Shared decision-making can improve obesity care in people with type 2 diabetes

Type 2 diabetes guidelines highlight the importance of weight management and of shared decision-making (SDM). This narrative review, published in *Diabetes Care*, highlights factors which act as barriers to SDM at the person, provider and systems level. The authors identify three types of tools to aid SDM: decision support tools for people to use independently in preparation for their consultation; decision aids for use in the consultation; and clinician decision support tools to aid clinician preparation. Examples of US and UK models and tools to aid SDM are linked for us to explore. Not everyone will want to participate in SDM. This is a gentle reminder to us as clinicians to reflect on how often we enable SDM and how we could incorporate this more, and to recognise the benefits when we do.

Pam Brown
GP in Swansea

Ninety percent of people with type 2 diabetes are living with overweight or obesity, and the focus on weight management as a core part of type 2 diabetes care has increased over recent years. **Shared decision-making** (SDM), in which the person living with a condition and their care provider collaborate to agree management decisions, is advocated by all the major global obesity guidelines, and evidence suggests it improves quality of care.

Since SDM enables the person living with the condition to participate fully in a discussion about why and how the medication or lifestyle change can help improve their health, and to choose to be an active partner in deciding their management option(s), it is likely to improve motivation and encourage adherence. However, with rising obesity rates, growing evidence for different behaviour change options on weight, and increasing complexity and nuancing of drug treatments, all without additional clinician education and training, it is difficult to know how best to encourage and implement SDM in obesity care.

Note that some people may not wish to participate in SDM about their care, and we need to respect this. This may result from perceived lack of knowledge (so offering information verbally or as leaflets may increase participation in future discussions), or from a genuine belief that the "clinician knows best" and that their role is to follow guidance.

Narrative review

In this narrative review, Schumacher and colleagues explore barriers to implementing SDM and share strategies for overcoming these.

Patient- or person-level barriers to SDM

In a large survey of people living with overweight or obesity, although two-thirds agreed that obesity is a disease, 81% expressed a belief that it is their personal responsibility to manage, likely due to long-standing weight stigma suggesting that excess weight is due to lifestyle choices. Such internalised weight stigma, defined in the new ADA Obesity Association's weight stigma and bias standard as "weight beliefs and attitudes applied to oneself", can have major impact on beliefs and choices (Bannuru et al, 2025).

Studies have demonstrated that many people are not well equipped to participate in SDM, for reasons including mistrust of the process, mistrust of medications, and lack of experience and hence understanding of how to participate in SDM. Increased involvement of family in decision-making (where this is acceptable) and an "informed decision-making" approach, in which information is provided and the person has the opportunity to discuss options with family and friends before sharing their choices, may be more acceptable.

Provider-level factors

Key barriers to SDM identified in relation to obesity management in people with type 2

Citation: Brown P (2026) Diabetes Distilled: Shared decision-making can improve obesity care in people with type 2 diabetes. *Diabetes & Primary Care* **28**: 33–5

Read more

How to find the ideal words in consultations

Guidance on using the right language for effective, person-centred care.

Diabetes & Primary Care **23**: 71–2

Click here to access

diabetes are lack of provider education about the expanding range of drug and metabolic/bariatric surgery options; lack of confidence in starting and continuing conversations about weight; and lack of ready-made management plans which can be implemented in a few minutes in a short consultation.

In one large study, Caterson et al (2019) found that more than 70% of healthcare professionals said they did not start conversations about weight because they did not think people were interested in discussing this, while two-thirds of people living with overweight or obesity wished their provider had talked about weight and 77% were glad that their clinician did raise the subject.

System-level factors

Funding and availability of care for overweight and obesity can also seriously impact SDM since, for example, it can feel pointless to raise the topic and discuss options which are difficult or impossible to access on the NHS. This has resulted in very large numbers of people in the UK currently choosing to privately fund injectable medications for weight loss, some without access to supported SDM or purchasing the drug from inappropriate suppliers. High workload and lack of people resources across the NHS also makes it difficult to find time for SDM discussions.

What works to enhance SDM?

Three types of SDM tools are described.

- Patient-centred tools (e.g. **decision support tools**) designed for independent use by the person with the condition, in preparation for the consultation.
  - ➤ These provide education and enhance understanding of the condition.
  - ➤ They improve confidence in decision-making, health literacy and trust of providers.
  - ➤ Most focus on a single health condition rather than the complexity of real-life care.
  - ➤ However, there is no interaction or ability to ask questions until the later consultation.
- Shared decision-making tools (e.g. **decision aids**) for enhancing the discussion between patient and clinician during the appointment.
  - ➤ May also be used during the consultation.
  - ➤ Examples include the NICE obesity guideline, the Kidney Failure Risk Equation and the QRISK3 calculator.
- Provider-centred tools (e.g. **clinician decision support tools** or prognostic tools) for use by clinicians prior to the consultation.

The SHARE model for SDM

SDM should ideally meld the provider's knowledge of the management options available with the patient's preferences and life situation. We may need a prompt or structure to help us implement this in our consultations, and **SHARE** is a well-researched model developed by the US agency for Healthcare Research and Quality:

Seek the person's participation.
Help to explore and compare management options.
Assess the person's values and preferences.
Reach a decision with the person.
Evaluate the person's decision.

Online training is available at www.ahrq.gov/sdm/share-approach/index.html to help clinicians implement the SHARE model.

Decision aids

Various formats of patient decision aids can provide evidence-based information about treatment options, which can then aid decision-making and/or inform discussions in the shared consultation. These have been shown to improve knowledge, aid understanding of risks and increase participation in decision-making without prolonging consultations.

The NICE (2026) NG246 guideline on obesity and weight management provides a section on SDM in the *Tools and resources* tab, and a practical guide to using medicines to manage overweight and obesity, addressing people living with obesity directly.

Provider-orientated tools

Training on the use of the 5As obesity discussion structure from Obesity Canada has been demonstrated to improve SDM in some studies (Rueda-Clausen et al, 2014), although it has been criticised as too simplistic, and does not specifically address obesity in relation to type 2 diabetes.

In a recently published paper, Zisman-Ilani et al (2026) explored SDM in relation to advanced chronic kidney disease and decision-making around management of end-stage renal disease. This further clarifies the challenges of

implementing SDM especially in people with multiple chronic conditions and offers some specific tools to help.

Encouraging engagement in SDM

Strategies to encourage engagement in SDM are listed in *Box 1*.

Implications for practice

Although we all believe we are implementing SDM in most consultations, the reality may be different, and I know I need a reminder to include more of this on busy days.

SDM is highlighted in all NICE guidelines, including the NG246 obesity guideline and the draft update of NG28 type 2 diabetes guideline due for publication shortly. This narrative review is a timely reminder of the importance of SDM and how this can enhance the experience of the consultation both for people living with chronic conditions and for ourselves as clinicians.

To fully participate in SDM, both people living with obesity and clinicians need to be willing to prepare, ask and answer questions, learn about management options, and make time for an informed discussion about locally available and personalised choices. In busy general practice, finding time for each of these can be challenging.

The good news is that providing a decision aid or link and encouraging the person to work through this prior to their consultation can improve understanding about the condition and management options, and may translate into shorter and more satisfying consultations. It is likely to result in an individualised discussion tailored to the person's needs, rather than a generic discussion providing too much or too little information, possibly pitched at the wrong level. In turn, this can translate into improved patient–clinician trust and, hence, improved adherence with agreed management.

When was the last time we provided a decision aid and encouraged preparation for a clinic visit? Or really made time for the person consulting to ask questions? Or concluded a consultation and felt good that we had had a collaborative discussion and reached an outcome we were both really happy with? As we begin 2026, let's try to do a little more of this. ■

Box 1. Options for improving engagement in shared decision-making.

- Invite people to participate in decision-making unless they refuse.
- Listen to and acknowledge beliefs, and incorporate these in planning and decision-making.
- Avoid using medical terms or jargon – speak in plain English; use LanguageLine or other support if English is not the person's preferred language.
- If the person is keen to have family or friends participate in the consultation, facilitate this.
- Use tools before and in the consultation to aid learning and decision-making.
- Use evidence-based techniques like motivational interviewing if you or a member of your team is trained and comfortable using this approach.

Bannuru RR; Professional Practice Committee (2025) Weight stigma and bias: Standards of care in overweight and obesity – 2025. *BMJ Open Diabetes Res Care* **13**(Suppl 1): e004962

Caterson ID, Alfadda AA, Auerbach P et al (2019) Gaps to bridge: Misalignment between perception, reality and actions in obesity. *Diabetes Obes Metab* **21**: 1914–24

NICE (2026) *Overweight and obesity management* [NG246]. Available at: https://www.nice.org.uk/guidance/ng246

Rueda-Clausen CF, Benterud E, Bond T et al (2014) Effect of implementing the 5As of obesity management framework on provider–patient interactions in primary care. *Clin Obes* **4**: 39–44

Schumacher LM, Bass SB, Ard J et al (2025) The new obesity treatment landscape: Challenges and opportunities to promote shared decision-making in people with obesity and type 2 diabetes. *Diabetes Care* 3 Dec [Epub ahead of print]. https://doi.org/10.2337/dci25-0094

Zisman-Ilani Y, Rhee CM, Ammary FA, Kalantar-Zadeh K (2026) Shared decision making and decision aids in the management of kidney disease and renal replacement treatment options. *Curr Opin Nephrol Hypertens* **35**: 13–20

The new obesity treatment landscape: Challenges and opportunities to promote shared decision-making in people with obesity and type 2 diabetes

Read the article in full
(open access)