Shared decision making: what do clinicians need to know and why should they bother?

Shared decision making is a consultation process where a clinician and patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient’s values, preferences and circumstances. Shared decision making is not a single step to be added into a consultation, but can provide a framework for communicating with patients about health care choices to help improve conversation quality. It is a process that can be used to guide decisions about screening, tests and treatments. It can also be thought of as a mechanism for applying evidence with an individual patient through personalising the clinical decision. Although, to date, most research about shared decision making has focused on medical practitioners, it is relevant to clinicians of all disciplines, including nursing and allied health.

Shared decision making can be viewed as a continuum, along which the extent to which a patient or a clinician takes responsibility for the decision-making processes varies. At the extremes are clinician-led decisions and patient-led decisions, with many other possible approaches in between. The extent of involvement will vary between individuals and between consultations, and according to the patient’s preferences and the context in which the decision is occurring. Regardless of whether the patient or clinician takes the lead in the decision-making process, joint discussion should occur.

How can shared decision making help?

Internationally, shared decision making is seen as a hallmark of good clinical practice, an ethical imperative, and as a way of enhancing patient engagement and activation. Increasingly, it is being advocated for in clinical guidelines and health care policies. While shared decision making is applicable to most situations, it is especially important in certain circumstances; for example, where the evidence does not strongly support a single clearly superior option (most clinical decisions) or where a preference-sensitive decision is involved. That is, when there is uncertainty as to which option is superior, each option has different inherent benefits and harms, or the decision is likely to be strongly influenced by patients’ preferences and values.

Summary

- Shared decision making enables a clinician and patient to participate jointly in making a health decision, having discussed the options and their benefits and harms, and having considered the patient’s values, preferences and circumstances. It is not a single step to be added into a consultation, but a process that can be used to guide decisions about screening, investigations and treatments.
- The benefits of shared decision making include enabling evidence and patients’ preferences to be incorporated into a consultation; improving patient knowledge, risk perception accuracy and patient–clinician communication; and reducing decisional conflict, feeling uninformed and inappropriate use of tests and treatments.
- Various approaches can be used to guide clinicians through the process. We elaborate on five simple questions that can be used: What will happen if the patient waits and watches? What are the test or treatment options? What are the benefits and harms of each option? How do the benefits and harms weigh up for the patient? Does the patient have enough information to make a choice?
- Although shared decision making can occur without tools, various types of decision support tools now exist to facilitate it.
- Misconceptions about shared decision making are hampering its implementation. We address the barriers, as perceived by clinicians.
- Despite numerous international initiatives to advance shared decision making, very little has occurred in Australia. Consequently, we are lagging behind many other countries and should act urgently.

The relationship between shared decision making and evidence-based practice is becoming increasingly recognised. Shared decision making provides a process for bringing evidence into the consultation and incorporating it into discussions with the patient, along with discussion about the patient’s values and preferences. In other words, it is an important, if under-recognised, component to evidence translation, a route by which evidence is incorporated into clinical practice. Shared decision making may also help reduce the unwarranted variation in care that may partially arise from clinicians’ opinions dominating decision making, with insufficient consideration of both empirical evidence and patients’ preferences.

Patients and clinicians typically overestimate the benefits of interventions and underestimate their harms. Shared decision making can provide the opportunity for resolving this mismatch between clinician and patient expectations and the demonstrated benefits and harms of screening, tests and interventions. Consequently, shared decision making may reduce the inappropriate use of tests and treatments, such as those that are not beneficial for the majority or are
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### 1 An example of one approach to shared decision making

<table>
<thead>
<tr>
<th>Five questions that clinicians can use to guide shared decision making</th>
<th>Example phrases (for the opening clinical scenario of a child with acute otitis media)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What will happen if we wait and watch?</td>
<td>“In children, most middle ear infections get better by themselves, usually within a week. The best options to control pain and fever are paracetamol or ibuprofen.”</td>
<td>Quantitative information can be provided where possible, either at this step or in step 3 where each option is described. When this is not possible, descriptive information can be provided (eg, “most people find that the symptoms go away by ...”). Eliciting patient’s expectations about management of the condition (eg, “what have you heard or do know about ...?”), including previously tested approaches and experiences, along with fears and concerns, is important and may occur here or later in the process.</td>
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<tr>
<td>2. What are your test or treatment options?</td>
<td>“Waiting for it to get better by itself is one option. Another option is to take antibiotics. Do you want to discuss that option?”</td>
<td>For some decisions (such as in this example), the options may be familiar to patients and need little elaboration at this step. In others, a more detailed explanation of each option and its practicalities, including options which are time-urgent, will be required.</td>
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<tr>
<td>3. What are the benefits and harms of these options?</td>
<td>“We know from good research that of 100 children with middle ear infection who do not take antibiotics, 82 will feel better and have no pain after 2–3 days. Out of 100 children who do take antibiotics, 87 will feel better after about 3 days of taking them. So, about five more will get better a little faster. We can’t know whether your child will be one of the five children who benefit or not.” (A graphic representation of these numbers can also be shown at this point, and again after the harms information is discussed [Box 2].) “There are some downsides to antibiotics though. Out of 100 children who do take antibiotics, 20 will experience vomiting, diarrhoea or rash, compared with 15 who do not take them. That means about five children out of 100 will have side effects from antibiotics. But again, we can’t know whether your child will have any of these problems. The other possible downside is antibiotic resistance — would you like to hear more about it?” (The option of delayed prescribing could also be discussed here. Numbers used in this scenario are from Venekamp et al.[17])</td>
<td>In addition to descriptively discussing the benefits and harms of each option, the probability of each occurring, where this is known, should be provided. For dichotomous outcomes (eg, having a myocardial infarction), this should be in the form of natural frequencies (ie, the number out of 100 or 1000 people who experience the event) rather than relative risk. For continuous outcomes (eg, number of days of pain, and level of anxiety as reported on an anxiety measure), this may be expressed by the estimated size of the effect (eg, the average reduction in 20 points on anxiety on a tool that measured it as a score from 0 to 100). Decision support tools, if available, can be useful at this stage. Simple visual graphics can be particularly useful in helping to communicate the numbers. Principles of effectively communicating statistical information to patients should be followed, such as using natural frequencies (ie, x out of 100), being aware of framing effects, and using multiple formats.[16] The discussion of harms should extend beyond the risk of side effects and include other impacts that the option could have on the patient, such as cost, inconvenience and interference with daily roles, and reduced quality of life.</td>
</tr>
<tr>
<td>4. How do the benefits and harms weigh up for you?</td>
<td>“With all I’ve said, which option do you feel most comfortable with?”</td>
<td>This step includes eliciting patients’ preferences and working with them to clarify how each option may fit with their values, preferences, beliefs and goals. Some decision aids include formal value clarification exercises that may be used to supplement the conversation and/or enable the patient to reflect further following the consultation. Clarifying the patient’s understanding of what has been discussed so far, using the teach-back method, can help to identify if any information needs to be repeated or explained in another way.</td>
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<tr>
<td>5. Do you have enough information to make a choice?</td>
<td>“Is there any more you want to know? Do you feel you have enough information to make a choice?”</td>
<td>This provides another opportunity to ask if the patient has additional questions. Patients may feel ready to make a decision at this stage or it may be jointly decided to defer the decision and plan when it should be revisited. The patient may wish to seek further information before deciding, discuss with family, or take time to process and reflect on the information received.</td>
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### The process of shared decision making

A common misperception is that shared decision making is synonymous with the use of decision aids. However, the core of shared decision making is a process, which might additionally use decision support tools but is not dependent on them. This process varies according to numerous factors related to the patient, clinician and other circumstances. One set of questions that can be used to guide the process is shown in Box 1. Originally phased for use by patients,[16] we have amended the wording to the clinicians’ perspective.

As many patients are unfamiliar with being invited to share in decision making, it may help to briefly explain the process. Outlining that they have some choices that you would like to go through with them before deciding together about the next step may reassure patients who might otherwise feel overwhelmed, uncertain or even abandoned. If the problem or diagnosis is clear, and a decision about the next step is necessary, the next step involves describing the nature of the problem or condition (question 1, Box 1). This should usually include providing information about the natural history of the condition — that is, what is likely to happen without any intervention (“watch and wait”). Eliciting the patient’s expectations about management of the condition, including previously tried approaches and experiences, along with fears and concerns, is important and allows for discussion and correction of misperceptions where necessary (either at this stage or later in the process). The second question triggers a discussion of the options and identification of those that the patient would like to hear more about (Box 1). The third
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question enables discussion about the benefits and harms of each option, including their likely probability or size (Box 1 and Box 2). The fourth question provides patients the opportunity to weigh up the benefits and harms of the options, and consider them in the context of their preferences, values and circumstances (Box 1). Finally, the fifth question explores whether the patient is ready to make a decision or whether further information, time or involvement of other people is needed before a choice can be made (Box 1). If a high-quality and appropriate decision support tool is available for the decision under consideration, it can be incorporated before, during or after the consultation.

There are other approaches to shared decision making, in addition to the approach shown in Box 1. One alternative model breaks the decision-making part of the consultation into choice talk (helping patients to know that options exist), option talk (discussing the options and their benefits and harms) and decision talk (helping patients explore options and make decisions).19

The role of decision support tools in shared decision making

Evidence summaries can be useful in supporting decision making, but current formats such as clinical practice guidelines and systematic reviews typically do not map well onto decision points in the consultation, nor do they promote patient interaction and discussion. This is particularly so where the evidence is uncertain or where benefits and harms need to be weighed up with patient preferences and clinical contexts to individualise decisions.

Specifically developed decision support tools can help clinicians and patients to draw on available evidence when making clinical decisions.20 The tools take a number of formats (Box 3). Some are explicitly designed to facilitate shared decision making (eg, decision aids). Others provide some of the information needed for some components of the shared decision-making process (eg, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (eg, communication frameworks, question prompt lists).

When appropriate tools do exist, clinicians can use them in various ways: during the consultation (Box 1); as homework tools (where the patient is invited to use them either in the waiting room or at home, before or after the consultation); and either with or without assistance. Decision support tool use is not always straightforward. They may not fit the patient’s clinical or personal circumstances; clinicians and patients need to be willing to use them; they require clinicians to have some skills in how to use them; and there may need to be support for their use and delivery. Decision support tools alone are not the answer, and providing them does not guarantee that shared decision making will occur. Knowledge exchange alone is not sufficient — shared decision making needs to occur in a context where patients are enabled and supported to have a more active role.21,22

Misconceptions about shared decision making

Shared decision making is making headway in many countries.23 However, a number of misconceptions are hampering its implementation. Box 4 lists the barriers to shared decision making, as perceived by clinicians,24 along with comments and, where possible, research findings about each perceived barrier.

Challenges to shared decision making

There are several key challenges to the widespread use of shared decision making within the Australian health care system. First, training in shared decision-making skills is essential for its uptake, yet unlike various international initiatives,40 limited training options exist in Australia for both student clinicians and practicing clinicians. Second, shared decision making is dependent on clinicians having access to up-to-date high-quality evidence, preferably already synthesised. Decision support tools can assist with this, but they exist for only a minority of health care decisions, are of varying quality, are scattered across multiple sources and are difficult to find, and ones developed internationally may not be readily applicable to the Australian context or vulnerable populations. Third, shared decision making is hampered for clinical questions where quality evidence does not exist or has not yet been synthesised. Finally, shared decision making in the area of Indigenous health and vulnerable populations (such as patients with

2 A simple graphic that can be shown to parents when discussing the benefits and harms of antibiotics for acute otitis media

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Antibiotics</th>
<th>No antibiotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>= better (at about Day 3)</td>
<td>🟢</td>
<td>🟡</td>
</tr>
<tr>
<td>= not better (at about Day 3)</td>
<td>🟡</td>
<td>🟢</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Harms</th>
<th>Antibiotics</th>
<th>No antibiotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>= no diarrhoea, vomiting or rash</td>
<td>🟢</td>
<td>🟡</td>
</tr>
<tr>
<td>= diarrhoea, vomiting or rash</td>
<td>🟡</td>
<td>🟢</td>
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</tbody>
</table>
### 3 Examples of types of decision support tools to facilitate shared decision making

<table>
<thead>
<tr>
<th>Type of tool</th>
<th>Brief description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Condition-specific</strong></td>
<td></td>
<td></td>
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<tr>
<td>Decision aids</td>
<td>Describe the options, and the benefits and harms of each option, along with a values clarification exercise and sometimes a guide to decision making. The International Patient Decision Aid Standards Collaboration (<a href="http://www.ipdas.ohri.ca">http://www.ipdas.ohri.ca</a>) provides information about assessing the quality of decision aids</td>
<td>Ottawa Hospital Research Institute A to Z Inventory of Decision Aids: <a href="http://decisionaid.ohri.ca/A2Invent.php">http://decisionaid.ohri.ca/A2Invent.php</a></td>
</tr>
<tr>
<td>Option grids</td>
<td>A one-page summary of the evidence for the possible options, addressing patient-centred outcomes, and questions and concerns frequently raised by patients; can be useful within the consultation for a patient to highlight what is important to them</td>
<td>Option Grid Collaborative: <a href="http://www.optiongrid.org">http://www.optiongrid.org</a></td>
</tr>
<tr>
<td>Evidence summaries</td>
<td>Clinical practice guidelines and other summaries of the body of evidence</td>
<td>Clinical Evidence: [<a href="http://www.clinicalevidence.bmj.com">http://www.clinicalevidence.bmj.com</a>; UpToDate: <a href="http://www.uptodate.com">http://www.uptodate.com</a></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication frameworks</td>
<td>A generic set of questions or scripts and a structure for clinicians and patients to use during decision making</td>
<td>Ask Share Know: [<a href="http://www.askshareknow.com.au">http://www.askshareknow.com.au</a>; Ottawa Personal Decision Guide: <a href="http://decisionaid.ohri.ca/decguide.html">http://decisionaid.ohri.ca/decguide.html</a></td>
</tr>
</tbody>
</table>

poor health literacy) is important but presents additional challenges, and there is less research to guide implementation in these areas.36

Australia is drastically lagging behind many other countries in all aspects of shared decision making — policies, lobbying, advocacy, research funding, training, resources and implementation.41,42 In the absence of a coordinated national effort, we encourage individual clinicians to begin incorporating shared decision making into their consultations with patients when a health decision is needed. Australia’s health training and delivery organisations need urgently to begin prioritising and planning to make shared decision making a reality in Australia.

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2 Kon A. The shared decision-making continuum. *JAMA* 2010; 304: 903-904.


15 Stacey D, Légaré F, Col NF, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2014; (1); [CD001431; doi:10.1002/14651858.CD001431.pub4](http://www.clinicalevidence.bmj.com; [http://www.clinicalevidence.bmj.com](http://www.clinicalevidence.bmj.com).


### Misconceptions about shared decision making and key research findings that refute them

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Research findings</th>
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</table>
| **The duration of the consultation will be lengthened** | Three systematic reviews (on interventions to implement shared decision making, and impact of decision aids on processes of care and patient outcomes) indicate that there is no systematic increase in consultation duration when shared decision making is implemented or decision aids are used.  


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