Executive Summary

i. In many countries, patients are actively involved in their own medical care, with medical decisions made in partnership with physicians after clarifying acceptable treatment options available. Factors supporting this trend include the increasing availability of medical information to patients; endorsement of individual autonomy and responsibility; and difficulty for physicians to accurately identify patients’ concerns.

ii. Situations that could benefit from patients’ input would be those where there is more than one reasonable course of action and where no single option is self-evidently best for the individual patient. These preference-sensitive decisions are made where the choice of the treatment should take into account the patient’s clinical and personal context, and preference for life and health care, as each treatment method may lead to a different course.

SHARED DECISION-MAKING

iii. This document focuses on the recommended actions for physicians in shared decision making which, in this document, refers to a “process in which patients are involved as active partners with the physician in treatment decisions”. Shared decision-making can be characterized in the following way:
   a) At a minimum, both the physician and the patient are involved in the decision-making process.
   b) Both the physician and patient share information with each other.
   c) Both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences and goals of treatment.
   d) A consensus is reached. The professional and the patient, after having engaged in a rational deliberation on all available options, reach a mutual agreement over a particular clinical decision.

IMPLEMENTING SHARED DECISION-MAKING

iv. The application of shared decision-making can largely be divided into two stages – sharing and consensus.

Sharing aspects (for the physician)

v. Clinicians should always try to find patient preferences through effective communication, using the following components:
a) **Risk Communication**: Explain risks objectively. Avoid biased interpretation of statistical information and mis-communication of actual risk to the patient, e.g. choice of statistics used and framing effects when discussing risk of treatment. Use absolute risk rather than relative risk. Avoid the use of percentages.

b) **Share your own thinking as appropriate**: Sharing of the physician’s own thought processes, ideas and dilemmas will allow the patient to better understand the key points the physician had taken into account when proposing a certain line of management.

c) **Offer options, not directives**: Highlight reasonable options, rather than automatically propose just one particular course of action.

d) **Engage the patient and establish preferences**: Establish the level of involvement the patient wishes, and the patient’s views and values.

e) **Explore management options**: Share details of the options available with the patient and provide information on the risks and benefits of each available procedure. Confirm the patient’s understanding about the situation.

**Consensus (building a mutual agreement)**

a) **Physician leads to negotiate a mutually acceptable plan**: The physician and the patient agree on the next course of action, based on the physician's professionally-based recommended treatment options, taking into account patient's concerns and preferences.

b) **Final check with the patient**: Confirm that the patient is happy with the decisions that have been made and accepts the plans, and if the patient’s concerns have been addressed.

**OTHER USEFUL INFORMATION**

vi. For effective shared decision-making, the physician should consider the following:

a) Carry out discussions in comfortable, unhurried surroundings;

b) Facilitate shared decision-making processes with patient decision support aids;

c) Avoid making assumptions, based on the physician’s observation of the patient about the degree of involvement the patient desires or the patient’s financial ability to pay;

d) Focus on the individual, and tailor all information to the individual, such that the individual understands; and

e) Avoid imposing one’s values/opinions.
INTRODUCTION

1. Traditionally in Singapore, the ill patient submits to the physician’s directives as the prescribed course of treatment is expected to bring relief. Such a model of medical decision-making had dominated medical treatment in the local context. This paternalistic decision-making model evolved from the physician’s role as a caretaker of the patient’s interest and had been widely accepted as long as the patient achieves benefits. However, as our society becomes more educated, interconnected and saturated with information, and as patients become more aware of the medical and technological advances in health care, numerous management plan options exist for a single disease condition.

2. In many countries, the next step towards better health outcomes has been the involvement of patients in their own medical care, with decisions made in partnership with physicians, rather than by physicians alone. In the partnership model, patients are involved as active partners with the physician in clarifying acceptable medical options and choosing a preferred course of clinical care.

FROM PATERNALISTIC TO SHARED DECISION-MAKING MODELS

3. Many factors support the need for healthcare professionals to involve patients more in decision-making:
   a) Patients’ increasing medical knowledge, which has been fuelled by the greater and easier access to medical information through the media, internet and other sources, has led them to desire a more participatory role in decision-making.
   b) In better-educated patients, prevailing social values endorse individual autonomy and responsibility, leading to these patients questioning their physicians about decisions made with regard to their medical care.
   c) There is a growing pool of evidence that physicians frequently make inaccurate guesses about the patient’s concerns, and that differences exist between the physician’s and the patient’s preferences.
   d) Significant numbers of evidence-based reviews have proven that, contrary to the opinion of many physicians, it is nearly impossible to identify one treatment as clearly superior to all alternatives since each alternative brings its own set of trade-offs between benefits and risks.

4. The primary ethical principle in a partnership model is respect of the individual’s autonomy. The model allows the individual to have some control over his future care through prior discussion on treatment options. This raises the patient’s awareness of his
own role in the achievement of his health outcomes whilst still allowing the physician to express his clinical opinion and to guide the patient to make a sound decision. This allows the patient to feel more empowered and included in the decision-making process, thus contributing towards making the best decision suited to the patient’s personal needs. Notwithstanding patient empowerment, medical care, unlike the provision of many other goods and services, is not and should not be considered a commodity that is merely to be bought and sold. This is because patients, by virtue of their medical condition, are often vulnerable to the notion of the hope for a medical cure.

CURRENT OVERSEAS DEVELOPMENTS

(a) World Health Organization (WHO)

5. The European regional office of the WHO endorsed a policy brief of the European Observatory on Health Systems which called for greater engagement of patients in protecting their health, taking appropriate action and choosing appropriate treatments for their conditions. The strategies for promoting an active role for patients called for shared decision-making, in addition to health literacy and self-management of chronic conditions. Some of the proposed shared decision-making initiatives included well-designed training courses in communication skills for healthcare practitioners, patient coaching and evidence-based patient decision aids.

(b) United Kingdom (UK)

6. The July 2010 UK Department of Health document on Equity and Excellence, Liberating the NHS, highlighted the need for healthcare services to involve patients fully in their own care, with decisions made in partnership with physicians, rather than by physicians alone. The aim was to realize the Government’s goal of achieving healthcare outcomes that are among the best in the world. Using the slogan “No decision about me without me”, it assured of NHS’ commitment to champion patient and carer involvement to transform care through shared decision-making.

7. The UK General Medical Council and UK Council of Clinical Communication produced guidances calling for appropriate sharing of information by physicians to facilitate informed decision-making by patients.

8. Some UK hospitals also participate in HealthDialog and the Health Foundation’s initiatives to promote the use of patient decision aids to facilitate informed decision-making by patients in their clinical management. The Health Foundation, an independent charity in the UK, supported an 18-month shared decision-making programme (August 2010 to January 2012). Called MAGIC (Making Good Decisions in Collaboration), the programme designed and tested shared decision-making models across a range of sites and clinical areas in hospitals (e.g. primary care, urology,
obstetrics), with the aim of embedding shared decision-making into clinical practice as a core part of mainstream health service.

(c) United States

9. In the state of Washington, legislation was passed in 2007 to mandate the provision of high-quality, up-to-date information to the patient about the condition, the risks and benefits of available options, and a discussion of the limits of scientific knowledge to better equip the patient for more fully informed decisions. The legislation also ensured that the healthcare authority will evaluate the impact of a shared decision-making demonstration project.

10. Similarly, the National Quality Forum, in its 2009 report to the US Department of Health and Human Services, emphasized the goal of informed decision-making, explicitly stating that “all patients….should have access to information and assistance that enables them to make more informed decisions about their treatment options". Various other groups, such as the US Renal Physician's Association, American Society of Clinical Oncology have also produced guidelines targeted at both patients and physicians to facilitate shared decision-making in the appropriate initiation of, and withdrawal from, dialysis, and in care management plans in the various malignancies.

11. Shared decision-making demonstration projects are also being tested at various US hospitals. Sponsored by the Foundation for Medical Decision Making, the projects' aim is to institutionalize shared decision-making in clinical care.

SITUATIONS REQUIRING PATIENT INPUT

12. Increased participation of the patient in decision-making is appropriate in any situation where there is more than one reasonable course of action and where no single option is self-evidently best for the individual patient. These preference-sensitive decisions are made where the choice of the treatment should take into account the patient’s clinical and personal context, and preference for life and health care, as each treatment method may lead to a different outcome. In our local context, the patient’s preferences could largely be influenced by preferences and opinions of family members. However, these clinical decisions should never be dictated by family member(s) without the doctor having first confirmed with the patient, his wishes to defer decision-making to that family member.

13. Examples of preference-sensitive situations would include:

   a) A peri-menopausal patient with the option of taking up an elective treatment like hormone replacement therapy (HRT) for menopausal symptoms, knowing that HRT can lead to serious side effects;
b) A patient with a family history of breast cancer with the option of undergoing a BRCA 1 screening programme to identify her risk for developing breast cancer;
c) A patient with symptomatic dyspnoea and severe aortic valve stenosis with the options of a median survival of less than 2 years without surgical intervention or a risky yet potentially life-prolonging aortic valve replacement surgery;
d) A patient with advanced incurable cancer which progressed despite 2 different lines of chemotherapy, with the options of trying another treatment using more toxic chemotherapy combination or choosing palliative care to control symptoms.

EXCEPTIONS

14. However, shared decision-making is not applicable in situations where the patient does not want to participate in the decision-making process. For instance, less educated patients have been found to prefer to relinquish all responsibility to the physician, as are older people or those with life-threatening conditions.

15. Additionally, shared decision-making may not be possible for cases where the patient is incapable of making the decision in an autonomous or rational way (e.g. severe mental incapacitation, unconsciousness, acute intoxication) and in urgent cases, where immediate clinical intervention is warranted in the best interest of the patient (e.g. an emergency department physician needing to drain a pericardial tamponade). In such cases, the physician will not have the time to run through an entire gamut of options with the patient and may instead have to act quickly in the patient’s best interest.

SCOPE OF DOCUMENT

16. In this document, shared-decision making will be taken to mean “a process in which patients are involved as active partners with the physician in treatment decisions”. Patients need encouragement from well-trained clinicians, if they are to play an active role in decisions about their care. The guidance will be for physicians and will focus on the recommended actions for physicians. Shared decision-making will be applicable in any situation where there is more than one reasonable course of action and where no single option is self-evidently best for everyone.

SHARED DECISION-MAKING

17. In shared decision-making, the focus is explicitly on two main stages: Firstly, **sharing**: the decision-making is being shared, or involves sharing. Secondly, **consensus**: the final decision is mutually agreed upon. The process can be characterized in the following way:
a) At a minimum, both the physician and the patient are involved in the decision-making process.
b) Both the physician and patient share information with each other.
c) Both the physician and the patient take steps to participate in the decision-making process by expressing treatment preferences.

d) A consensus is reached. The professional and the patient, after having engaged in a rational deliberation on all available options, reach a mutual agreement over a particular clinical decision.

**IMPLEMENTING SHARED DECISION-MAKING**

18. The application of shared decision-making can largely be divided into two stages – sharing and consensus.

(A) **Sharing aspects (for the physician)**

19. During the sharing session, what is important is that the health professional should not make assumptions, based on their observation of the patient, about the degree of involvement the patient desires or the patient’s financial ability to pay. Clinicians should always try to ascertain patient preferences through effective communication, using the following components:

20. **Risk Communication:** Physicians should explain risk objectively. There is a great potential for biased interpretation of statistical information and mis-communication of actual risk to patients, where although unintentional, benefits could be magnified and risks minimized. Physicians should be conscious of the choice of statistics used and framing effects when discussing risk of treatment with patients:

   a) Preferably, use absolute risk rather than relative risk. A relative risk statistic used alone such as “Treatment X reduces the risk of death by 22%” is not meaningful unless you can say “from what to what”.

   b) Avoid the use of percentages. It has been found that the most effective way of explaining risk to patients without confusing them is through the use of “natural frequencies” in a reference population rather than percentages. E.g. “if 100 men with your condition started this medication, 40 of them will develop a sexual problem” rather than “this medication will cause a development of a sexual problem 40% of the time”.

21. **Share your own thinking as appropriate:** The sharing of the physician’s own thought processes, ideas and dilemmas will allow the patient to better understand the key points the physician had taken into account when proposing a certain line of management:

   a) Uncertainty is reduced and a mutually understood common ground is established.

   b) Patient will be encouraged to contribute their views and engage in more open dialogue when the physician’s dilemmas are made apparent.

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1 Examples in this section take reference from the document “The Skills of Planning and Shared Decision Making” by the UK Council of Clinical Communication.
c) Omission of logical steps or information (e.g. diagnosis, aetiology or prognosis) that patients need to participate effectively in the decision-making process preferably is avoided.

22. **When applicable, offer reasonable options, not directives:** The physician should highlight these options, rather than automatically propose just one particular course of action:

   *E.g. “Currently, there are 2 available options. Would you like to take Hormone Replacement Therapy now or would you like to soldier on for the next few months and see what happens to your symptoms?”*

23. **Engage the patient & establish preferences:** It is important for the physician to encourage the patient’s participation during the joint decision-making process:

   a) Establish the level of involvement that the patient wishes. It has been found overseas that 60% of patients wish to be involved in making choices, while 40% would prefer to leave decisions to their physician. While some patients might not want to play an active role in choosing a treatment – because of age-related and cultural differences – at a minimum, most would want physicians to inform and, clarify acceptable medical options, and choose a preferred course of clinical care, taking their preferences into account.

   *E.g. “There are several options in the treatment of Parkinson’s disease: When to start therapy? Which drugs to use? Whether you see a specialist? Some patients would like to be involved in these decisions and I welcome that. Some prefer for the physician to take the lead. How would you like to proceed?”*

   b) Establish the patient’s views and values

   i. The patient may have other options in mind that the physician has not considered.

   ii. Many patients are hesitant to express their views directly to the physician and need to be asked overtly to overcome their reservation of speaking up.

   *E.g. “Do you have any other choices in mind? What are your thoughts?”

   “So, here are several things we might try, each with their own advantages and disadvantages…Have you any clear preference?”

24. **Explore management options:** It is recommended that the physician explores the options available to the patient in greater depth, goals of treatment and shares information on the risks and benefits of each available procedure:

   a) Patient decision aids (e.g. brochures, pamphlets, websites) facilitate the patient’s understanding.

   b) Medical jargon and technical terms (e.g. statistics) should preferably be avoided.

   c) After discussion of the facts, it is recommended that physicians ask the patient what he has understood so as to confirm their understanding about their
situation: e.g. What is your understanding about your disease condition and treatment options?

(B) **Consensus (building a mutual agreement)**

25. **Physician leads to negotiate a mutually acceptable plan:** The physician and the patient need to come to a decision on the next course of action, that both can agree upon:
   a) The physician should make a professionally-based recommendation of a particular treatment option based on medical evidence:
   
   E.g. *In this particular instance, from a purely medical stand-point, I personally would come down on one side here – I think given the very strong history of IHD in your family and the effect that has on your risk equation, I am of the opinion that it is it’s best for you to take medication to reduce your blood pressure.*

   b) The physician should also indicate that the patient’s concerns are just as important, and should reassure the patient that no offence will be taken if a different treatment option is selected:
   
   E.g. “Regardless of my opinion, we need to take your view into account here.”

   c) If the patient has indicated active involvement in the decision-making:

   i. offer the patient the chance to make a decision
   
   e.g. “So, here are the several things we might try, each with their own advantages and disadvantages…What is your preference?”

   ii. If the physician has strong reservations about the patient’s choice, resolve any differences and negotiate a mutually acceptable plan
   
   e.g. “I do have some reservations about taking the approach you suggest. Can I explain them to you and perhaps we can try to find a solution?”

26. **Final check with the patient:** As a final check at the end of planning, it is good practice to confirm that the patient is happy with the decisions that have been made and accepts the plans, and if the patient’s concerns have been addressed.

   E.g. “Now, can I just check if you are comfortable with the plan?”

**OTHER USEFUL INFORMATION FOR PHYSICIANS**

**Discuss at comfortable, unhurried settings**

27. Discussions should preferably be carried out in comfortable, unhurried surroundings. Ideally, patients should be provided with multiple patient-decision aids to help them thoroughly understand their situation and make their decision. This will help individuals make sound decisions in a calm state of mind and less stressful environment. It also
allows for sufficient time for the patient to reflect and perform a thorough evaluation of all available options.

**Use of patient decision aids**

28. In countries such as US, UK and Australia, formal shared decision-making processes are generally facilitated through the use of electronic or paper-based patient decision support aids. These aids are often developed by reputable third parties based on available evidence and can be distributed by the physicians to patients.

29. Through these aids, patients are given evidence-based information about treatment options and outcomes that is specifically designed to help them evaluate the tradeoffs of picking certain treatments in context of their own feelings and preferences.

30. These decision support aids supplement the communication between physicians and patients and provide a focus to the decision the patients have to make.

31. Patient decision aids can come in various forms:
   a) Brochures from National Support Groups (e.g. Breast Cancer Foundation, National Kidney Foundation)
   b) Website recommendations (e.g. health.nih.gov)
   c) Personal contacts (with permission) of others who had undergone similar conditions
   d) Recommendations of computer-based programmes (e.g. HealthDialog)
   e) Prompt sheets (list of suggested topics to discuss with the physician which is to be provided to the patient before consultation)

32. Physicians can make it a priority to compile relevant patient decision aids and distribute them, when necessary, to patients so as to preserve patient autonomy and facilitate patients in their decision-making.

**Good attitudes to be adopted by the healthcare professional**

33. **Focus on the individual:** All information given is recommended to be tailored to the individual, such that the individual understands. Healthcare professionals should clarify any ambiguous terms used by the individual and avoid using any ambiguous/technical terms themselves. Summarizing, checking and reflecting in this way ensure that the physician fully understands the patient’s situation and wishes.

34. **Avoid imposing one’s values/opinions:** The physician should take account of his personal experiences and beliefs, and ensure that they do not act as a barrier to communication or bias the patient. For example, even if the physician has a particular preference for a certain treatment option and may recommend it, he must express openness to the patient’s choice of a different treatment option so that the patient’s autonomy is preserved.
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