Is there a role for shared decision-making in pediatric weight management?

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**Summary** Shared decision-making (SDM) is central to personalising health and medical decisions. This decisional model encourages patients to act as managers of their own care while maintaining a partnership with health professionals. Although applied to some conditions, SDM has been used infrequently in pediatric weight management (PWM). Herein, we highlight the applicability and usefulness of SDM in making several important decisions related to PWM, including referral-making to different levels of care and treatment initiation and implementation. We conclude by describing possible challenges that may arise when implementing this model and suggest strategies to optimise the use of SDM in PWM.

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Shared decision-making (SDM) is a decisional model in which patients and clinicians share expertise to identify and make decisions in a collaborative manner [1]. Clinicians share evidence-based, clinical information about health conditions (e.g., etiology, consequences) and treatment options, while patients assess the risks and benefits of different therapies based on the information provided and their own beliefs, preferences, and values. SDM is useful when a range of therapeutic options exist, the available evidence does not point to a clearly superior option, and patients must assess the risks and benefits of available options [1]. Although suggested to support decision-making in pediatric healthcare, to our knowledge, this model has been used infrequently in pediatric weight management (PWM) specifically.

Given that most children referred for PWM do not enroll in care [2], clinicians can use SDM with families at the ‘front end’ to discuss excess weight and potential value of a referral. Consistent with expert

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recommendations [3], once a primary care provider establishes that a child’s weight may compromise his or her health, several therapeutic services could be offered. The stage of care most suitable to families can be explored using SDM. The following clinical scenario highlights this example:

Sammy is a 10-year-old boy who continues to gain weight despite his parents’ attempts to address this issue on their own. His parents are concerned about his weight gain and decide to visit his physician, who believes that he might benefit from multidisciplinary care. She summarises the issue and describes the option of referring Sammy for PWM at the local children’s hospital. After ensuring that Sammy and his parents understand the referral’s potential value, the physician shares the pros and cons of this option considering their preferences, values, motivation, and resources. Once both parties agree on the best option for Sammy, the physician follows up with the family to query whether they acted on the referral and explore Sammy’s progress over time.

Lifestyle and behavioural interventions are foundational to PWM across different levels of care [3]; however, intervention delivery can vary substantially across areas of focus, frequency, duration, modes, and target groups. With uncertainties regarding the ‘best’ approach to take, SDM can help families and clinicians make decisions related to their personal care pathway. As with implementation, effectiveness of lifestyle and behavioural modifications can vary; different therapeutic approaches may be chosen when success is limited. Consider Sammy who is now a 17-year-old adolescent with severe obesity enrolled in multidisciplinary care. After two years of weight stabilisation and modest improvements in cardiometabolic risk factors, Sammy’s physician suggests their local surgical program for which he is eligible, and provides information regarding potential benefits and harms of undergoing surgery. Specifically, she mentions that adolescents at his weight can lose ~75% of their excess body weight [4] and that careful follow-up is required by a multidisciplinary team [5] after the surgery is performed. Asked about his interest, Sammy assesses the situation and replies: ‘The weight I could lose is tempting, but there are some side effects, too. It’s a big decision. I need some time to talk to my parents about it.’ This illustrates the process of SDM and outlines key steps to follow, including seeking a partnership with patients, identifying alternatives, evaluating and presenting the evidence, assessing patients’ preferences and values, and reaching a decision.

With the potential for success of SDM in PWM comes challenges. In pediatrics, patients usually include more than one family member, all of whom can hold different preferences and values, lending to different perspectives on particular decisions. Although children’s attitudes towards SDM in PWM remain to be explored empirically, empowerment via SDM may be particularly relevant to adolescents who show (i) increased autonomy, higher cognitive development, and capacity for abstract thought but (ii) lower rates of success in PWM [6] compared with children.

There is value in developing and testing patient decision aids (PtDAs) tailored to cognitive development and information needs of different audiences; however, no PtDAs have been developed for and tested in PWM. PtDAs, which act as adjuncts to clinical counselling, can facilitate the SDM process (especially when decisions are preference sensitive) by clarifying values, outlining alternative routes of treatment and associated outcomes, and framing decisions [7]. PtDAs have also been shown to improve rapport and communication with clinicians [8], who often find it difficult to address obesity with families due to stereotyping, blame/shame, and guilt. Since some families may agree to recommended courses of action to cope with unpleasant feelings or stress, PtDAs may help alleviate ambivalence and tension in PWM.

Despite challenges, SDM has the potential to improve referral-making and treatment enrollment and adherence, all of which are necessary to optimise outcomes for children and adolescents with obesity. Research is warranted to assess acceptability, feasibility, efficacy, and effectiveness of SDM in PWM.

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Conflicts of interest
None.

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