Data, analysis, perspectives | No. 4, 2018

Shared Decision Making

Young physicians criticize poor framework conditions for patient involvement in everyday hospital practice

- **Open-minded physicians:** "Almost all of the younger generation of physicians aspire to implementing the model of shared decision making."
- **Economic pressure:** "Sometimes there's the announcement in the morning: Oh, there are no surgeries planned for today. Now you really have to work on getting patients to the OR."
- **Hierarchies as an obstacle:** "Sometimes you reach a decision together with a patient, and then the boss intervenes and just does it differently."
- **Competent patients:** "Sometimes the planned intervention was out of the question because the patient said: No, I don't want that; don't you have an alternative?"

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A hospital stay is a significant event for anyone. It almost always involves important decisions – about further examinations, taking new medication, or an operation. According to our recent survey, some 80 percent of the public would like to make these decisions together with their physician (see Figure 1). Shared decision making has been a patient right for more than five years. "The treating party and the patient should work together to implement the treatment," is stated in the Patient Rights Act of 2013 (Section 630c of the German Civil Code). For physicians, this gives rise to the obligation to comprehensively inform and involve patients (Section 630e of the German Civil Code), which almost all of the German public are aware of (see Figure 4).

There are good reasons – in addition to the legal framework – for shared decision making. Studies show that shared decisions have a positive impact on the treatment process, adherence to treatment and patient satisfaction.

The Bertelsmann Stiftung has looked into the extent to which the patient right to comprehensive information and participation in everyday hospital care is already practiced. What does this look like in everyday hospital activity? What helps hospital physicians or hinders them from including patients in decisions? What has to change?

For the study *Gemeinsam entscheiden im Klinikalltag* (Shared Decision Making in Everyday Hospital Practice), the Bertelsmann Stiftung interviewed 14 young hospital physicians on their experiences. Seven experts from academia and clinical practice have evaluated the key results of these focus group discussions with respect to their relevance and validity, and have formulated solutions (see box, page 4).

In the Bertelsmann Stiftung study presented in this Spotlight Healthcare, young physicians criticize above all the poor framework conditions for shared decision making in hospitals. As the study is a qualitative study, it makes no claim to representativeness. However, many of the

Significant interest in shared decision making

	Paternalistic model	Shared decision making	Informed model
Information flow	physician → patient	physician ↔ patient	physician → patient
Information type	medical	medical and personal	medical
Who decides which treatment to implement?	physician	physician and patient	patient

Who should decide?
What the public thinks:

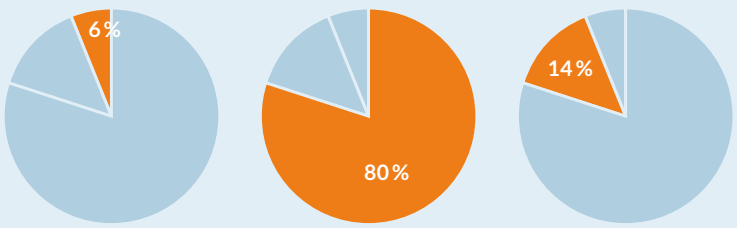

Figure 1 | Sources: Kantar Emnid, CATI survey, October 2018, n=1,039;
Spectrum of physician patient interaction: The authors, based on Charles et. al. (1999)

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What is Shared Decision Making?

Shared decision making (SDM) means that physicians and patients discuss and decide upon the further course of treatment together as equals. In this relationship, the physician is the expert on treatment options and their effects, and the patient contributes their personal experiences, needs and preferences. The core elements are the exchange of information and – after all treatment options have been explained – the active participation of the patient in medical decisions. The model outlined in Figure 2 lies between the paternalistic approach that completely delegates all decision-making responsibility to the physician, and the information model, where the physician assumes merely an advisory and informational role, and patient autonomy is the focus (see Figure 1).

Three-talk model of shared decision making

Figure 2 | Sources: Elwyn et. al. (2017) and the authors

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obstacles, including a lack of time, are well documented in surveys of physicians.

Young physicians experience obstacles

In our focus groups, young physicians were interviewed who reported having a positive to very positive general attitude towards shared decision making with patients. They had an average of almost three years of hospital experience. According to the physicians, shared decision making is already being applied in certain situations and disciplines. Overall, however, it seems that the reality of care lies far removed from the objective of patients having an equal say in treatment decisions. Many of the interviewees suspect that shared decision making is applied far less frequently in everyday hospital practice than in the outpatient sector. The young physicians also tend to have a pessimistic view of the future with regards to this issue.

Both groups in the study (Dresden and Frankfurt am Main) described significantly more obstructive than supporting factors with respect to patient involvement. According to the physicians, there is a wide range of different

> **"The patient should be able to have a say in any case. Shared decision making is an investment in a good relationship with patients, an investment that can make work easier."**
> Focus group participant

> **"Hospital culture is not SDM-oriented."**
> Prof. Dr. Jürgen Wasem

influencing factors that determine whether shared decision making can succeed in everyday hospital practice. These factors can be sorted into five thematic groups (see Figure 3).

Training in communication is fundamental

In the view of the physicians interviewed, an obstacle is presented by the fact that current education and training in the field of physician–patient communication takes insufficient account of everyday treatment. In the study of medicine, the concept of shared decision making is often presented only in theoretical terms. The available time in the practical exercises does not correspond with the reality in hospitals. Looking

Methodological approach

1. Focus group interviews
For the study *Gemeinsam entscheiden im Klinikalltag*, Patientenprojekte GmbH and Dr. Next GmbH conducted group interviews with 14 physicians (eleven women, three men) between the ages of 25 and 35 working in hospitals. The two-hour focus group sessions took place in Dresden and Frankfurt am Main in 2017. Two facilitators jointly conducted guided interviews, analyzed them, and distilled the key results. Focus group studies are not representative but provide detailed insight into topics and issues. The quotes selected for this Spotlight Healthcare are individual statements provided for illustrative purposes. Although they cannot be generalized, they indicate potential shortcomings in hospitals.

2. Expert reviews
Subsequently, seven experts were asked to review the content and validity of the key findings of these focus group interviews, and to outline solutions for the problems described.

The interdisciplinary team of experts

- **Dr. Martin Danner,** Federal Chairman of the Federal Association of Self-Help Organisations for people with disabilities and chronic diseases and their relatives
- **Prof. Dr. Friedemann Geiger,** Head of the Innovation Fund Project to fully implement SDM at UKSH Kiel
- **Prof. Dr. Bernd Griewing,** Chief Medical Officer RHÖN-KLINIKUM AG
- **Prof. Dr. Dr. Martin Härter,** Director of the Institute and Polyclinic for Medical Psychology, UKE Hamburg
- **Prof. Dr. Jana Jünger,** Director of the Institute of Medical and Pharmaceutical Proficiency Assessment, Mainz
- **Prof. Dr. Jürgen Wasem,** Chair of Medicine Management, University of Duisburg-Essen
- **Prof. Dr. Christiane Woopen,** Executive Director of ceres, University of Cologne

back, young physicians often perceive this as a frustrating gap between theory and practice.

That said, practice-based training should not be adapted to the reality in hospitals, rather it should guide future physicians in changing everyday hospital practice. For example, they should be empowered to demand that more time be spent talking with patients. To date, it has been generally left to medical faculties to decide how and to what degree they deal with the subject of physician-patient communication. This is likely to change with the *Masterplan Medizinstudium 2020* (Masterplan Medical Studies 2020), which will anchor communication between the physician and the patient more firmly in curricula and examinations.

The experts consulted by the Bertelsmann Stiftung regard education and training as areas of activity that can have a lasting positive influence on the implementation of shared decision making. However, it is also necessary to continue developing these areas after graduation. In addition, the experts recommend considering interdisciplinary communication and methods such as personal coaching, supervision and online courses.

> **"We had enough time to talk with patients in the communication courses. In the hospital, the boss starts rolling his eyes after only ten minutes."**
> Focus group participant

> **"Education should not adapt to the flawed reality of everyday hospital practice; education should instead contribute to changing this reality."**
> Prof. Dr. Christiane Woopen

Economic pressure hinders shared decision making

For the young physicians, there is a direct relationship between the working conditions in hospitals and the difficult implementation of shared decision making. Economic pressure is perhaps the most limiting factor. Financial interests have a very significant influence on the selection of treatment options. Some young physicians have seen patients presented with deliberately incomplete information on treatment options in order to direct them towards a therapy that was lucrative for the hospital. This approach makes a mockery of shared decision making.

> **“Services that are not offered in our hospital are not even mentioned as options.”**
> Focus group participant

> **“Communication should be accorded a higher importance. Medicine is largely also a communication-based discipline.”**
> Prof. Dr. Bernd Griewing

Other participants in the focus group study report that talks with patients are kept as short as possible. Communication is given low priority because of inadequate incentive systems – the time spent in patient discussions is not reflected in the remuneration system. Because it ultimately does not matter how a decision is arrived at, the time for talks with patients is calculated so tightly that implementing shared decision making as an integral component of everyday hospital practice is almost impossible. For young physicians, this is a burden and a moral dilemma. They seem trapped between the demands of their employer or superior and the obligation they feel to the patients. There is the risk that the needs of patients will regularly be neglected if physicians are forced to weigh up these different expectations in the everyday provision of care.

Some of the experts consulted saw a potential solution to these problems arising from the passing on of economic pressure in a change to the remuneration system: there must be an economic incentive for conducting discussions for shared decision making. Others, however, also point out that implementation could be difficult in view of the effort required for monitoring this.

Obstacles: hierarchies and culture of dialogue that avoids criticism

According to the experts consulted by the Bertelsmann Stiftung, the culture of communication and cooperation that has developed over decades in hospitals is poorly geared towards shared decision making. Strong formal and informal hierarchies usually inhibit patient involvement, especially when the head and/or senior physicians do not think much of it or impose treatment decisions that have already been made regardless of patient preferences. According to the young physicians, this is accompanied by a culture of dialogue that avoids criticism of superiors or more experienced colleagues. At the same time, a strong hierarchical structure can promote the implementation of shared decision making. Some individual physicians report that their superior attaches great importance to informing patients and patient involvement.

According to the interviewees, good interprofessional collaboration is particularly helpful. Due to their proximity to patients, nursing staff can play a supportive role in providing information, as can psychologists, counselors and social workers. Some physicians tell of their experiences in fields such as oncology, pediatrics and intensive care, where interprofessional cooperation was already functioning well in some cases. However,

> **“Sometimes, the boss just makes a decision. And, unfortunately, this kind of behavior rubs off on us a bit.”**
> Focus group participant

> **“Despite increased awareness of active error management, a good feedback culture is still often lacking.”**
> Prof. Dr. Jana Jünger

Groups of described influencing factors

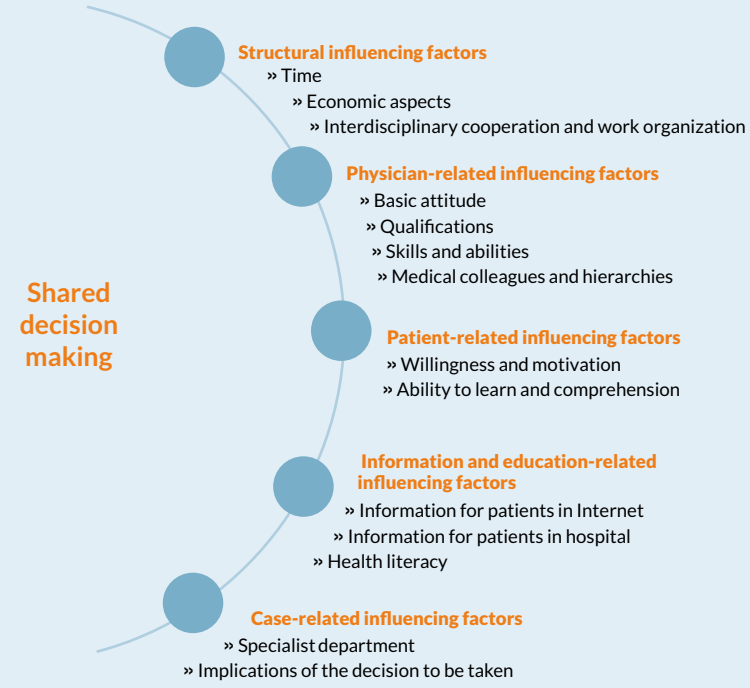

Figure 3 | Source: The authors

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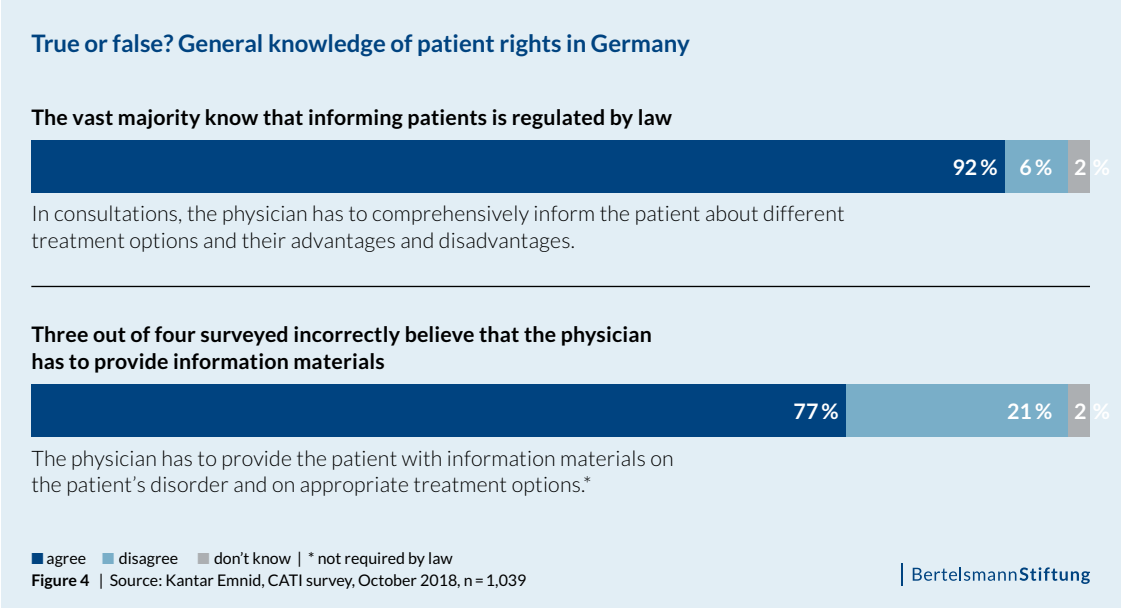

Figure 4 | Source: Kantar Emnid, CATI survey, October 2018, n = 1,039

this often takes place in an unsystematic manner. In individual cases, this could even result in greater effort for the treating physicians if information is conveyed in an uncoordinated manner and/or is even contradictory in nature.

The experts confirm that leaders can sustainably motivate and empower young physicians, but can also frustrate and dishearten them. This is why they think it is essential that the culture of dialogue in hospitals is given higher priority as a whole. If shared decision making were a central quality standard anchored in a quality management system, then patient involvement could be viewed and implemented as a team objective.

Physicians would like more support in communicating information

According to the study participants, the information sheets and materials currently used are only partly suitable for use in patient discussions, so self-developed materials are often used. The young physicians would like to have information that is well-prepared in terms of didactic content. In addition, there needs to be better guidance on using the Internet to help patients select trustworthy sources for their own research. The interviewees had a unanimously positive assessment of the use of videos to convey information, and they expect this to promote shared decision making. Thus far, however, these technologies have been implemented in few hospitals or only sporadically.

> **"I would really like more supporting information materials to inform patients with, and I don't understand why these don't exist."**
> Focus group participant

> "The future belongs to interactive formats, but only to prepare for talks with patients, not to replace them."
> Dr. Martin Danner

According to the experts, better supporting materials can only work if the other framework conditions for implementing shared decision making are right. Formats like educational videos are not sufficient on their own, as patients cannot ask questions directly. The variety of information already available today poses challenges for physicians in selecting suitable material for their respective patients.

Shared decision making depends not least on the patients themselves

In the focus groups, it was repeatedly stressed that there are always two sides to shared decision making, as patients also have a significant influence on the whole process. However, their willingness and motivation to take responsibility and play an active role in decision making varies. In particular, older people who grew up with different role models of physicians and patients often reject shared decision making. In the experience of the young physicians interviewed, they tend

“You learn these great techniques, but the patients don’t demand this because they’ve learnt something different for sixty years.”
Focus group participant

“It is necessary to develop understanding with an interlocutor, even if it takes them somewhat longer to develop this understanding.”
Prof. Dr. Friedemann Geiger

to favor a paternalistic approach. Especially with serious decisions, older patients are often overwhelmed and want the physician to determine the treatment. Younger patients, on the other hand, are better informed, ask more questions, and demand more often shared decision making.

Shared decision making in everyday hospital practice depends on many individual factors. The patient clientele are very heterogeneous, both with respect to their health literacy as well as their motivation to actively participate in their treatment. The importance of patients’ personal motivation is indicated by the fact that, according to the interviewed physicians, discussions about treatment options frequently only come about at patients’ initiative. However, most of the experts consulted by the Bertelsmann Stiftung are of the opinion that the responsibility for active patient involvement should lie with the physician rather than with patients. Improved patient health literacy should not lead to medical responsibility being shifted towards patients.

A patient-oriented attitude is key

In the interviews, the physicians confirmed that a patient-oriented attitude and a positive view of patient involvement are among the most important prerequisites for achieving shared decision making in the treatment process. To this end, the young physicians occasionally put in extra work or have to accept conflicts with superiors and colleagues – which they find frustrating.

Despite their positive attitude, there are clear limits to shared decision making for some of the interviewees, depending on the scope of the decision from a medical perspective and the abilities of the patient. The physicians agreed that patients had to be involved with all treatments with serious consequences or high risks, such as with operations or invasive examinations. Some also stressed that, from a medical perspective, less serious interventions, such as changing blood pressure medication, can have a major impact on patients, and should therefore be discussed with patients.

In the opinion of the experts, a key factor is the development of a personal attitude that supports the exchange between physicians and patients and enables shared decision making. However, attitudes cannot simply be prescribed or picked up from a textbook. Rather, they result from experience and expertise accumulated over years. This is why it is necessary to continuously embed communication and shared decision making in education and training and to interlace it with practice. In doing so, the primary goal should also be to impart skills that enable prospective and young physicians to implement good physician-patient communication, even under difficult conditions, thereby incrementally improving the framework conditions for shared decision making at the same time.

“In order to be able to spend more time with patients, I frequently have to work unpaid overtime.”
Focus group participant

“Physicians’ attitude towards patients and a patient-centric approach is a key factor for the success of shared decision making.”
Prof. Dr. Dr. Martin Härter

The study Gemeinsam entscheiden im Klinikalltag (in German only) is available for download at www.patient-mit-wirkung.de.

Recommended actions

Better support for shared decision making

Thus far, shared decision making has been poorly integrated into everyday hospital practice. The obstacles – ranging from a lack of practice-based training, through time pressure, to a lack of acceptance by superiors – are too great for individual measures to achieve success. Rather, a whole package of measures is required.

Implement patient rights

› Physicians and nursing staff have to take the legal obligations regarding patient information, education and involvement seriously; hospital managers and chief physicians have to further promote their implementation in everyday hospital practice.

Adapt quality standards

› Policymakers and self-governing bodies should elevate shared decision making to a quality standard for hospitals so that patient-oriented discussions can be systematically embedded in treatment processes.

Change the remuneration system

› The partners of self-governing bodies should adapt the remuneration system in such a way as to incentivize not so much the provision of services, but rather the exploration of patient preferences and needs-based indications.

Improve education and training

› Medical faculties, professional societies and medical associations should overhaul education and training so that communication competency can be trained and continuously consolidated as a medical core competency.

Employ information materials

› Evidence-based information materials tailored to patient groups and decision making aids have to be systematically developed and increasingly used in medical practices and hospitals. The potential of digital media and platforms should be taken greater advantage of.

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