Shared Decision Making in Orthopaedics

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The process of shared decision making (SDM) helps physicians and patients move beyond passive informed consent to more collaborative, patient-centered experiences. By offering a balanced review of conservative and invasive treatment options, including the option of observation only, SDM provides patients an opportunity to express their personal values and goals in the context of health decisions.

As orthopaedic surgeons, we use a careful history, exam, and imaging or other studies to build a case for our recommendations, based on our own perspectives. By engaging patients through SDM, we are able to more fully incorporate patient values and perspectives. SDM offers the greatest value in preference-sensitive medical conditions for which there are alternative treatments. As such, it should be a natural fit for elective orthopaedic procedures. Yet studies in the field and expansion of SDM beyond isolated health systems have been limited. However, healthcare payment reform and the momentum toward patient-centered care are stimulating greater interest in SDM and aligning financial incentives to support the process.

Roots of SDM

SDM is not a medical term but an ethical-legal term first used in the early 1980s. A report prepared by the President’s Commission for the Study for the Ethical Problems in Medicine reviewed the historic evolution of the legal requirements for “informed consent” and determined that the ethical imperatives of patient self-determination and patient well-being were the underpinnings for the legal doctrine.

Central to the report was how to improve the informed consent process, which had devolved into obtaining the patient’s “ritualistic signature” on a written form. The commission suggested revitalizing the process of communication essential to the therapeutic alliance by employing a new paradigm of communication called “shared decision making.”

Intrinsic to SDM is integrating the patients’ values and preferences with medical evidence to inform treatment decisions, which form the foundation for patient-centered care. Robust communication between provider and patient is the hallmark of the SDM process. The provider shares all relevant treatment risks, benefits, and alternatives, while the patient shares all preferences and values regarding his or her choices. The resultant mutual decision on best care reflects both these components.

SDM commonly employs patient decision aids. Quality patient decision aids are designed to impart information to the patient in a manner that will allow patients to understand their options, comprehend the risks, benefits, and alternatives to the proposed treatment, and enable them—in conjunction with their provider—to make a decision that aligns with their values and preferences.

Improving informed consent

An accurate informed consent requires that the provider share with the patient all relevant information about risks, benefits, and alternatives—including the severity and probability of risks and benefits. Without this disclosure, the patient’s consent to treatment was deemed neither informed nor consensual.

State laws have not been uniform, resulting in the following two standards for informed consent:

• In the physician-centered standard, the practitioner is required to disclose the information about risks, benefits, and alternatives that a “reasonably prudent practitioner” would disclose under similar circumstances.

• In the patient-centered standard, the provider must disclose information about the benefits, risks, and alternatives that “a reasonable patient” would want to know under similar circumstances.

Current research suggests that neither standard is sufficient. The physician standard fails to recognize that physicians do not practice in a uniform manner and that substantial practice variation exists, while the patient standard does not recognize that individuals are idiosyncratic and will value risks and benefits very differently.

SDM goes beyond passive disclosure of information to establish a process for a bidirectional exchange of information. Similar to informed consent, the provider shares information with the patient about the risks, benefits, and alternatives of a proposed treatment. However SDM also elicits values and preferences from the patient so that the treatment choice can then be aligned with these values and preferences.

A meta-analysis of 115 SDM trials has concluded that SDM, with the use of quality decision aids, leads to greater knowledge of risks and benefits by the patient, more accurate risk perceptions, greater comfort with the decision, greater participation in decision making, and fewer people remaining undecided (Table 1). SDM has the potential to become the gold standard for informed consent for many preference-sensitive conditions.

SDM in orthopaedics

Because a variety of treatments, including conservative and surgical options, may frequently be used for musculoskeletal diseases, orthopaedics is ideal for exploring patient preferences to guide treatment recommendations. But little literature on SDM in orthopaedics is available. Geographic variations in rates of hip and knee arthroplasty and spinal fusion cannot easily be explained on the basis of medical need alone; clarification of patient (rather than surgeon) goals and preferences may reduce variation in orthopaedic procedures and establish optimal surgical rates for different conditions.

Studies have shown that patient outcomes after various orthopaedic surgeries can be strongly influenced by preoperative expectations. As health care moves into an era of assessing patient-determined outcomes, more thorough expectation-setting can be accomplished through SDM. This, in turn, can be expected to improve self-reported patient outcomes.

An extensive literature search on SDM experiences and the use of decision aids found few orthopaedic examples. In their article, Slover et al addressed the value of SDM for providing “quality information...in the world of direct-to-consumer advertising and unvetted websites.” They also noted the need for further research in orthopaedics to assess SDM and decision aids for different patient groups.

Another review included experiences from disciplines other than orthopaedic surgery. Youm et al also addressed implications inherent in the Patient Protection and Affordable Care Act of 2010 and associated shifts in reimbursement occurring in both government and private models. The latest review, from the Cochrane Collaboration (www.cochrane.org), finds that literature on SDM and decision aids broadly and in orthopaedics specifically has expanded.

Arthroplasty

Early studies in orthopaedics involved assessing physician interest in SDM and demonstrated that orthopaedic surgeons supported use of decision aids. Recently, an observational study on the use of SDM examined the rates of total joint replacement (TJR), the impact of receiving a decision aid on progression to surgery, and costs. The study demonstrated that patients who received decision aids for hip or knee arthritis had lower levels of surgical intervention compared to historical controls. However, the observational nature of the study and the limited follow-up (6 months) were seen as limitations.

One prospective, randomized study evaluating the impact of SDM on patients considering TJR used a health coach to review the

TABLE 1: BENEFITS OF SHARED DECISION MAKING (SDM)

| Greater knowledge of risks and benefits by the patient |
| Greater patient participation in decision making |
| More accurate risk perception |
| Lower decisional conflict |
| Fewer patients remain undecided |
| Greater patient comfort with the final decision |

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