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Shared decision-making; fiction or reality?

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Shared decision-making

Nowadays, when persons meet in healthcare, more and more effort is put into achieving balanced interactions that allow for equal input from both parties: the patient and the clinician. Such a balanced interaction is the first step towards shared decision-making. This worth pursuing situation is, however, not yet a reality for all. Many clinicians are of the opinion that patients are not willing or able to participate in decision-making. Other clinicians feel that patients are less willing and able than what they perceive or report. As a result, many of patients' decision-making preferences are not met [1]. Still, research shows that the more patients know about their options, the more they wish to participate in treatment-related decision-making and the more they actually participate in decision-making about their care. In turn, participation in decision-making to the level one desires is related to higher satisfaction about the decision-making process and better health-related quality of life. There are also indications that sharing decisions by itself leads to decisions that better fit patient preferences [2]. Yet, the complexity of information, especially in an oncology setting, may overwhelm patients and lower the perceived clarity of their preferences. In turn, this may discourage them to participate in decision-making about health management options. Identifying what participatory role a patient desires or is able to fulfill, is one of the key but, at the same time, one of the more difficult tasks to accomplish when striving to reach shared decision-making.

Clearly, daily clinical practice continues to challenge the implementation of the ideals of shared decision-making [3]. Physicians who communicate more affectively (empathically) and give more information do appear to involve their patients - especially younger patients - more often in decision-making [3,4]. This underlines the role of empathy as a fundamental determinant of quality in medical care, enabling the physician to fulfill key medical tasks more accurately while achieving enhanced patient health outcomes [5]. The extent to which shared information provision and decision-making is accomplished is determined by the setting in which the medical visit takes place. An oncology setting with cancer patients who face preference-sensitive treatments [6] constitutes a totally different setting for enhancing patient involvement and autonomy than a primary care setting with patients with minor ailments [7,8]. A one-size-fits-all strategy for achieving shared decision-making is therefore likely to fail.

Every clinical interaction should instead be personalized by identifying which patients are willing or capable to be involved and if so, how they can be encouraged to achieve their preferred role within the broader aims of health care. This patient role may be further triggered by a drive to achieve autonomy given the fear of being left alone in making health-determining decisions and respect for a physician's professional expertise [6,9,10]. As most of these premises result from qualitative, practice-based studies, support for the advocated person-tailored healthcare is in need for stronger evidence using rigorous, experimental designs.

During our annual Geneva Conferences on Person-Centered Medicine as well as during our annual International Congresses of Person Centered Medicine, ample attention is paid to the studies and teaching which are needed to accomplish the goal of shared decision-making for all patients.

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