the nature of shared decision making, the incompatibility of shared decision making with evidence-based practice, and the degree to which patients wish to share in decision making.[30]

In contrast to clinician-reported factors which reflect clinicians' presumptions that many patient will not benefit from shared decision making or do not wish to take part, patients reported a multitude of barriers which limit their capacity to participate in shared decision making. These patient-reported barriers include inadequate information provision, lack of continuity of care, inadequate environmental conditions, interpersonal characteristics of the clinicians, medical terminology used by clinicians, and a power imbalance in the physician-patient relationship.[33] The power imbalance between clinicians and patients causes patients to undervalue their knowledge and expertise relative to that of clinicians and adopt a passive and compliant role out of the fear of being labeled as "difficult" patients.[33,34] Additionally, patient perceptions of shared decisions may differ from physician perceptions of shared decisions.[35,36] Understanding patient perceptions of shared decision making and barriers to its implementation is particularly important, as only patient-reported shared decision making is significantly and positively associated with improved patient outcomes.[37]

While the major obstacles to the implementation of shared decision making are misconceptions about shared decision making, organizational factors, and factors associated with decision-making interactions, inadequate physician-patient communication is largely attributable to the lack of emphasis on communication skills in medical training. Most communication training takes place during the preclinical years of undergraduate medical education in the form of lectures and role plays with standardized patients. In the clerkship years, at a time when students have direct encounters with patients and communication skills are most crucial, little attention is devoted to communication training. The teaching of diagnostic skills and patient management takes the central stage. Rarely do students receive specific instruction or feedback regarding their interactions with patients. Similarly, communication skills are often not addressed in postgraduate medical training, leaving residents and practicing physicians to learn communication skills on their own. Additionally, physicians cite time pressures as a significant barrier to establishing effective communication with patients, as listening to patients, addressing their needs and emotional concerns, and helping them make decisions that are consistent with their values and preferences all require time.[38-40]

To successfully achieve the provision of patient-centered care and improve the quality of health care, critical barriers to shared decision making and effective physician-patient communication must be addressed. A number of effective interventions directed at clinicians and patients have been developed for this purpose.[41] Well-designed training programs for clinicians have been shown to be effective in transferring patient-centered skills to clinicians, leading to significant increases in the patient-centeredness of consultation processes.[42] Decision aids, on the other hand, improve patients' knowledge and risk perceptions, promote their active participation in decision making, and reduce their internal decisional conflict related to feeling uninformed and unclear about their personal values.[31] Various other patient engagement strategies have also been developed and proved to be effective in improving health literacy, helping patients make appropriate health decisions, and improving the quality of care process.[43] These findings are encouraging. Nonetheless, a genuinely patient-centered care would not be possible if power imbalances, either perceived or real, continue to exist in the physician-patient relationship. Interventions must be developed to redress these power imbalances to facilitate shared decision making and effective communication between physicians and patients.

Patient-centered care is the answer to the health care reform necessitated by today's increasingly complex and fragmented health care delivery system. A paradigm shift towards patient-centered care promises many potential gains, including improved health care quality and safety, increased patient satisfaction and adherence to treatment plans, improved health outcomes, and reduced health care cost. Regrettably, despite the ubiquitous talk about patient-centered care in modern health care, shared decision-making and effective physician-patient communication—the two cruxes of patient-centered care—are

yet to become the norms. Strategies to promote and enhance shared decision-making and effective communication between clinicians and patients should be rigorously implemented to establish a health care system that truly values patients as individuals and turn the rhetoric of patient-centered care into reality.

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