Editorial

Understanding when, why and how shared decision making is used in routine care

In a 1963 speech at San Diego State College [1], John F. Kennedy famously said, *"To govern is to choose, and the ability to make those choices wise and responsible and prudent requires the best of all of us."* Indeed, much the same could be said about medical care. For any given patient or condition, the path between symptom, presentation, diagnosis, treatment, and resolution is populated by a myriad of choices. Some of these choices are explicit, while many are implicit. Choices can range from the seemingly innocent to the most deeply consequential. In each case, the care team should work together with patients and families to arrive at the best possible outcome for the individual affected, a process often referred to as shared decision making (SDM).

In this issue, the paper by van der Horst and colleagues [2] provides occasion for us to reflect on the decisions investigators and clinicians have examined as most appropriate for SDM. In the authors' definition, SDM is "*a collaborative decision making process, including clarifying a decision is needed, discussing the options, exploring patient preferences, and ultimately making a decision (or deferring it)*." There are many situations where SDM is appropriate and even mandated by clinical guidelines, typically for situations in which there is uncertainty in evidence [3]. Yet there are some situations in which SDM might be inappropriate, unnecessary, and could potentially strain the patient-clinician encounter. For example, although SDM could apply to some scenarios in emergency medicine, there are others in which the acuity of the clinical situation necessitates timely action [4], and SDM could interfere with achieving the best possible care.

The field of SDM can build on this thorough review by using implementation science [5] and its frameworks to study ways to translate SDM guidelines into routine care when deemed feasible and appropriate. For example, *when* it is appropriate to use SDM, the behavior change wheel [6] can encourage motivation (*why* engage in SDM), capability (*how* to engage in SDM, with step-by-step processes or training in this process and how to differentiate SDM from patient-centered care), and opportunity (incentives, social norms, system change to enable SDM) to facilitate its adoption. Normalization Process Theory [7] could be used to engage key stakeholders and to study mechanisms that support individual and collective SDM behaviors for the right patients at the right time in the care pathway [8]. Even in 2022, decades after the field of SDM emerged, for some clinicians, the notion that patients should be engaged at all is a radical concept. A broader cultural shift toward valuing SDM [5], considering individual and system-level factors influencing or inhibiting implementation, can guide SDM translation in the right context.

Implementation science frameworks can also track *adaptations* made to SDM interventions in research and practice, and document those that are both fidelity-consistent and those that change the fundamental meaning of SDM [9,10]. For example, some have described SDM as a way to reduce overtreatment in the context of high-risk surgery or unnecessary interventions at the end of life [11]. Yet SDM should not be used to steer a patient towards or away from a treatment; such a process runs counter to the goal of empowering patients and incorporating their values and preferences into care plans. We, too, have observed interventions such as patient decision aids being used in practice to guide a patient to an option or defend a clinician's preference for or against a treatment. We have observed other situations in which a resident who has thoroughly trained in SDM counsels a patient about benefits and possible harms of options, only for the process to be undermined by a more senior clinician who enters the room and strongly recommends an option. Tracking these real-world adaptations and practices that contradict the meaning of SDM can help identify gaps in implementation efforts.

Developing high-quality patient decision aids might "level the playing field" by presenting information in plain language with balanced information, reviewed by stakeholders. In theory, they can be less biased than conversations because words and evidence can be thoroughly reviewed and supported by stakeholders and the scientific literature [12]. However, it is not always possible to develop high-quality patient decision aids for each nuanced scenario in which SDM might be appropriate, at least not quickly when one might be needed. In addition, since clinicians could use patient decision aids to justify a strong recommendation, rather than deliberating with the patient, training and education in SDM needs to augment decision aid development [13]. Even if SDM is recommended or mandated and a high-quality decision aid is developed, in practice, it could fail to achieve patient-centered outcomes and could lead to harm if done in a way that is inconsistent with patient empowerment or patient preferences. An implementation science approach can identify fidelity-consistent and inconsistent processes to refine SDM interventions and training.

Finally, more concerted efforts are needed to engage diverse groups in SDM and measure its impact on issues important to health equity. SDM and related interventions could reduce health disparities [14] by engaging patients in accessible ways to improve knowledge and informed choice, benefiting patients with limited health literacy or lower education. As part of knowledge provision, SDM and related interventions can and should incorporate practical issues associated with options, including costs of care, coordination of care, and relevant social implications [15]. These practical issues influence patients' health choices and the ability to implement those choices. Failing to mention them as possible outcomes of treatment choice can contribute to health disparities for those who hesitate to bring up challenges to care implementation. The Health Equity Implementation Framework [16] might

be one guiding model to ensure that all patients can benefit from SDM when appropriate and that interventions consider the needs of socially or economically marginalized patients.

This systematic review by van der Horst and colleagues [2] addresses a much-needed concept about when SDM can and should be used. In many other contexts, though, those who can benefit most from interventions are often least likely to receive them [17]. Focusing on implementation efforts, tracking intervention adaptations, and addressing issues of health equity can serve as important next steps to support feasible, appropriate and routine use of SDM.

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Mary C. Politi [a], [*], Mark D. Neuman [b]
[a] Division of Public Health Sciences, Department of Surgery, Washington University School of Medicine, USA
[b] Department of Anesthesiology and Critical Care, University of Pennsylvania Perelman School of Medicine, USA

[*] Corresponding author.
E-mail address: mpoliti@wustl.edu (M.C. Politi).