THE JOURNAL OF FAMILY PRACTICE

ASSOCIATE EDITORS
HENRY C. BARRY, MD, MS
Professor Emeritus, Department of Family Medicine, and Senior Associate Dean Emeritus, College of Human Medicine, Michigan State University, East Lansing

KATE ROWLAND, MD, MS, FAAFP
Rush University, Chicago

RICHARD P. USATINE, MD
University of Texas Health, San Antonio (*Photo Rounds*)

ASSISTANT EDITORS
DOUG CAMPOS-OUTCALT, MD, MPA
University of Arizona

RICK GUTHMANN, MD, MPH
Advocate Health Care Illinois Masonic Medical Center Program, Chicago

GARY KELSBERG, MD, FAAFP
University of Washington, Renton

COREY LYON, DO
University of Colorado, Denver

E. CHRIS VINCENT, MD
University of Washington, Seattle

SAMINA YUNUS, MD, MPH
Cleveland Clinic, Chagrin Falls, OH

EDITORIAL BOARD
FREDERICK CHEN, MD, MPH
University of Washington, Seattle

MARK S. JOHNSON, MD, MPH
Howard University College of Medicine Washington, DC

JEFFREY T. KIRCHNER, DO, FAAFP, AAHIVS
Penn Medicine/Lancaster General Hospital, PA

TRACY MAHVAN, PHARMD
University of Wyoming, Laramie

MICHAEL MENDOZA, MD, MPH, MS, FAAFP
University of Rochester, NY

FRED MISER, MD, MA
The Ohio State University, Columbus

MICHAEL RADDOCK, MD
The MetroHealth System, Cleveland, OH

KATE ROWLAND, MD, MS, FAAFP
Rush University, Chicago

LINDA SPEER, MD
University of Toledo, OH

DIRECT INQUIRIES TO:
Frontline Medical Communications
283 - 299 Market St.
(2 Gateway Building), 4th Floor
Newark, NJ 07102
Telephone: (973) 206-3434
Fax: (973) 206-9378

Have a comment or feedback?
Email: jfp.eic@mdedge.com

GUEST EDITORIAL

Kate Rowland, MD, MS, FAAFP
Associate Professor and Vice Chair for Education, Department of Family and Preventive Medicine, Rush University, Chicago

The author reported no potential conflict of interest relevant to this editorial. Dr. Rowland is an associate editor for The Journal of Family Practice.

jfp.eic@mdedge.com

doi: 10.12788/jfp.0546

Shared decision-making (when you're wearing the paper gown)

I offer screening mammograms to my patients starting at age 40. I have developed a little script to explain that I recommend them routinely by age 50, but at younger ages, individual decision-making is required because the science to support breast cancer screening has more tradeoffs in younger patients.[1] Some patients have questions; many immediately know their preferences.

For me, personally, I felt comfortable waiting until sometime after age 40 to start screening. I have a reassuring family history; my mother has 5 sisters, without any breast or ovarian cancer among them. When, in my mid-40s, I told a doctor that I preferred to wait until I was closer to age 50 to get a mammogram, she urged me to begin screening immediately. Even as a physician, the drive to be a "good patient" was strong. I made the mammogram appointment.

"Well, do it, don't do it, but I recommend it," the radiologist said. The conversation was over.

Like many patients, my first mammogram was not normal.[2,3] After a second round of tests, and then a third, the radiologist gave me the results: *Everything is fine. It is just normal breast tissue. To be on the safe side, you should do a follow-up mammogram and ultrasound in 6 months.*

I asked why I needed to do follow-up imaging if the only thing that multiple diagnostic tests had shown was normal tissue—not a cyst, nor a fibroadenoma or any other abnormality.

"Well, do it, don't do it, but I recommend it," the radiologist said. The conversation was over.

My experience as a patient came to mind when I read this month's article on shared decision-making by Mackwood et al.[4] The authors discuss principles and techniques for shared decision-making in practice, which include enlisting the patient as the expert in their own values, and putting forth the health care professional as a source of reliable information when the evidence supports more than one reasonable strategy in a health care decision.

Aligning values, science, and action can be challenging, to be sure. It can be made easier through long-term relationships, such as the ones that family physicians have with their patients. One of the benefits of longitudinal practice is coming to know what our patients prefer instead of having to start from scratch with each visit. The belief that our values will be mutually respected is part of what builds trust in a doctor–patient relationship. We can use tools to support information delivery at the patient's health literacy level to make the science more understandable. This in turn makes it easier for patients to integrate the science into their own value system.

CONTINUED ON PAGE 17

CONTINUED FROM PAGE 6

One of the most critical aspects of shared decision-making is also one of the hardest. As physicians, we need to be comfortable with a patient making a choice that we might not make ourselves. Perhaps we would choose to observe an otitis media in our own afebrile 6-year-old, or maybe we would not opt for semaglutide to treat our own obesity. Patients can have a different set of values and experiences driving their decision-making. The principles of shared decision-making teach us that our training and experience are not the priority in every situation.

In my case, the radiologist may have assumed that because I had gone through all of the testing, I believed that screening did far more good than harm and that I would be back in 6 months. From my point of view, I saw the screening as more of a mixed bag; it was possibly doing good, but at the risk of doing harm with false-positives and the possibility of overdiagnosis. She also may have been pressed for time and not had any available point-of-care tools to help explain her decision-making process. I left without understanding what the evidence was for close-interval follow-up, let alone having a chance to share in the decision-making process.

Shared decision-making and evidence-based medicine are closely connected concepts; the decision rests on the evidence, and the evidence cannot be applied to patients without asking their perspectives.[5] Mackwood et al[4] point out that shared decision-making can be implemented with little to no increase in the time we spend with patients, and at no substantial increase in costs of care.

Shared decision-making is a skill. Like any skill, the more we practice, the more capable we will become with it. And frankly, it doesn't hurt to remember how we've felt when we've been the patient wearing that paper gown. JFP

References

1. USPSTF. Breast cancer screening. Accessed January 6, 2023. www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening
2. Rauscher GH, Murphy AM, Qiu Q, et al. The "sweet spot" revisited: optimal recall rates for cancer detection with 2D and 3D digital screening mammography in the Metro Chicago Breast Cancer Registry. *AJR Am J Roentgenol*. 2021;216:894-902. doi: 10.2214/AJR.19.22429
3. Sumkin JH, Ganott MA, Chough DM, et al. Recall rate reduction with tomosynthesis during baseline screening examinations: an assessment from a prospective trial. *Acad Radiol*. 2015;22:1477-1482. doi: 10.1016/j.acra.2015.08.015
4. Mackwood MB, Imset I, Morrow C. How to integrate shared decision-making into your practice. *J Fam Pract*. 2023;72:7-17. doi: 10.12788/jfp.0536
5. Hoffmann TC, Montori VM, Del Mar C. The connection between evidence-based medicine and shared decision making. *JAMA*. 2014;312:1295-1296. doi: 10.1001/jama.2014.10186