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Transition from paternalism to shared decision making – a review of the educational environment in Bosnia and Herzegovina and Croatia

Marta Vučemilović[1], Mersiha Mahmić-Kaknjo[2*], Ivančica Pavličević[3]

[1]School of Medicine, University of Split, Croatia, [2]Department of Clinical Pharmacology, Zenica Cantonal Hospital Zenica, Bosnia and Herzegovina
[3]Department of Family Medicine, School of Medicine, University of Split, Split Croatia

*Corresponding author:
mmahmickaknjo@gmail.com
Tel.: + 387 32 405 133
Fax.: + 387 32 226 576

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In this article we will review the benefits of a system built on partnership of physicians and their patients, highlight some of the factors which impede this transition, and propose ways to address these factors. Also, we are going to analyze the educational environment in Bosnia and Herzegovina and Croatia concerning ethics and communication skills. Personal responsibility of patients for their health should be reflected in their joint involvement in health decisions with their physicians. Patients, insecure about their individual competence surrounding their health decisions, tend to shy away from responsibility, whereas physicians, pressured by the responsibilities of the profession, do not always show sensitivity to all of the patient's concerns. They often treat illnesses instead of patients. A more open and collaborative relationship between the patient and the physician through shared decision making would be a better alternative. In the end, the patient ultimately decides whether a health intervention was satisfactory in fulfilling his or her specific needs. Transition from a paternalistic to a mutual relationship between doctors and patients has already begun. In an era of intense information sharing, shared decision making is a sensitive, ethical, legal, and political concept which needs empathic doctors with well-developed communication skills to integrate their clinical knowledge with patient-centered care. **Conclusion.** Transition from paternalistic to partner relation between physicians and patients is moving slowly ahead in Croatia and Bosnia and Herzegovina. Educational environment is improving but needs intense efforts to develop further.

Introduction

Over the last several decades, medicine has undergone a paradigm shift from a model based on paternalism to one based on partnership (1). This transition from a paternalistic system to a system built on partnership has not been uniform across the globe. Different countries have different cultural, historical, and political factors which affect the speed and shape of this transition.

In this article we will review the benefits of a system built on partnership, highlight some of the factors which impede this transition, and propose ways to address these factors.

Factors and benefits of the transition

As technology improves and is used more frequently, a feeling of distance between the

patient and the doctor emerges (2). This can cause patients to become confused or overwhelmed, leading to a loss of trust toward both the doctor and the healthcare system. Consequently, this can result in low adherence to the prescribed regimens by patients. Conversely, a new concept known as shared decision-making (SDM) can effectively limit confusion and dissatisfaction surrounding health decisions, lead thus often to better compliance, improved health outcomes, fewer lawsuits, and more meaningful interactions with health care professionals (2).

The SDM concept is defined as "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported, while considering their options, to achieve informed preferences" (3). It is a patient-centered system which aims for a better means of communication and trust. Its implementation includes options, discussion, and decision making (4). The patient must feel free to discuss personal goals or concerns, and find a way to align them with available treatments that are supported through evidence-based medicine (EBM) (5).

Furthermore, the concept of SDM aligns well with today's legal requirements. As early as 1978, the Declaration of Alma-Ata recognized that "people have a duty and a right to become involved participants in their healthcare" (1). Additionally, the Declaration highlighted that health is not only the "absence of disease" but, rather, is "the state of complete physical, mental, and social wellbeing" (6).

Through SDM, both the physician and the patient feel more assured that they have established an accurate diagnosis and subsequent follow-up procedures. With this improved decisiveness, there is a reduction in avoidable costs for specialty care visits and diagnostic tests (7). Furthermore, more engaged patients tend to decide against costly invasive treatments. In fact, according to a 2014 Cochrane systematic review, more engaged and properly informed patients tend to decide against costly invasive treatments which can lessen costs and hospital burdens (RR 0.79; 95% CI 0.68 to 0.93) (8). Understandably, physicians are most concerned with the eradication of illness, whereas the patients are more concerned about their well-being and will consequently be more concerned with potential side effects of procedures than the physicians (9).

Challenges to shared decision making

Although the interest in supporting the adoption of SDM is growing, actual implementation is slow, and faces many challenges. There are extensive systemic barriers which prevent physicians from being able to champion SDM (10). The three most often reported barriers to SDM are: time constraints, lack of applicability due to patient characteristics, and the clinical situation (11). Additionally, patients may be initially reluctant to fully participate in the decision making process. Strong emotions such as anxiety, fear, and anger may interfere with the patient's ability to process information for good decision making; low health literacy, cultural and religious differences may cause disagreement with the physician (12).

Decision aids provide pertinent information for selected patient conditions, supported by credible research through EBM. The information can be provided through videos or audiotapes, workbooks, pamphlets, etc. (13). Decision aids are used as an addition to discussions with physicians, and, therefore, are provided in a distinctly neutral and informative manner. It is important to note that they are not a method of acquiring informed consent. Their purpose is to equip the patient with pertinent material for future discussion during doctor visits (13).

It has been demonstrated in multiple randomized control trials that their use:

1) improves patient knowledge; 2) lowers decisional conflict; and 3) increases active patient decision making (14). A 2014 Cochrane review of 115 studies (8) highlighted that, when compared with patients who received usual care, those who used decision aids had increased knowledge, more accurate risk perceptions, reduced internal conflict about decisions, and a greater likelihood of receiving care aligned with their values. Moreover, fewer patients were undecided or passive in the decision-making process – changes that are essential for patients' adherence to therapies. However, despite this evidence, decision aids are still not being sufficiently implemented. Their distribution remains relatively low due to the slow progress of physician adaptation to patient involvement and a lack of proper education in decision aids (15). Therefore, in order to successfully begin SDM, it is imperative that decision aids are correctly administered and implemented, with constant adjustment to new relevant science.

During the War for Independence, Croatia and Bosnia and Herzegovina (BH) faced devastating losses to their health infrastructures, funding, and professional personnel, and have been forced to make more efficient use of now severely limited resources (16). The concept of patient-centered medicine through active SDM has great benefits in the form of reduced overall workload, making it a natural fit for a health care system that still faces many burdens.

Unfortunately, although sufficient legislature is in place, implementation is lacking in Croatia and BH, where the culture of physician omnipotence has just recently been challenged. Concerning patients' health concerns, many patients may feel that their physicians are not open to discussion. Many of the patients do not even object to this one-sided relationship because they fear the effort would be fruitless and would simply cause more strain. It is, therefore, important that both physicians and patients are better informed of their rights and responsibilities regarding their collaboration.

Regret is a common consequence of decisions and greatly influences overall participation in SDM, yet the instruments to measure this are still undeveloped (17). Although there has been the development of many scales in English and other languages, which indicates growing research efforts in various countries (18), the methodological guidelines that could improve future preference-match studies of the patient-physician interaction are still missing. Adoption of patient-match assessment and intervention strategies are both necessary, and should be used as an addition to patient-centered and shared decision-making approaches (19). However, the latest Cochrane review revealed uncertainty in whether interventions to improve the adoption of SDM were effective, given the low quality of the evidence (20). However, the authors conclude that any intervention that actively targets patients, healthcare professionals, or both, is "better than none".

Public notion of SDM in Croatia and BH does not seem to be very high and academic research on SDM in these regions remains fairly rare. Only recently have some studies started to address the benefits of SDM. In 2013 and in 2014, two studies argued its benefits in respect to flu vaccination and cardiovascular health in female patients respectively (21, 22). The few studies introducing the practice of SDM to the Croatian community mirror those conducted in Brazil or Chile, where actual research in SDM remains in its infancy (23, 24).

A call to action: Proper training and decision aids

In order for patients to become more involved in health decisions, it is essential that they are treated as equal partners, meaning

that physicians are required to create a pleasant environment where the patient would feel that his or her input is welcome. Physicians need to be trained in advance on how to create a rapport with patients surrounding health decisions. Consequently, medical education and training should include both communication skills and ethics focusing on patient-centeredness (20). These topics should be emphasized more in undergraduate medical studies where students would become more familiar with possible scenarios and adequate and sensitive reactions to patient needs (25). This training would provide better skilled and empathetic clinicians. In order to better prepare future physicians, undergraduate and postgraduate training should integrate a more patient-centered approach.

Table 1 gives an overview of ethics and communication courses in medical schools in Croatia, BH, Macedonia, Montenegro, Serbia, Kosovo, and Albania, and represents the picture of continuous efforts for improvement. This data was obtained from primary care physicians gathered in an initiative called the "Split Initiative", which consists of a series of conferences attended by representatives from each of the regional family medicine departments from their respective schools of medicine (26). These conferences, held so far in Split, Ljubljana, Zagreb, and Podgorica, allowed sharing of knowledge and experiences regarding family medicine teaching methods, patient-doctor relations, and international research collaboration. In total, data from 14 schools of medicine were analyzed; 4 from Croatia (all), 5 from BH (all), 1 from Macedonia, 1 from Montenegro, 1 from Serbia (the oldest and largest university), 1 from Kosovo, and 1 from Albania.

Both ethics and communication skills classes are already available in the majority of medical schools included in this analysis. However, they are not equally emphasized in each of the curricula. When comparing the availability of either ethics or communication skills courses in neighboring countries, such as in Italy, there is also a similar lack of emphasis in such courses (27). Overall, it is clearly necessary for these universities to offer more credit hours on these subjects. Communication skills should be more than an elective course, and should provide students with more real life practice, including training in both face-to-face and electronic communication. The way to improve patient-doctor communication is by understanding the theory behind good doctor-patient communication, and by practicing these skills while maintaining the capability of modifying communication styles in accordance to specific situations (28).

In the similar light of encouraging ethics and communication classes, related SDM training could also be provided through the use of several specialized toolkits. These include: face-to-face encounters for physician training purposes, on-the-fly coaching and feedback to health care providers during training, as well as reminder cards, cue posters and decision aids (29). While this sort of training has the potential to benefit health care providers at any stage of their professional career, ideally it would be implemented as an elective undergraduate class, in order to introduce the aspiring physicians to the concept of SDM as early as possible.

Croatian medical professionals have generally recognized the value of applying data supported by EBM. In fact, Cochrane Croatia was established by the medical school in Split with the aim to promote the development and usage of EBM for physicians, students, and patients. More than 1,000 Cochrane summaries have already been translated into Croatian and further translation activities are currently being planned (30, 31). In 2013, the 5th annual Croatian Cochrane Symposium was dedicated to lay users, e.g., patients. Efforts in popularizing

Table 1 Details from ethics and communication skills curricula at medical schools in Croatia, Bosnia and Herzegovina, Macedonia, Montenegro, Serbia, Kosovo and Albania (data from 2014)*

Medical School	Ethics			Communication skills		
Split University (HR)	Subject: Ethics in "Medical humanistic science"			Subject: "Psychological medicine"		
				Years	Hours/Year	Type
				3rd	25	S
				Subject: "Family medicine"		
				Years	Hours/Year	Type
				6th	2	S
				Elective subject: "Communication skills"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	2nd, 3rd, 4th, 5th, 6th	15	L6, S9	4th	25	-
Zagreb University (HR)	Subject: "Medical Ethics"			Subject: "Basics of physicians' knowledge"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	5th	45	L4, S41	1st-6th	30	P
Rijeka University (HR)	Subject: "Medical Ethics"			None		
	Years	Hours/Year	Type			
	6th	45	L15, S 30			
Osijek University (HR)	Subject: "Medical Ethics"			Subject: "Family medicine"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	6th	40	L20, S20	6th	2	S
	Elective subject: "How to apply Hippocrates oath"			Elective subject: "Communication skills"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	1st	-	-	4th	25	L15, S10
Mostar University (BA)	Subject: "Medical Ethics and bioethics"			Elective subject: „Communication skills"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	1st-6th	10	L5, S5	1st	-	-
Tuzla University (BA)	Subject: "Introduction to medicine"			Subject: "Psychology of communication"		
	Years	Hours/Year	Type			
	1st	3	L2, P 1			
	Subject: "Family medicine"					
	Years	Hours/Year	Type	Years	Hours/Year	Type
	6tth	2	L2	1st	3	L2, P1
Sarajevo University (BA)	Subject: "Medical Ethics and sociology"			None		
	Years	Hours/Year	Type			
	1st	45	L30, P15			
Eastern Sarajevo University (BA)	Subject: "Ethics"			Subject: "Clinical Praxis II"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	1st	25	-	2nd	30	L15 + P15
Banja Luka University (BA)	None			Subject: "Family Medicine"		
				Years	Hours/Year	Type
				6th	2	S
Skopje University (MK)	Subject: "Medical Ethics"			Subject: "Medical Psychology and Sociology"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	1st	60	-	1st	-	-

Continuation of Table 1 Details from ethics and communication skills curricula at medical schools in Croatia, Bosnia and Herzegovina, Macedonia, Montenegro, Serbia, Kosovo and Albania (data from 2014)*

Medical School	Ethics			Communication skills		
Podgorica University (ME)	Subject: "Medicine and Society"			Subject: "Family Medicine"		
	Years	Hours/Year	Type			
	1st	-	-			
	Subject: "Family Medicine"					
	Years	Hours/Year	Type	Years	Hours/Year	Type
	4tth	1	L	6th	1	L
Beograd University (RS)	Subject: "Medicine and Society"			Elective subject: "Communication in Medicine"		
	Years	Hours/Year	Type			
	-	20	S			
	Elective subject: "Bioethics 3"					
	Years	Hours/Year	Type			
	3rd	30	L15, P15			
	Elective subject: "Bioethics 5"					
	Years	Hours/Year	Type	Years	Hours/Year	Type
	5th	30	L15, P15	-	30	L15, P15
Priština University (RKS)	Subject: "Medical Ethics"			Subject: "Medical Psychology and communication skills"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	1st			1st	-	-
Tirana University (AL)	Subject: "Medical Ethics"			Subject: "Communication in health care"		
	Years	Hours/Year	Type	Years	Hours/Year	Type
	1st	25	L13, S 12	1st	35	L15, S20

*Types of classes: L=Lectures, S=Seminars, P=Practicals. HR=Croatia; BA=Bosnia and Herzegovina; MK=Macedonia; ME=Montenegro; RS=Serbia; AL=Albania; RKS-=Kosovo.

Cochrane have been started in BH, where a conference about the perspectives of Cochrane and EBM was organized at the Sarajevo Medical School in October 2015, and although this symposium was targeted at academia and decision makers, the efforts will be continued to better present evidence to the lay public.

Due to the fairly regular media coverage of such events and programs that raise awareness about EBM, professional meetings in both countries seem to be a fairly effective method of relaying the importance of EBM to health care system policy-makers and regulatory officials (such as the top officials at ministries and institutes of public health and heads of hospital departments). As such events become more frequent, perhaps their message could be disseminated through a top-down movement resulting in a systemic change toward the implementation of SDM and EBM.

Aside from physician education, patients should also be better educated regarding their health. Demand for patient education is demonstrated by the involvement of the Croatian Patient Association in the International Association of Patient Organizations. Through this organization, patients have expressed demands for greater involvement in decision making on the health policy level (32). Patients should be both properly informed about their condition and about associated risks of each treatment, so that they could be involved in effective conversations. The issues of time constraint and insufficient

patient medical literacy can be overcome by utilizing decision aids. Yet, there is a lack of translated material, which is an issue that Cochrane Croatia will tackle by pursuing the translation of decision aids in cooperation with the Patient Decision Aids Research Group. This research group in Canada is exemplary, being famous for its Ottawa Personal Decision Guide and various toolkits, along with other materials available online for free (33). Overall, the current level of development of decision aids in Croatia again seems to be similar to the situation in neighboring Italy, where there are still insufficient examples of decision aids structured around SDM. One critical point which prevents a stronger movement in Croatia and BH toward their production is a lack of specific evaluation tools which can track SDM progress. This is in contrast to the progress in Italy where versions of the OPTION scale and the SDM-Q are already instilled, which supply reliable outcome measures (27).

Some attempts to give public lectures and workshops with the aim of introducing the concept of SDM have already been made in Split, but have so far failed due to a lack of resources. Another way to put SDM into the spotlight with the general public might be through the media, such as local TV, radio stations, or newspapers, especially in programs or news articles which focus on health information and advice.

Conclusion

Transitioning to SDM has become a global initiative because it gives any growing health care system a more efficient method for providing the highest quality care. In addition, the physician has the obligation, both legal and moral, to stop practicing medicine in a paternalistic manner. Patients have expressed their desire to become more involved in the decision making process, and are unsatisfied when their input is underestimated. The physician can no longer rely only on professional opinion, but must become open to accepting patients' choices. This trend, although definitely present, has been developing more slowly in Croatia and BH. However, with the help of international collaborations, academic research done by scientists from Croatia and BH, decision aids, and proper training of ethics and communication skills in medical schools, SDM will become more widely practiced. Soon, this culture of productive collaboration will provide the many benefits necessary to improve the health care system.

What is already known on this topic

Shared decision making is becoming more and more important, as there is a lot of medical information publicly available. Not all patients are capable or willing to share all the decisions all the time. The greatest challenge is to communicate information and willingness to share with the individual patient.

What this study adds

In this paper we aimed at defining risks, benefits and barriers to shared decision making. As physicians' communication skills seem to be the corner stone of quality SDM, we collected data on teachings on ethic and communication skills at medical schools in Croatia, BH, Macedonia, Montenegro, Serbia, Kosovo and Albania Universities.

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