TTG report

Implementing Shared Decision Making in Different Contexts

Host Institute: Centre for Shared Decision Making, Vejle Hospital (Lillebaelt Hospital), Vejle, Denmark

Dates of visit: 23 February - 13 March 2020

Aim of the visit

Shared decision-making (SDM) is based on the premise that treatment decisions should be based on the best clinical evidence as well as on the patient's values and preferences. The number of cancer therapies is growing and the emergence of machine learning/artificial intelligence techniques to harness big data is generating new insights that may enable personalised medicine. Thus, patients are faced with increasingly complex treatment choices. Patient decision aids (PDAs) are tools that support SDM by helping patients to learn about their options so that they can make informed choices. Efforts to implement SDM and PDAs in the clinic often falter due to lack of awareness, time pressure, and a prevailing culture of paternalistic decision-making.

The Maastro clinic and the Vejle Centre for Shared Decision Making have complementary approaches to SDM implementation; Maastro develops data-driven clinical decision support and IT (web-based) PDAs, which are soon to be implemented in practice. In Vejle, SDM has been implemented successfully through use of paper-based PDAs during the consultation to encourage dialogue between clinicians and patients.

The goal of this visit was to study the barriers and facilitators to SDM in the Danish context compared with the Dutch context and to determine how to adapt the process of SDM delivery.

Scientific content of visit

The visit consisted of three main activities: a) meetings with SDM experts; b) time spent in the clinic to observe SDM in practice; c) interviews with clinicians.

a. My visit began with meetings with PDA developers, teachers who train clinicians and nurses in SDM, and researchers. These experts provided insights into the history of the centre's SDM initiative, the organisational structure and leadership that guided the implementation, the process of development of paper PDAs, SDM training materials, and the outcomes that were observed in the clinic.

b. Subsequently, I spent a day in the clinic shadowing the head of the centre, Dr Karina Dahl Steffensen, who is an oncologist who specialises in gynaecological cancer. I was present in her consultations with patients and observed how the five steps of SDM are put into practice and how use of the PDA supports these steps.

c. I conducted in-depth, semi-structured interviews with seven clinicians: oncologists who worked in lung, colorectal, gynaecological and breast cancer, nurses and team leaders. The interviews were transcribed and analysed using thematic analysis. Themes that emerged included prior experiences with traditional decision-making, challenges in switching to SDM, benefits of SDM, and critical success factors for implementation.

Results from the visit

The initial analysis of the interviews has been presented and discussed within Maastro and is being drafted into a manuscript for publication. The full results will be presented shortly at a seminar with the centre as well as with a wider group of Maastro clinicians. This will result in an implementation plan that will involve training and hybrid PDAs that combine the

strengths of paper-based PDAs and the benefits of web-based PDAs. In addition, we are writing a workshop proposal about data-driven SDM for the 2021 International Shared Decision Making Conference (Kolding, Denmark), which is organised by the centre.

I would like to extend my heartfelt thanks to Dr Steffensen, the members of the Centre for Shared Decision Making, and the clinicians with whom I worked, for sharing their insights and for giving me the opportunity to observe SDM in action. I greatly look forward to continuing the collaboration.

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