Shared Decision-Making: The Norm, Not The Exception, In Prevention And Management Of Wounds

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A Key For Patient-centered Care And Engagement

In the current Canadian health-care landscape, patients increasingly seek to take an active role in decisions related to their health.[1] Patient-centered care (PCC) emphasizes the importance of engaging patients and their caregivers in the decision making processes and taking time to understand their needs, priorities and preferences.[2,3]

Moreover, informed patient preferences are seen as the optimal objective, as this tends to lead to more realistic expectations and a better understanding of the positive and negative consequences of the plan.[4] A call to action for PCC and shared decision making for wound care (prevention, assessment, treatment and management) highlights the importance of providing sufficient information to enable patients and caregivers to play an active part in their care planning. This engagement supports transparency in infor-

mation-sharing with the patient and facilitates a time to discuss the plan, ask questions and participate.[5] Shared decision-making (SDM) is a great way to do this. Palmer (2022) states in reference to shared decision making and wound care: shared decision-making involves providing all the information that is necessary to help the patient[6] critique and review what is best for them, and to give the patient the choice to make a decision about not only the treatment, but regarding who provides it.[7]

The process of engaging in shared decision making in wound care is important and it complements other goals such as focusing on patient-related outcomes and experiences (PROMs and PREMs). The engagement of patients in the decision-making process beyond informed consent are deemed important for effective management in recent years.[8] With increasing emphasis on patient-centered care, SDM between interprofessional wounds care team members, the patient and their caregivers is becoming essential in wound care.

What is Shared Decision-making?

When both health-care professionals and patients acknowledge the necessity for a decision, the process in which a health-care choice is informed by evidence and what matters most to the patient and is jointly made by both parties is known as shared decision-making (SDM).[1,4] For example, in wound care, this could be the decision on offloading modalities for diabetic foot ulcers, or the choice of compression modalities for venous ulcers, or pressure redistribution devices for persons with a spinal cord injury and at risk of pressure injuries.

Engaging in SDM empowers patients to comprehend the evidence-based risks and benefits of each option, enabling them to make decisions based not only on their health-care professional's (or team) recommendations but also on what matters to them.[1]

What Steps Need To Be Taken To Engage In A Shared-decision Process?

SDM is a process grounded in a model of deliberation and exploration of patients' priorities and what is most important to them. Although SDM is influenced by a plethora of psychological, social, and emotional factors, Elwyn, et al. (2012) have proposed a three-step parsimonious model to simplify SDM and promote its integration into clinical practice. It is essential to note that this model is not a prescriptive guideline but rather

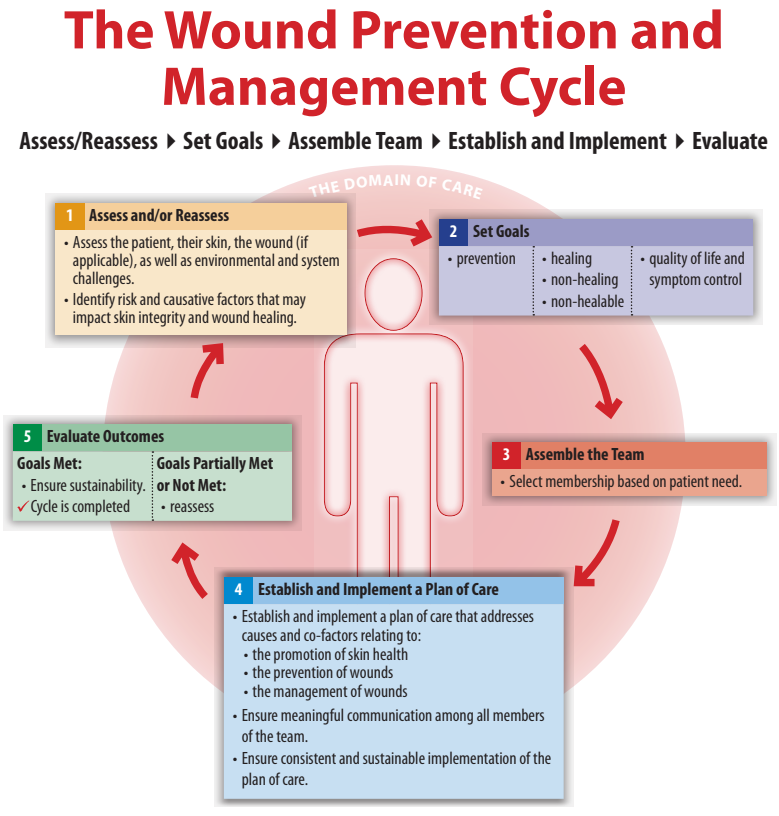

Figure 1: The Wound Prevention and Management Cycle (Wounds Canada).

outlines a stepwise process.[4] The model consists of the following steps:

1. Choice talk
2. Option talk (utilizing patient decision support) and
3. Decision talk.

Integrating these steps into interprofessional wound care teams at step 3 of the wound prevention and management cycle (see Figure 1) would facilitate the use of SDM throughout by defining a decision coach within the team that will support the SDM process. The SDM's interprofessional model (IP-SDM) was developed to support the decision process with a team with all stakeholders involved in the decision making process (patient, family, first responders, health-care professionals).[10]

Step 1: Choice Talk: Introducing Options

The first step involves ensuring that patients are aware that there is a decision point and, therefore, that there are options available to them for risk screening, prevention, diagnosis, treatment and/or follow-up regarding their skin and wounds. This step does not necessarily have to occur during the clinical encounter. For instance, patient decision aids (DAs), evidence-based tools designed to assist patients in making informed choices among health-care options, can be highly beneficial in this regard and distributed outside the consultation time.[11] For example, *The Ottawa Hospital Research Institute: Patient Decision Aid* features an A to Z inventory. Here is an example related to skin: *Basal Cell Skin Cancer: Should I have Surgery or Use Medicated Cream?* This tool also features an introduction to the topic, patient options, key points to consider (including surgical and other treatment options) and risks of treatment. *The Ottawa Hospital Research Institute Patient Decision Aid* is available at: https://www.healthwise.net/ohridecisionaid/Content/StdDocument.aspx?DOCHWID=abp6164

Referring patients to educational online platforms or electronic DAs can also be an interesting alternative where educational material is available and easily accessible online. During this step, it is recommended to step back, summarize, and

guide the patient (and caregiver) through their decision-making process after presenting options. It is also important to justify the options while emphasizing the significance of respecting individual choices and acknowledging the role of uncertainty in health care, especially regarding the level of evidence-based facts, unpredictable treatment outcomes and potential side effects. It is also suggested to defer closure if patients directly ask health-care professionals, "what to do", and instead encourage patients to reflect on their options. Only after explaining all options in depth and ensuring patients understand what is at stake should health-care professionals offer to help them think their options through.

For example, in a recent study, researchers in Calgary took an existing Decision Aid regarding rheumatoid arthritis to Indigenous patients for their review and adaptation. In focus groups on medical and cost coverage information (formulary), Umaefalam and colleagues (2022) included Indigenous traditional health practice options, language and text and integrated Indigenous images and colours representative of the community.[12] From this study, researchers recommend co-creating DA with Indigenous partners to increase use and relevancy. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8866334/

Step 2: Option Talk: Describing Options

The second step involves providing more detailed information about the available options. Before listing out the options, it is important to assess the patient's knowledge and inquire if they have already heard about a specific screening option or treatment. This approach helps ease into the conversation gradually and facilitates the process of explaining different options while involving and empowering the patient. When discussing the options, it is crucial to be attentive to the patient's reaction, assess their understanding, and ensure that each option and its respective benefits and risks are thoroughly explained and fully understood. Summarizing, reformulating, and listing the options again, known as "teach-back", is a valuable method for detecting and addressing any misconceptions. Risk and benefits and explaining in lay terms the probabilistic nature of evidence is crucial. For example, the Agency for Healthcare Research and Quality provide *A Patient's Guide to Teach-Back* that includes:

Teach Back IS:

- A way to make sure you and your provider understand each other.
- A chance for you or your family to ask questions during your visit.
- A safety check that your provider wants to do with you.

Teach Back IS NOT:

- A test of what you know.
- Something to be nervous about.

Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/PatientsGuideToTeachBack.pdf

Step 3: Decision Talk: Helping Patients Explore Preferences And Make Decisions

The third step is a deliberative process in which health-care professionals' recommendations and patients' preferences are considered. It entails determining which option aligns with their personal values and is, therefore, the best choice for them. During this step, it is important to focus on the patient's preferences and encourage them to think about what matters most to them. Health-care professionals should be willing to guide the patient throughout the decision-making process, gradually moving towards a decision. Finally, it is important to offer a review to patients and remind them that decisions can be revisited until they are sure about their choice. They can adjourn the decision.

With the examples of offloading modalities for diabetic foot ulcers, or the choice of compression modalities for venous ulcers, this represents presenting all the options available to patients (and caregivers) and not imposing a particular choice of offloading or compression. Give patients all the evidence-based medicine information available

Figure 2: Building a health-care system that's Fit for Purpose. Ma. A. (2022). Available from: https://www.pwc.com/ca/en/industries/healthcare/system-fit-for-purpose.html

on these options, discuss with them, observe their reflective process by supporting them to make a choice with facts and figures they can understand, so that they can construct their own ideas to make their own choice. The final choice is shared between all stakeholders involved directly in this specific process. So, the final choice may not be the one that will heal the ulcer fastest in a certain context, but it's a choice that respects both parties.

What Are The Impacts Of SDM?

SDM has demonstrated positive impacts on the health system as a whole, aligning with the quintuple aim (see Figure 2).[13] SDM enhances patient experience, improves outcomes, optimizes value-based care, and improves providers experience. A fifth aim was recently added in terms of health equity, and it was shown that SDM seems to benefit more vulnerable people.[14,15,16] However, there is very little data related to SDM and its impact in wound care, but it is promising, espe-

Resources To Support SDM In Practice

Note: This list is not inclusive.

International Patient Decision Aid Standards (IPDAS) Collaboration. (2023). Available at: http://ipdas.ohri.ca/

National Institute for Health and Care Excellence. (2021). Quality Standard- Shared Decision-Making Guideline. Available at: https://www.nice.org.uk/guidance/ng197

Agency for Healthcare Research and Quality. (2014). The SHARE Approach. Essential steps of shared decision making: Expanded references guide with sample conversation starters (Workshop curriculum: Tool 2). Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/shareddecisionmaking/tools/tool-2/share-tool2.pdf

National Institute for Health and Care Excellence. (2023). Making Decisions about Your Care. Available at: https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids

Wounds International. (2016). Best Practice Statement: Optimising patient involvement in wound management. Available at: https://www.woundsinternational.com/uploads/resources/9fcc-d1d852f5fc23b853a0a00066c5b9.pdf

Cochrane UK. (2023). Decision aids: Helping people make better healthcare choices. Available from: https://www.evidentlycochrane.net/what-matters-most-to-you-how-decision-aids-help-patients-make-better-choices-2/

The Ottawa Hospital. (2023). Ottawa Decision Support Framework (ODSF). (2023). Home Page. Available at: https://decisionaid.ohri.ca/odsf.html

The ODSF: A to Z Inventory of Decision Aids: Available at: https://decisionaid.ohri.ca/AZinvent.php

London Health Sciences. (2023). Decision aids. Available at: https://www.lhsc.on.ca/shared-decision-making/decision-aids

University of Laval. (2023). Decision box. Available at: https://www.boitedecision.ulaval.ca/en/

cially in self-care.[17,18] In the context of patients with non-life-threatening conditions, SDM presents a truncated risk-benefit ratio for its application as a communication tool that engages patients and their caregivers with the wound care team. SDM's positive impact on communication can support the Quintuple Aim.[19]

In terms of patient experience, SDM is inherent to informed consent and is rooted in a health promotion perspective. It aims to involve patients in decisions related to their health. It has been shown that SDM contributes to improved health outcomes by empowering patients, minimalizing conflict and regret in the decision-making process and increasing satisfaction with the received care.[11,20] SDM also facilitates high-quality communication to support the decision-making process and helps patients choose the most suitable option for them.[21] By providing a more accurate perception of the risks and benefits associated with different health conditions and the probabilistic nature of evidence, an SDM-based approach helps reduce unrealistic expectations and reduce regret after a decision is made. It has also been demonstrated that patients (and caregivers) who use DAs feel better informed and have a clearer understanding of their preferences within the decision making process.[11] Unfortunately, there are very few DAs to help SDM in wound care. However, some do focus on the patient as a whole and not only the wounds, and thus are relevant in wound care. (see Resources To Support SDM In Practice). DM is developing in the wound care sector, and specific DAs will soon be available. Regarding health outcomes improvement and health system optimization, emerging evidence suggests that SDM promotes treatment "adherence" among patients to their chosen option. A positive correlation exists between patient involvement in treatment decisions and higher treatment compliance.[22] Improved adherence to treatment leads to cost minimization in health care, reducing hospitalization rates and complications.[11] Therefore, SDM contributes to cost optimization and enhances the efficiency of the health-care system.[22] Patients receiving enhanced support for SDM had lower overall medical costs (5.3%) and fewer hospital admissions (12.5%) compared to a usual support group, indicating potential cost savings. Additionally, for preference-sensitive conditions, the use of DAs has been found to influence patients to opt for conservative treatment options rather than invasive surgery.[21-22]

SDM establishes positive clinical encounters, promoting meaningful and fulfilling work for physicians, and it can be suggested that SDM potentially reduces burnout in the health-care force. SDM is embedded in the Interprofessional Shared Decision Making (IP-SDM) model, which involves at least two health-care professionals with different backgrounds working together towards an SDM-based approach. This model expands the perspective of SDM beyond the patient-physician dyad. Aligning with Bodenheimer's vision (2014) of expanding roles within the health-care team to improve the work life of health-care professionals, IP-SDM is seen as a suitable approach to address the fourth aim.[24] Finally, regarding the equity aim, results from a systematic review indicate that SDM interventions significantly improve outcomes for disadvantaged patients.[25]

SDM Myths, Realities And Limitations

There are many myths surrounding the practice and implementation of SDM in the health-care landscape. Some argue that SDM is an unsustainable trend in the modern world and will eventually fade away, as not every patient is ready to engage in it.[26]

However, considering that SDM is at the core of patient-centered care, which is a priority in the health-care system in Canada, that it is deeply rooted in the way we perceive our health, SDM should not be dismissed as a passing fad. Moreover, an increasing body of literature suggests that patients desire more information about their health condition and wish to play an active role in decisions concerning their health.[27,28]

It is often misunderstood by health-care professionals who mistakenly equate SDM with patient informed consent or with what is commonly

and broadly perceived as a patient-centered approach. Some health-care professionals who hold this misconception fail to adequately engage with patients during clinical encounters. SDM, in reality, follows a rigorous approach with well-defined steps that encompass specific behaviours from both patients and health-care providers. In contrast with the common belief that SDM is limited to the patient-physician relationship, SDM-based approaches can also be applied to interprofessional health-care teams with the aim of improving continuity and quality of care, reducing professional silos and fostering a more harmonious work environment.[18,29]

Although there are numerous myths surrounding SDM practice and implementation, certain situations can impose limits on its application in specific contexts. These limits arise when broader interests override individual preferences. For instance, some medications cannot always align with patient preferences due to the need for cautious use and reliance on the clinical judgment of the health-care professional. This is particularly relevant for antibiotics and opioids to address concerns of antibiotic resistance and opioid addiction, respectively. Moreover, SDM may face limitations when population health prevails over individual preferences, as seen in the emphasis placed on the broader societal benefits of immunization methods, especially in the context of vaccine hesitancy. Additionally, SDM faces resistance from health-care professionals, primarily when patient preferences do not align with the existing evidence in favour of a specific clinical option compared to others, or when the treatment is considered a standard of care and a widely accepted clinical practice recommendation. Furthermore, there are specific contexts where SDM-based approaches cannot be fostered, such as medical decision points mandated by the law or explicitly guided by societal norms or system-level legislation, like newborn screening or medical screening for work activities. In life-threatening conditions, highly stressful situations, where an unfavourable prognosis of a severe disease is announced, patients' judgment may be impaired and limit their cognitive abilities to process medical information, statistics, evidence and to consider different treatment options with their respective benefits and side effects.[27] In such cases, SDM cannot be achieved.

Conclusion

Patient-centered care of high quality integrates SDM in wound care prevention and management. This is the standard of care. SDM has demonstrated its benefits in many areas of medicine and should be the norm, not the exception, for patients with chronic wounds or at-risk. The benefits would include an informed patient and family. Patients may change health behaviours and engage in self management. However, SDM success lies in its implementation, which requires considerable effort on the part of health-care professionals and patients, as well as at the organizational level. There is a great deal of research to be done in this sector to measure its potential at the patients' bedside.

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