

Shared Decision Making and Improving Health Care

The Answer Is Not In

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Achieving health care of higher quality at lower cost has fueled policy interest in shared decision making (SDM).¹ In SDM, clinicians and patients work together to understand the patient's situation and determine how best to address it.² Programs are in place in the United States to promote SDM using legal and financial incentives, mostly by implementing patient decision aids (PtDAs).¹ The Cochrane review³ of SDM tools for people facing treatment or screening decisions is the key evidence cited in policy statements that propose to implement, distribute, and use certified PtDAs.

There are at least 2 distinct types of SDM tools, PtDAs and conversation aids (sometimes called within-encounter decision aids).⁴ Typically, both types of tools describe the current science about a specific medical condition and about the available options to address it. However, they serve different purposes. Patient decision aids aim to provide patients with relevant information, improve knowledge, and encourage patient involvement in decision making. Thus, they directly assist patients in making their own decisions (so-called informed decision making), or indirectly in preparing them to participate in SDM conversations with their clinicians. In contrast, conversation aids are designed to encourage and directly support the conversations that patients and clinicians have when making decisions together.² Their aim is to improve the quality of the SDM process rather than surrogate outcomes such as patient knowledge.

For the last 16 years, an international team of researchers with the Cochrane collaboration has periodically updated meta-analyses summarizing results of the published randomized trials on SDM tools. In this issue of *JAMA*, Stacey et al⁵ summarize their recent Cochrane review of 105 randomized trials of SDM tools, focusing on 50 different decisions and involving a total of 31 043 participants. The authors found that PtDAs consistently improved patient knowledge of options and outcomes compared with control interventions (mean knowledge scores, 70% vs 57%, respectively; high-quality evidence) and patient knowledge of risks (relative risk, 2.1; moderate-quality evidence) (control interventions included usual care, no intervention, general information, guidelines, and placebo interventions). Also, patients were more clear about what mattered most to them (mean difference, 8.8%; high-quality evidence). These results were consistent with earlier Cochrane reviews on SDM tools.

Policy makers interested in improving the quality of care and reducing costs have promoted the use of PtDAs as a tactic

to achieve patient-centeredness through SDM and to reduce the use of invasive and costly procedures, such as joint replacement surgery for knee osteoarthritis or coronary angioplasty for stable angina.⁶ Does the updated Cochrane review support these policy justifications?

Stacey et al⁵ concluded that patients receiving an SDM tool (ie, a PtDA or a conversation aid) reported feeling more involved in decision making. However, only 10 of the 105 trials included in the review sought to estimate the effect of using SDM tools on achieving SDM. No trial of pre-encounter PtDAs assessed whether their distribution increased SDM. Five trials directly observed how patients and clinicians made decisions during consultations and found SDM tools were effective in promoting SDM. All 5 of these trials used conversation aids rather than PtDAs.

The Cochrane review found inconsistent effects of PtDAs on health care use, outcomes, and costs. In particular, use of PtDAs did not consistently reduce the use of invasive or expensive treatments. Thus, the extent to which these tools can reduce costs remains unclear. Previous observational data suggesting that PtDAs may reduce health care use and cost were limited by confounding (eg, by observing a reduction in elective orthopedic procedures during the great recession⁷), by regression to the mean when procedures are overused, or by using PtDAs to reduce access to care. Informed patient choice with PtDAs, nonetheless, seems superior to restricting access (eg, preauthorizations, formulary restrictions) or restricting coverage for invasive and expensive treatments, which may prevent patients from receiving desired and helpful treatments. However, empowering patients who are ill to refuse their clinicians' recommendations to correct health care overuse is also problematic. Health care should provide care for patients and should not use patients as a means to correct systemic problems.

The review reveals important limitations in the evidence regarding SDM tools. For instance, only a small fraction of developed tools has been tested in published randomized trials. Patient-centeredness or even the quality of SDM processes were rarely ascertained. The lack of trustworthy evidence about the effects of SDM tools on quality of care and cost, however, should not be construed as evidence of no effect. In fact, policy makers may be willing to overlook these limitations in the body of evidence given the low cost and low risk of harm from implementing PtDAs. Although the low cost of these tools may reduce the evidence required to justify their use in practice, it does not eliminate the need for reliable evidence that their use is more likely than not to achieve the policy goals.

Furthermore, policy makers should consider the costs incurred by patients who use PtDAs. Although invisible to the health care system, the work required of patients may be substantial because tools designed for patients to use alone must be sufficiently comprehensive and thorough. Patient decision aids that lead to new questions and concerns require patients to invest intellectual and emotional effort to seek clarity and address distressing information, ambiguity, and uncertainty. Moreover, PtDAs may even reduce patient involvement in SDM if patients prefer to make autonomous decisions without consulting their clinician, or when clinicians assume patients who have used the PtDAs no longer need to discuss tests or treatments.⁸

Conversation aids for use within the clinical encounter appear to promote patient-clinician interactions consistent with SDM.^{2,3} When properly designed, they offer only the information necessary to support the patient-clinician conversation (the clinician can supplement information as needed), and demand little to no work of the patient before the consultation. Yet, practices may hesitate to bring more tasks into the consultation. Use of conversation aids may compete for time with other tasks such as documentation for reimbursement, which

consumes half of the total consultation time.⁹ For these reasons, administering a PtDA before a clinical encounter has potential advantages. Yet, only a small portion of patients use the PtDAs distributed to them,⁷ and the additional time spent in consultation with SDM tools is, on average, the same—2 to 3 minutes—with PtDAs as with conversation aids.² Furthermore, delegating SDM to parties outside the consultation is unlikely to improve clinician satisfaction with care. Thus, the available evidence challenges the assumption that distributing PtDAs is the most efficient approach to promoting patient involvement in decision making.

Many unanswered questions remain 16 years after the first Cochrane review on SDM tools and after 5 updates on this topic. Additional evidence is needed to estimate the extent to which these tools improve the situation of patients in a way that makes intellectual, emotional, and practical sense to them. Future research should discover and evaluate new ways to promote patient involvement in making important health care decisions that rely on, rather than eschew, meaningful conversations between patients and clinicians. This work should not prioritize cost savings, a welcome byproduct, but foster, against all forces, careful and kind patient care.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. The authors work at the Knowledge and Evaluation Research (KER) Unit on developing, implementing, and testing conversation aids. The 5 conversation aid trials included in the Cochrane review and favorably discussed in this Editorial were conducted by KER Unit investigators. The KER Unit or these investigators do not derive income from these tools, which remain in the public domain for free at <http://shareddecisions.mayoclinic.org>.

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