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Incorporating Shared Decision-Making in Clinical Practice: Key Considerations

Announcer:
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This episode of *Living Rheum*, titled "Incorporating Shared Decision-Making in Clinical Practice: Key Considerations" is sponsored by Novartis US Clinical Development and Medical Affairs. The host and speaker have been compensated for their time. This program is intended for health care professionals.

Here's your host, Dr Jason Liebowitz.

Dr. Liebowitz:
Shared decision making, or SDM for short, is rapidly growing in the field of medicine. Implementing SDM tools in rheumatology can improve patient knowledge and help us make better treatment decisions. This is ReachMD, and I'm Dr. Jason Liebowitz. Joining me to discuss SDM in rheumatology is Dr. Michael Putman, an Assistant Professor of Medicine in the Division of Rheumatology at the Medical College of Wisconsin. Dr. Putman is also the Associate Fellowship Program Director and Medical Director of the Vasculitis Program. Dr. Putman, thanks for being here today.

Dr. Putman:
Thanks so much for having me. I'm very excited to share this podcast with you.

Dr. Liebowitz:
Very well said, and Dr. Putman, what strategies do you use to better understand your patients' treatment goals when you're working with them in the office?

Dr. Putman:
That's a good one. I mean, I think that the most important strategy is just the time-honored, open-ended question. I think that's a real skill, asking an open-ended question that encourages someone to start talking. But I think that the more you can illicit the patient's story, and the more you can refrain from interrupting them, and let them just tell the story of how they came to see you, and get a sense for what's been hurting or what's been bothering them, and how they see you interacting in their care – I think the more you can just let people talk, and ask open-ended questions, I think the better of a job you'll do at trying to understand people's goals, and what they're looking for.

I also think warmth is really important. You know, a lot of us work in big academic centers, or fancy, shiny clinics and you know, you have a team of people following you around. I think it can be very intimidating, and so, you know, just sitting down, making eye contact, shaking hands, just smiling at people – doing the kinds of things that, you know just encourage people to feel comfortable sharing, I think is really, really critical. I'm kind of a goofball. I think that helps sometimes. But you gotta be careful with that. You gotta be a professional goofball.

And then, I think the other thing is just understanding that this is not, you know, trying to elicit goals is not a one-off thing. It's an ongoing process, so you're going to reassess throughout the conversation. You're going to reassess over time, and I think that just making sure that you don't prematurely close your perspective on what someone's looking for is really critical.

Dr. Liebowitz:
Beautifully said, making communication warm and open, and recognizing that the relationships we establish with patients are long-term

relationships, and that's okay to come back to topics and help that relationship grow and better understand our patients.

What are the benefits you've seen in using shared decision making with patients in the clinic, and please feel free if you can share some personal examples from your own clinical practice?

Dr. Putman:
That's a great question. You know, I think that the first and most important thing is to just understand that the patient is ultimately the one who's going to execute the plan you put together. So, the best, most evidenced-based treatment isn't useful if your patient doesn't take it. And the more they're a part of that plan, the more they're going to understand why that they're taking it, and the more they're going to be invested in it, and so I think involving patients very closely, and understanding the risks and benefits of therapies early on, will really help you be a team in their care, as opposed to you just making recommendations that sort of float off into the ether. I think part of that is just empowerment. I think that when patients own the treatment choices that they've made, I think they feel like they have more of a locus of control. I mean, rheumatic diseases can be very challenging for people.

There's also for one problem with rheumatic disease is there's no why. People can't say why you got the rheumatic disease, and I think that can make people feel very helpless, and so giving back some control, over at least the plan to address it, I think can be a very empowering thing. And then, you asked for an example from my own practice. And, you know, this is kind of an unfortunate side of this, but I think this is another reason that shared decision making is so important.

And so don't judge me for this statement, but a lot of our treatments don't work very well, and you need to be ready for your treatments to not work very well, and if your patient goes into a treatment, understanding that it's not a panacea, and understanding that there's limitations to it, then they will be much more willing to try the next thing that you recommend, because oftentimes in rheumatology, the first thing we do doesn't get the job done, and when someone understands your plan, and made that decision in concert with a discussion with you that was open, and acknowledged the risks and benefits of the therapy, they're going to be much more likely to go along with you for the next one. So, I think that shared decision making can be really important in those situations.

Dr. Liebowitz:
As a specialist in vasculitis, you deal with diseases that certainly can have significant morbidity and mortality, and often you are responsible for discussing possible toxicity of treatments and weighing that against the potential benefits of inducing remission and providing maintenance of remission. Can you talk a little bit about how you approach these very challenging discussions, and work together with patients to make the best decisions together with them?

Dr. Putman:
Yeah. A couple thoughts. I mean, I think the first thing is, you mentioned toxicity, which is hugely important to me. I had an attending when I was training who would just read the laundry list for every single treatment. And in the back of my mind, I felt like it was excessive, and then later on in the year, we had a patient come in who developed cataracts, and had to have surgery. It had been very challenging for them, and they said, you know but she did tell me that that could happen. And I just realized how important acknowledging toxicities and risks are, even if they seem, you know, like something that is, you know, the ninth most important thing from glucocorticoids. Like, it is very beneficial to make sure the people know exactly what they're getting into, and so I take toxicity extremely seriously, and I'm very clear before we launch into any therapies.

Dr. Liebowitz:
If you're just joining us, I'm Dr. Jason Liebowitz, and this is a special episode of *Living Rheum*. Joining me for this discussion about innovations in rheumatology is Dr. Michael Putman.

Are there any challenges you've encountered in trying to use shared decision making effectively in your practice?

Dr. Putman:
Oh, wow. I could list a number of 'em. Let me give you a couple that I think are common ones that I have encountered, and maybe try and see if I can help people if they encounter the same. Now, the first one that I really struggle with, is when people ask me to drive the bus, and it's funny because I think a lot of people know me as having strong opinions about things and being a little too open to share how strongly I feel about stuff, but when it comes to patient care, I'm kind of the opposite.

I am very, very deferential to patient opinions, and it's so important to me that people drive their care, that when someone says, "You know, doc, just tell me what I should do." I have a hard time with that question, and I do think that there's a substantial group of people who really do just want to know –they really just want to know what you think they should do, and for a long time, I tried to dodge that, but I've kind of embraced it, and I make a point of saying, "If I was in your shoes, this is what I would do," because I think it lets patients feel that they have been given that directive counsel, while also I have a hard time actually doing it myself.

The other dynamic that I think can be really challenging for shared decision making is when there's another person in the room. I think our friends in pediatrics are especially acutely aware of that, because they always have a patient in the room, and so all of their decisions go through two parties, one of which is not the patient, and one of which may have a stronger opinion. But I see that lot in my practice.

Family members are often involved, which is hugely important, but family members are often very involved in a way that can impact the way a patient winds up making choices. And so, I try to involve family members explicitly – say, "What do you think? What are your opinions on this?" But then I try to make sure that I'm constantly redirecting, so that we're really eliciting what the patient themselves wants for themself. And so, I actually think that, especially with family members who are very involved, it's good to embrace that, but then also make sure that you're transitioning to getting the patient's wishes involved.

The last thing is that – you know, there's a lot of trouble with misinformation these days, and I think that that's kind of a hot topic. And I find that the approach that many people take, which is to cite authority or to cite figures, doesn't work very well when you're addressing misinformation. I think that personal stories and the power of narrative is something that we should embrace. If you're trying to discuss an important issue, such as vaccination, I think that discussing people, and the people you've seen and the experiences that you've had in an honest and open manner, I think is the best way to do that. And so, part of shared decision making for me is sharing stories with people about people who are similar to them, of course, in a HIPAA-compliant way, but, still trying to connect on that level.

Dr. Liebowitz:
That's very well said, and if I could ask, what are some ways clinicians can assess if they're effectively using shared decision making in clinical practice?

Dr. Putman:
Yeah, that's a good one too. So, you know, the thing – I think this is going to be a controversial opinion, but I actually like patient satisfaction scores. I think that this is something medicine has been very averse to because there's this feeling that you can't possibly assess a doctor. But I think that we should lean into this, because this goes back to my feelings on patient report outcome measures – you know, what's the best way to know whether a patient's quality of life improved? You should ask the patient. And, what is the best way to know if you're communicating effectively? You should ask the patient if you were communicating effectively. And so I think that satisfaction scores are actually quite useful.

The second thing is just eliciting feedback, and not just doing it once, doing it frequently. So, if I'm talking about something, especially that's somewhat dense, I will always ask, you know, "How did you feel about that discussion?" or, "Do you have any questions about this?" Or, you know, "Is there anything else that came up while I was talking?" Just to try to make sure that you're giving people openings to both, you know, become more engaged in the conversation, but also to just say how they felt about the conversation itself. And I've had people be very blunt. They'll say, "Frankly, doc, you know, you came on a little hard there." And I'm like, "Okay, great. That was a mistake. I'll do better next time."

And so, I think that, you know, actually just asking people how communication is going sometimes, can be really helpful, especially if you're reading their nonverbal cues, and you can tell that they're withdrawing, or that something you've said didn't register the way you expected it to. So, I think, literally just asking people is quite useful.

And the last thing is just having a thick skin. You know, often it's hard because we've spent so much time training, and we think that we have spent so much time talking to people and that we've figured it all out, but, social dynamics are very complicated. You need to be open to failure and open to some relationships not going the way you wanted, and I think that can be the hardest thing for us. Trying to learn from those experiences is really important, but then also being able to move on, and not let it negatively impact your next relationship is really important.

Dr. Liebowitz:
I think that's really beautifully stated, and we have this tremendous honor and privilege to take care of people, and it's important we never forget that the patient is the most important person in the room, and we're there to help guide them and support them. So I really want to thank our guest, Dr. Michael Putman, for helping our audience better understand the ways in which clinicians can use shared decision making in clinical practice. It was a pleasure speaking with you today. Thank you, Dr. Putman.

Dr. Putman:
Oh, absolutely. That was a really important topic, and it was an honor to be here, so thank you for having me.

Announcer:
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