Implementing shared decision making in the NHS: lessons from the MAGIC programme

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Shared decision making requires a shift in attitudes at all levels but can become part of routine practice with the right support, say Natalie Joseph-Williams and colleagues

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Adoption of shared decision making into routine practice has been remarkably slow, despite 40 years of research and considerable policy support.¹ Four In 2010, the Health Foundation in the UK commissioned the MAGIC (Making Good Decisions in Collaboration) programme to design, test, and identify the best ways to embed shared decision making into routine primary and secondary care using quality improvement methods (box 1).² ¹⁰

The learning from MAGIC derives from a variety of sources, including facilitated shared learning events, clinic and consultation observations, interviews with clinicians and patients, patient and public involvement panels, focus groups, and questionnaires. We assessed progress using "plan do study act" data collection tools,³ monthly project team meetings (including researchers, clinical teams, healthcare organisations, and patient representatives), and an independent evaluation report of phase 1.⁴ Here, we draw on our learning from the three year programme and subsequent experience to summarise the key challenges of implementing shared decision making and to offer some practical solutions (table 1).

Challenge 1: "We do it already"

Changing attitudes is a key challenge for any change programme. Both structural change, in terms of healthcare pathways and delivery, and culture and attitudinal change among clinicians and patients are required for shared decision making and patient choice to become routine. Many clinicians feel that they already involve patients in decisions about their care, so

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changing their view from, “We do this already” to, “We could do this better.”

**Challenge 2: “We don’t have the right tools”**

Many clinicians believe that a decision aid will itself enable shared decision making and that decisions cannot be shared without a tool to give their patients. A key learning point from the MAGIC programme was that “skills trump tools, and attitudes trump skills.” Developing attitudes and understanding is essential, but then clinicians need to consider their communication skills to engage patients in decision making, drawing on evidence based tools when appropriate. There will never be decision support tools for every decision; nor will every patient find them acceptable or helpful. The skills to have different types of conversations with patients are paramount, with or without an available tool.

In the skills training workshops, role play was particularly effective for showing that tools may support the process but do not replace communication skills. Patient information sources designed for use outside the consultation, such as websites, are costly and time consuming to develop and keep updated. Developing brief decision support tools helped overcome this challenge. Clinicians willingly designed brief evidence based tools to use inside the consultation, such as Option Grids in the Cardiff sites and brief decision aids in the Newcastle sites. These provide short (one to three pages) summaries of the treatment choices, the likely outcomes, and the factors that patients might consider when making their decision, including risk and benefit data.

Experience from MAGIC suggests that in-consultation tools are often better at facilitating discussion between patient and clinician than those used outside the consultation. Some patients used the tools to guide their questions for the clinician and it prompted them to discuss what mattered to them—the nub of shared decision making. However, the risk is that clinicians use brief decision aids to enhance information transfer and talk at patients, rather than improving how they work with patients.

**Challenge 3: “Patients don’t want shared decision making”**

Clinicians often report that their patients do not want to be involved in making healthcare decisions. This might be the case for some patients, and some patients want different levels of involvement, so the shared decision making process should respect the patient’s preference. This preference should itself be informed, rather than based on a clinician’s presumption about what the patient wants. Many patients feel unable rather than unwilling to share in decision making. Some patients think they will annoy clinicians by trying to be more involved, and their desire to be a “good” patient over-rides their desire for sharing decisions. Often this comes from longstanding experience and expectations of a paternalistic approach and seems to be more common in older people. This can be mistaken for lack of interest in engaging in decision making.

Clinicians’ misconceptions about what patients want must be addressed. It is neither possible nor desirable to make every patient more involved, but more can be done to make patients feel included and respected, and clinicians can often make more effort to understand what is important to the patient. However, patients may also need support and preparation to take part in a different type of consultation.

Patient activation and preparation can increase the likelihood of mutually useful conversations between patients and clinicians. Patient activation campaigns focus on changing patients’ attitudes about involvement in healthcare decisions, explaining what shared decision making involves, why it might help, and provide interventions such as question prompt lists. Interventions
such as the Ask 3 Questions campaign can help patients know what to expect and give “permission” and encouragement to be involved.\textsuperscript{26-28}

Successful implementation also needs wider patient and public involvement. In the MAGIC programme we included patients with the relevant conditions in designing local interventions as well as having a wider user panel to guide the broader implementation process. The lay panel was crucial in identifying areas for improvements in the implementation work, identifying users’ needs, and aiding intervention development and testing.

**Challenge 4: “How can we measure it?”**

Clinicians and managers implementing shared decision making want to know what difference it makes to their patients and to clinical practice. In the MAGIC programme we found it difficult to identify or develop suitable patient reported measures to capture experience of shared decision making. Patient reported measures are hampered by social desirability bias (wanting to give high satisfaction ratings), and patients may also not fully understand and identify shared decision making if they have not experienced it previously.\textsuperscript{29} However, the three item CollaboRATE measure (used in over 40 studies worldwide) shows promise in overcoming these problems.\textsuperscript{30}

Tensions exist between the need for validated and reliable measures for research and measuring for quality improvement. Focusing on quality improvement helped embed shared decision making more readily with some clinical teams. When measures directly informed practice and improved patient care we witnessed greater motivation to improve and to sustain the improvement (eg, the decision quality measure in breast cancer, table 1)).\textsuperscript{31} Linking with local quality improvement expertise and resources, where available, was valuable. For example, the 1000 Lives Plus national improvement service for NHS Wales had supported development of quality improvement skills across the Cardiff site, which was used to implement shared decision making.\textsuperscript{32}

**Challenge 5: “We have too many other demands and priorities”**

Changing attitudes and behaviours takes effort at all organisational levels. Clinical teams face many competing demands and priorities, some of which are compulsory, some even incentivised (whether financially or by targets). For example, the Quality and Outcomes Framework rewards general practitioners for behaviours that are evidence based but not necessarily about what matters most to patients. Tensions are also increasing between shared decision making and clinical threshold guidelines or referral management schemes, which are widely applied within commissioning in England. Similarly, for cancer treatment time targets, the current emphasis is on time to treatment but patients may prioritise time to make the decision.

Visible organisational buy-in and support are essential. During the MAGIC programme, key organisational leaders showed clinicians that shared decision making was an important organisational priority to drive improvement (table 1)) and clinical leadership was critical to implementation. This led to greater engagement because clinicians then saw shared decision making as something the organisation does, rather than as another initiative being imposed on them and competing with other demands. Teams sometimes needed support from the organisation to adapt clinical pathways to support effective shared decision making. Shared decision making is not the sole responsibility of doctors; it should be supported by all members of the clinical team. Responsibility can be distributed—for example, a breast care surgeon can explain the choices, but the specialist nurse can elicit the patient’s preferences in more detail. It is important to share learning about what works both within and between teams to avoid “reinventing the wheel.”

**Recommendations for implementation**

We have summarised the key challenges we faced during a programme to implement shared decision making in organisations across primary and secondary care, but many other factors also affect implementation (fig 2)). More detailed discussion of the barriers and solutions is available elsewhere.\textsuperscript{4-33} Similar findings have been reported in the US.\textsuperscript{4-36}

In the real world, finance, resources, and time are all scarce. Although shared decision making is mentioned in key policy documents, such as the NHS Constitution 2015,\textsuperscript{37} it has no incentives and is not promoted systematically at national, regional, or organisational levels. We still need to foster cultural change among clinicians and patients, and this is a momentous challenge. A receptive culture will truly exist only if clinicians view shared decision making as usual practice and as a fundamental component of safe, effective, and compassionate healthcare for patients. It needs to be embedded in the medical and nursing curricula and interprofessional training programmes. Similarly, much health policy and professional practice has led to feelings of powerlessness and passivity for many patients. Increasing patient agency, activation, and health literacy are equally important.\textsuperscript{37}

Although these actions may help embed shared decision making, they do not standardise the process: every discussion varies, depending on the patient, clinician, their preferences, and the type of decision being made. Shared decision making may not necessarily result in, or depend on, complete agreement between a clinician and a patient. Instead, it is about bringing both types of expertise together, and weighing up the available options in light of both of these perspectives; it makes it more likely that the final decision is informed by what the clinician knows (medical evidence, clinical experience) and by what the patient knows (what matters to them, the outcomes they are prepared to accept).

We need to change attitudes to reflect this, so that patients are not seen as “non-compliant” if they have a different opinion and clinicians are not seen as overly paternalistic if they are listening to the patient’s preferences and considering this in a recommended treatment plan. Furthermore, we should emphasise that shared decision making is not confined to one patient and one clinician, during one consultation. The process is distributed across healthcare teams, and between patients and their families, all of whom will influence the process, especially for patients with long term conditions.\textsuperscript{38}

Implementing shared decision making is challenging but possible. No one intervention will succeed in isolation. It requires interventions to support organisations, clinicians, and patients; a bundle of interventions working together holistically across all healthcare settings.

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Key messages

Shared decision making is about more than tools: skills trump tools, but attitudes trump skills
Successful implementation relies on a combination of interventions supporting the organisation, clinicians, and patients
Organisational support and local ownership are vital for engagement

contributors, including Andrew Rix (independent chair of the Delivery Board of Health and Care Research Wales, responsible for promoting public involvement in health and social care in Wales), the organisational representatives, clinical teams, and patients for their contribution to the learning.

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He has been a member of teams that have developed measures of shared decision making and care integration. These tools and measures are published and are available for use. For further information see http://www.glynwelwyn.com/. DT reports personal fees outside the submitted work for the delivery of lectures on shared decision making to professionals, funded by TEVA, and from workshops and seminars on shared decision making to various organisations in the north east of England.

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Table

Table 1 | Recommended solutions to challenges to implementing shared decision making*  

| Intervention/approach       | What it involved                                                                 | What it helped with                                                                 |
|-----------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Interactive skills workshops| Team based sessions lasting 2-3 hours based on shared decision model for clinical practice. Focus on practical skills using clinical scenarios and role play with actors or other participants. | Challenging clinicians’ attitudes and differentiating shared decision making from current practice. Developing shared understanding of the approach to decision making. |
| Development of brief tools  | Facilitating teams to identify key decision points suitable for shared decision making and mapping care pathways to agree on point of delivery. | Making reliable information available at the time of the consultation for both patient and clinician. Facilitating discussion between clinician and patient that is more than information transfer by changing the dynamics of the consultation. |
| Patient activation and preparation | Dedicated panel of patient and public representatives (general or clinical team specific) to guide development and testing of interventions, and guide implementation plans. | User panel identifies user needs rather than perceived needs. Changing clinicians’ perceptions that patients do not want to share decision making. |
| Measurement                 | Clinically useful measures that have a direct effect on practice—eg. decision quality measure for breast cancer, which measures patients’ knowledge and preferences. Breast care team uses the tool to identify knowledge gaps, demonstrate improvements in knowledge, and elicit patients’ preferences for further discussion. | Engaging organisations and clinical teams. Demonstrates improvement or change associated with shared decision making. Reminds clinical teams that shared decision making is a priority for them and the organisation. |
| Organisation buy-in/senior level support | Visible support—eg. through walkarounds (clinic visits) by executive board members; internal board reports identifying shared decision making as an organisational priority; grand rounds presented by senior clinicians; dedicated executive board member working with implementation team; “board check list” | Getting clinicians to support and engage with shared decision making. Belief that it is an organisational priority and a valued activity. Patients’ perceptions that the healthcare organisations and clinicians want them to become more involved. |
| Collaborative and facilitated approach | Dedicated clinical lead. Regular contact. Clinical team mapping care pathways and identifying areas for improvement. Also assessing fit with current pathways and other objectives or priorities. | Clinical leads help to drive the work forward in each clinical team. Understanding clinical teams’ priorities/demands and making sure shared decision making fits in with these. Getting clinicians to support and engage with shared decision making. |

* A wide range of the MAGIC resources/interventions listed in this table can be found on the Health Foundation’s Person Centred Care Resource Centre: [http://personcentredcare.health.org.uk](http://personcentredcare.health.org.uk) All of the MAGIC materials included on this website are available open access.
Figures

Fig 1  Shared decision making model for clinical practice

Fig 2  Summary of key factors influencing implementation of shared decision making (SDM). (QOF=Quality and Outcomes Framework)