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From the Editor

From the President

2014 North American Meeting

European Conference Recap

Malaysia: Translating Shared Decision Making in a Multi-Cultural Environment, Ng Chirk Jenn, Lee

SMDM Elections Open: Vote Today!

Career Development at 2014 Meeting

Networking Committee Update
Events and Opportunities

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Opportunities to Network
Job Postings
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From the Editor

by Joshua A. Hemmerich, PhD, Editor-in-chief, The University of Chicago

Summer greetings from the editorial team at the SMDM Newsletter! For many of us, summer brings vacation and professional travel, and a reminder of how diverse our world is in culture, language, beliefs, resources and practices. As those in Europe and Asia become more involved, the Society for Medical Decision Making continues growing and expanding so that it provides an ever clearer reflection of this global diversity. This quarter’s issue features pieces on how the Society is working to continue to grow and thrive in several parts of the world.
The opinions stated in the following commentaries are solely those of the authors and do not reflect the opinions of the Society for Medical Decision Making.

Malaysia: Translating Shared Decision Making in a Multi-Cultural Environment
by Ng Chirk Jenn, Lee Ping Yein, Lee Yew Kong

The 2013 International Shared Decision Making Conference in Peru focused on shared decision making (SDM) in the developing world. One such developing country is Malaysia. Malaysia has a population of 28 million, divided into a three main ethnic groups (Malay, Chinese and Indian) with many other smaller groups and a variety of religious beliefs and practices. It is a complex socio-cultural context in which adaptation of the SDM concept is necessary.

To help address the challenge of promoting SDM in a multi-cultural environment, we have formed the Malaysian SDM Group. Our members have developed decision aids for insulin initiation and breast cancer treatment in multiple languages. Prostate cancer and spinal cord injury decision aids are in the pipeline. We organize regular decision aid training workshops and have developed an e-learning module for healthcare professionals who are unable to attend workshops. We also host regular meetings to discuss and write papers. In the course of our research, a number of cultural factors have emerged that pose challenges to SDM implementation.

First, cultural paternalism is common in Malaysia. Patients view doctors as the expert or authority and are often passive during medical decisions. On the other hand, doctors often practice a paternalistic consultation style. They stop at informed consent and do not actively engage the patient in decisions. Options are often not discussed and some Malaysian doctors persuade patients by emphasizing benefits relative to risks.

Second, cultural collectivism is more prevalent in Eastern societies. Family harmony is important and decisions are often made collectively. It is common for a patient’s family member or spouse to be the main decision maker rather than the patient. Thus, the usual patient-doctor dyad paradigm in SDM is more effectively viewed as a patient-family-doctor triad.

Third, language barriers are particularly challenging in Malaysia with at least four main languages spoken by different ethnicities in urban areas. As a result, it is very difficult for doctors to cover all of the languages and they cope by having healthcare personnel who are fluent in the required language. In addition, we are working to ensure that decision aids are available in multiple languages.

Last, patient-centered care is still in its infancy in Malaysia. We realize that SDM is only one component of patient-centered care. Thus, it is important for us to collaborate and promote a
broad concept of patient-centered care to avoid development of disparate research silos. This collaborative direction has led us to brainstorming and discussions with experts on a unified model that incorporates the various components of SDM, evidence-based medicine and self-care.

SDM in Malaysia continues to see much progress. Patients have indicated a desire for more involvement in medical decisions. A cross-sectional survey of 470 patients in 2012 showed that nearly 75% preferred an active or SDM role in the consultation. In April 2014, an inaugural Shared Decision Making Workshop was organized for 24 healthcare professionals and policy makers from both public and academic settings. Moving forward, we have developed a patient involvement framework that maps key areas for future research, training and policy in Malaysia (BMC Health Serv Res 2013, 13:48).

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Using Multi-Group SEM to Study Culture & Medical Decision Making

by John Friend, Research Associate, University of Hawaii

Within the patient centered care movement, culture is recognized as an important influence on medical decision making (MDM). While there are many quantitative techniques available for studying culture’s influence on MDM, multi-group structural equation modeling (SEM) offers two key advantages that other analytical approaches such as regression and multivariate analysis of variance do not provide. First, by accounting for measurement error rather than assuming no error, SEM increases statistical power to identify significant relationships between latent factors. Second, multi-group SEM allows simultaneous comparisons of direct and indirect effects of several antecedent variables on one or more outcomes within and across cultures.

Consequently, multi-group SEM facilitates the development of nomological networks of underlying