Shared decision making and its role in managing uncertainty and reducing low-value care

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Background
Shared decision making (SDM) has benefits for patients, healthcare professionals and the healthcare system. Involving patients in decisions about their healthcare is a healthcare right.

Objectives
The aim of this article is to explore when and how to use SDM in consultations, and to increase awareness of the role of simple tools to support SDM, particularly in consultations where uncertainty and low-value care options exist.

Discussion
Implementing SDM into primary care consultations with general practitioners, practice nurses and other team members does not need specific tools, although there are many that can be helpful to assist clinicians and do not increase the length of consultations. Encouraging patients to ask questions in consultations, particularly about options; discussing the benefits and harms of options including waiting and watching; and exploring patients' values and preferences are important steps in the process.

CASE

Kim, aged 57 years, presents with ongoing mild-to-moderate left knee pain that together you have discussed and for which you have implemented a conservative management approach over the past 3 months. There has been overall mild improvement with an occasional exacerbation, which has been well managed. Today they present, somewhat sheepishly, with their phone in their hand, describing a new investigation and treatment they have been following on social media that is 'curing knee pain'. Kim requests imaging as the first part of following this social media–described plan.

THE FOCUS ARTICLES in this issue of *Australian Journal of General Practice* focus on challenges that general practitioners (GPs) face in consultations, such as uncertainty about diagnoses and managing increasing demands for tests and treatments where the evidence is limited or absent, or the benefits are unlikely to outweigh the harms (low-value care). This article will explore how healthcare workers and patients can use the process of shared decision making (SDM) to reach informed decisions collaboratively.

SDM is a two-way process where GPs and other healthcare professionals engage and partner with patients (and caregivers) in collaborative decision making based on the best available evidence and the patient's informed preferences and values.[1,2] GPs contribute clinical expertise, sharing their knowledge of the evidence on benefits, risks and uncertainties.[3] SDM provides the mechanism for integrating this expertise with patients' values, and it has been associated with improved experiences and outcomes for patients, clinicians and the health system.[4–7]

Among the drivers of low-value care are a lack of evidence-based knowledge, uncertainty, and clinicians' and patients' over-optimistic expectations about the possible benefits of interventions and underestimation of their possible harms.[8,9] Part of SDM involves addressing misperceptions that patients may have and explicitly discussing the likely benefits and harms of the options, which can reduce the uptake of low-value care.[10] When patients are provided with high-quality evidence about the benefits and harms of treatment options (eg knee osteoarthritis[11] and infections where antibiotics have limited efficacy[10]), their decisions are more likely to incorporate this evidence and align with their goals of care.

SDM is endorsed by the Australian Commission on Safety and Quality in Health Care as a cornerstone of person-centred care and embedded in the National Safety and Quality Health Service (NSQHS) Standards.[12] Involving patients in decisions about their care is a healthcare right and

ethical imperative.[1,12] Simple resources are available, such as decision aids or question prompt lists, to support SDM;[13,14] however, structural support for implementation is still needed in Australia to better support routine use of these to meet standards.[15] At present, SDM is rarely deliberately measured, although internationally validated measures exist.[16,17]

At this point many clinicians will say, 'Yes, but I already do shared decision making'. The evidence suggests that clinicians in many countries, including Australia, are not routinely doing all the recommended steps in the SDM process[18,19] and that understanding of what it is and how to incorporate it into practice could be improved.[20]

At this point, take a moment to reflect on your most recent interaction with a patient where a decision was made and rate yourself against the recommended components of SDM (Box 1, based on two published SDM measures: the 9-item Shared Decision Making Questionnaire [SDM-Q-9][16] and CollaboRATE[17]). Keep in mind that, particularly in general practice, these elements may have taken place over time and several consultations. It is also useful to consider how the patient might have rated their consultation with you when considering these criteria.

Here are some answers to questions about SDM you may have encountered or contemplated:

- 'Will doing SDM make me run late?' – Cochrane and other reviews have found that overall, interventions to increase SDM probably do not increase the length of consultations.[21-23]
- 'What are the risks of SDM?' – Some patients may experience decisional conflict in the process of making decisions and weighing up the evidence, but there is no effect on their levels of anxiety.[22]
- 'What if there is only one reasonable option?' – In some situations, for example treatment of a myocardial infarction or the removal of a melanoma, there may not be another option that is reasonable. In these instances, the process becomes one of providing the person with sufficient information that they can provide informed consent. What is considered a 'reasonable option' depends on the values and preferences of the person making the decision. There are rare instances when a patient may choose an option that is life-limiting such as for religious reasons, but in this case SDM would still be part of the process, despite the choice not necessarily being congruent with the healthcare professional's values and preferences.[23,24]
- 'When is SDM not appropriate?' – In life-threatening situations or where there is a threat to public safety, SDM may not be appropriate.[25]

SDM can be a useful tool to help manage decisions, especially where there is high uncertainty of evidence, and thus potentially reduce overdiagnosis and overtreatment. This article will provide further detail on what SDM is and a model to assist with using it in practice, with a focus on practical strategies for GPs and their teams with this patient-centred approach.

Box 1. Shared decision making healthcare provider self-assessment questions[16,17]

Did you:

- ensure that the patient knew there was a decision to be made and ask them how much they wanted to be part of the decision making?
- tell the patient all the options (including watching and waiting or doing nothing right now) and explain all the benefits and harms of the available options?
- help them understand the information (eg using patient information, pictographs etc)?
- ask which was their preferred option after weighing up the options with them and talk about a plan? (This could include deciding to talk about it further or a decision may have been chosen together.)

Shared decision making in general practice

SDM is often conveyed as a process that unfolds in a single consultation where a specific decision needs to be made,[23] for example to weigh up the benefits and harms of starting a cholesterol-lowering medication. While these types of decisions occur in general practice, many decisions are made in a less structured way over more than one consultation, are based on a long relationship developed between the GP and patient, and frequently involve input from other members of the healthcare team and the patient's family.

SDM is also appropriate in the common situation of decision making when there are multiple options with balanced benefit–harm trade-offs (often described as equipoise), such as between medications for hypertension.

Preference-sensitive decisions are those where multiple reasonable options exist but there is no clearly superior option and so the 'best' choice for a patient depends on their preferences and circumstances, including how they value each of the benefits and harms. Healthcare professionals may have different preferences to and make different decisions than patients and therefore should not assume patients' preferences or make decisions for patients (except in a minority of cases[26] where the patient may explicitly request that the clinician make the decision).[27] In preference-sensitive decisions, such as whether or not to engage in prostate cancer screening, the process of SDM can mean the options, benefits and harms and the patient's values and preferences can all be elucidated in the process of making a decision.

Shared decision making: A framework

General practice is being affected by patients' growing access to health information, often of low quality, from sources such as social media.[28] This increases the need to support patients in making evidence-informed health decisions by using SDM to discuss the options, the benefits and harms, and to elicit values and preferences. We present one possible framework to guide the incorporation of SDM into conversations, acknowledging that implementing this will vary depending on several factors such as the presenting issue, the level of existing shared knowledge between the clinician and patient, decisions that have already been made together, and others involved.

In Elwyn et al's 'three-talk model',[29] there are three explicit discussions for each type of 'talk', including:

- **team talk** – the patient and clinician discuss that there is a decision to be made and how and who could be involved in the decision

- **option talk** – options and evidence are outlined
- **decision talk** – the patient is involved in coming to a decision to the extent they choose; this is informed by their preferences and the evidence with guidance from the clinician.

Team talk

In this part of the process, the patient and clinician explicitly discuss that there is a decision to be made together.[30] It is not always obvious to patients that their clinician is considering a decision and that there are options available, including watching and waiting.[31] This part of the process does not have to be complicated – a simple statement in the case of Kim might be, 'It sounds like you have found another possible option for managing your knee pain, so there is a decision to make.'

As part of 'team talk', the patient's goals should be explored. In Kim's case, they may have a goal of remaining in their job, which is becoming increasingly challenging because of their knee issues. Understanding the patient's goals may open other evidence-based options. For example, in this case, an occupational therapist might be able to assist with modifications to make work more feasible.

Option talk

Many of the resources to support SDM focus on this part of the process. For example, the three-question prompt list Ask Share Know[13] can be used by patients[31–35] to ask their clinician questions or used by a clinician to structure a discussion.[2] The three questions are outlined below.

1. What are my options (including wait and watch)?

'Option talk' can begin with outlining the evidence-based options and, where it is appropriate and not a life-threatening situation, also the option to 'wait and watch' (ie some period of observation). It may also include listing options with limited evidence or those considered low-value care. As information becomes more accessible, people are bringing information about options for their care to their GPs.[28] In Kim's case, we need to include the option they have brought to the conversation.

2. What are the possible benefits and harms of those options?

For each option, the possible benefits and harms should be described. Where a decision-specific patient decision aid exists, this can be particularly helpful in discussing the benefits and harms. There is no single repository for decision aids in Australia,[15] so it can be helpful to bookmark those you find for decisions made frequently (refer to Table 1 for examples).

It is important to keep in mind the breadth of benefits and harms of options beyond efficacy. These can include, but are not limited to, financial costs to the patient, the amount of patient work involved (eg getting monitoring blood tests, frequency of visits for treatment), the strength of the evidence for the benefits and harms, and resource use and sustainability. The patients' values and preferences can guide which options are discussed in greater detail.

3. How likely are each of those benefits and harms to happen to me?

Quantifying the likely size or likelihood of the benefits and harms is important in helping patients and clinicians to make evidence-informed decisions. Patient decision aids typically contain pictographs or other tools to help clearly convey the numerical benefits and harms. If no visual tool exists, verbally conveying the numbers clearly is important and may include using natural frequencies/plain numbers (eg 4 in 100 people experienced this benefit and 2 in 100 had this harm).[36] Where possible, use resources that present these data for all available options, including watching and waiting where appropriate.

Decision talk

The goal of 'decision talk' is to reach a plan together with the patient that considers their values and goals and incorporates their informed preferences about the options. Acknowledging the uncertainty of the evidence for some or all the options is frequently part of decision talk.

SDM does not mean that the patient must make the final decision. Using phrases such as, 'Based on what you have shared, it seems you are leaning toward option X, what are your thoughts about it?' can facilitate discussion that guides towards a shared decision.

The important outcome of SDM is that the final decision made by/with the patient is an informed one, even where the patient opts for a lower-value option or an option where there may be insufficient evidence that the benefits may not outweigh the harms.

Table 1. Shared decision making (SDM) tool examples with links

Resource	Link
Australian Commission on Safety and Quality in Health Care: Website with resources for SDM	www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making
Heart Foundation's Australian CVD risk calculator: Online cardiovascular disease risk tool	www.cvdcheck.org.au/calculator
Finding Your Way: A co-designed SDM model for Aboriginal people and strategies for implementing SDM	https://aci.health.nsw.gov.au/shared-decision-making
Heart Health Yarning Tool: A website that supports health professionals to make shared decisions about heart health checks with Aboriginal and Torres Strait Islander people	https://heartyarningtool.com
The Ottawa Hospital Research Institute's decision aid inventory: A useful international resource to search for international decision aids by clinical problem	https://decisionaid.ohri.ca/AZinvent.php

Kim may choose to follow the path they have found online despite discussion about the lack of evidence. As part of this, your discussion will likely have included that the specific imaging is not covered under Medicare. You may not be able to provide a referral for the imaging. In this case, Kim says they were glad for the discussion of the options and your acknowledgement of their preferences. You accept that Kim did not leave with what they had requested and that the conversation will likely continue as evidence evolves. Kim stays with you as their regular GP.

Conclusion

SDM is a practical strategy for helping to manage uncertainty and supporting informed decision making in Australian general practice. By fostering informed, patient-centred care, GPs can help support patient decision making about interventions, improve their satisfaction with the decision, and potentially reduce the uptake of low-value interventions. Implementing SDM requires commitment, resources and cultural change, but this delivers benefits for patients, clinicians and the healthcare system.

Key points

- Involving patients in decisions about their healthcare options is a healthcare right and part of Australian standards.
- SDM improves patient and clinician satisfaction and informed decision making, and it can potentially reduce low-value care.
- Genuinely encouraging questions from patients about options is a simple first step in SDM.
- SDM probably does not increase the length of consultations.
- National action to support implementation of SDM into routine care is still needed.

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