Shared decision making case study – Dr Simon Eaton, consultant diabetologist, Northumbria Diabetes Service, North Tyneside Hospital

Imagine a clinical scenario: Mrs X has come to a diabetes clinic appointment. She started on insulin 18 months ago. She is not keen on the insulin or increasing the dose and her diabetes control hasn't improved. She says her neighbour was put on a different treatment that is working really well and Mrs X wonders why she can't have that.

This is not a diabetes-specific issue. This could be any treatment that might have a long-term benefit but doesn't make you feel better in the short term – eg blood pressure, cholesterol, anticoagulation. There may be good reasons why insulin is the most appropriate treatment for Mrs X, or she may have had other options that weren't fully explored and her concerns are legitimate. Either way, it is certainly not working for her and she is not getting the benefit intended.

We have almost come to accept that 50% of people don't take their treatments as prescribed. However, perhaps we should be approaching this as one of the greatest challenges to modern medicine – arguably, we doctors are only half as effective as we could be.

Decision crossroads – such as deciding between insulin and other alternatives in type 2 diabetes – offer enormous potential. Handled well, they may mean that the treatment is used more effectively and enable people to become more engaged in the decision and their ongoing healthcare.

This is shared decision making. So how do we do it? The first step is helping people to understand that they have a role in making the decision and what options are available, and then work out what's right for them based on their personal preferences.

Patient decision aids (PDAs) are extremely useful to this process and have a considerable evidence base. In the scenario above, we developed a local PDA and were then involved in developing the NHS Right Care decision aid, which we encourage people to use. Patients find PDAs helpful, and clinicians struggling to stay up to date with new treatments and where they fit in also value them.

There are numerous PDAs available through NHS Right Care and Option Grid, and recently NICE has produced decision aids for anticoagulation in atrial fibrillation and cholesterol-lowering

treatment. It's fair to say that the NICE ones are a little long, but there is still a lot to be gained from using the relevant 'hundred person chart' to improve a conversation.

Crucially, a lot still depends upon the healthcare professional and their skills and approach to using PDAs in consultations. If we believe that we know what's right for a person better than they do, then there is likely to be only one outcome (which may also contribute to the 50% 'compliant' statistic!).

This may seem like common sense, but statistics around involvement in decisions show that it really isn't commonplace in healthcare. There is much to be gained from looking carefully at how we involve patients in decisions and what we can do better/differently to make sure that we're making the best of the resources in treatments we are prescribing, but also the resources of the person themselves.

For more information, see:

- Joseph-Williams N et al. Power imbalance prevents shared decision making. BMJ 2014;348:g3178.
- Health Foundation, 2014. Person-centred care resource centre. http://personcentredcare.health.org.uk/

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