Interprofessional Shared Decision Making to Achieve Health Equity

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Interprofessional Shared Decision Making

Shared decision making (SDM) is supported by evidence as an optimal way to make complex medical decisions. It is a collaborative process between patients (and/or their proxies) and healthcare providers, informed by the best evidence available and the patient's values and preferences.[1,2] There are various models of SDM, some of which include interprofessional team members,[3] thus having high relevance to rheumatology. SDM is not always used in clinical practice, primarily due to health care providers' perspectives — they often perceive it takes too much time to implement, that it is not applicable to their patients, or that the decision taken by the patient is not consistent with clinical practice guidelines' recommendations.[4,5] However, SDM may be more efficient for chronic conditions. Choices aligning with patient values and preferences are more likely to result in adherence to the selected treatment plan.

Important Elements of SDM

SDM is not "one size fits all" and must be centred on each patient's needs. Patients emphasize the need for health professionals to listen to their questions and concerns, and provide them with the information required to make autonomous decisions (see infographic with tips provided by patients: *choiceresearchlab.ca/tools-and-resources-to-facilitate-the-use-of-shared-decision-making-sdm/*. A video also highlights the elements critical for high quality SDM implementation: *www.youtube.com/watch?v=4OxXIXMfJAo*). Patient decision aids (PDAs) and decision coaching are interventions to help facilitate SDM (*decisionaid.ohri.ca/*). They lead to increased knowledge and a more active role in decision-making.[6,7] However, further efforts in knowledge mobilization are required for health professionals to become familiar with the unique roles of PDAs as compared to other patient education materials used in clinical practice.[8]

SDM Use in Rheumatology Practice

A scoping review on applications of SDM in rheumatology is available.[9] There are various PDAs in adult and pediatric rheumatology (*choiceresearchlab.ca/tools-and-resources-to-facilitate-the-use-of-shared-decision-making-sdm/*). SDM is especially important for preference-sensitive decisions, meaning when there is no single best treatment option based on the available evidence and the decision will depend on patient values and preferences, as is common in rheumatology.

SDM is included in rheumatology clinical practice guidelines such as the Canadian Rheumatology Association (CRA) Living Guidelines for Rheumatoid Arthritis (RA) (*rheum.ca/resources/publications*) and a decision tool has been developed for COVID-19 Vaccination in patients with autoimmune rheumatic diseases (*rheum.ca/decision-tool/*). In a recent example of applying SDM in practice, a CRA decision aid on tapering biologic/targeted synthetic disease-modifying anti-rheumatic drugs (DMARDs) in RA was sent to patients one month ahead of their annual visit.[10] The decision aid was well received, prompted discussions around tapering medication, and resulted in many people choosing to try tapering their medication after discussion with their rheumatologist. This research provides preliminary evidence that using a decision aid that is consistent with clinical practice guidelines, in combination with patient reflection and discussions with rheumatologists, may support cost-effective patient-centered decision-making about tapering.

Health Equity and SDM

Health equity is a fundamental human right. As described by the World Health Organization, "Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality . . ." (*who.int/health-topics/health-equity#tab=tab_1*). Engaging patients in their health decisions through SDM in the context of their

A few of the members of the panel from the 2024 CRA ASM workshop, "Clinical Practice Guidelines and Interprofessional Shared Decision Making: A Journey Towards Health Equity." Pictured from left to right: Dr. Karine Toupin-April, Dr. Cheryl Barnabe, Dr. Chance McDougall, Natasha Trehan, and Dr. Elizabeth Stringer.

own circumstances can help them attain their full potential for health and well-being and enhance health equity. SDM rebalances power between patients and healthcare providers, increasing autonomy, reducing paternalism, and improving trust in healthcare providers. It can also reduce unwarranted variations in care by reducing biases, as provider assumptions about patient values may influence the treatment options presented.[11,12,13]

SDM for Indigenous Women

SDM can be particularly helpful for Indigenous populations. Culturally safe and empathic care that incorporates all aspects of health, and that respects knowledge and experience from Indigenous worldviews, are a requirement for establishing trust with Indigenous patients. Decision-making should be collaborative with active involvement of the patient. Professionals should be knowledgeable, honest and use effective communication, including active listening skills. According to a study of Indigenous women with RA in urban Calgary, priorities were to use treatment decisions informed by Indigenous population data, including traditional and cultural treatment options in care plans, and reflecting available medication cost coverage options.[14,15] In addition to adapted PDAs, decision coaching may be preferred, with nurses, family members or an Elder serving as the trusted source of information and support, with the emphasis placed on dialogue and community-based decision support and consultation.[14,15]

Implications

SDM has a strong potential to improve engagement and self-determination in decision-making, which could reduce barriers to health equity. Adaptations to SDM tools and approaches may be required to be effective in diverse populations.

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