Saving Shared Decision-Making

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ABSTRACT

The Agency for Healthcare Research and Quality encouraged a re-examination of the concept, process, and measurement of shared decision-making (SDM) in 2016. Progress, however, has been slow. One illustrative example is SDM's relationship with the concept of equipoise: there remains little consensus on what equipoise means in the context of SDM, creating confusion about when SDM is and is not indicated. In this paper, we describe the ways in which this focus on equipoise in SDM is counter-productive and argue that equipoise is neither a necessary nor sufficient criterion in determining the need for SDM. Moreover, we suggest that what is needed to move the field of SDM forward is a shift away from focusing on when SDM is needed to instead focusing on how best to accomplish SDM across a variety of contexts by advancing the science of SDM implementation.

KEY WORDS: shared decision-making; health communication; patient preference; medical ethics

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Shared decision-making (SDM) is at a crossroads. Though there is general agreement that SDM is a collaborative decision-making process that involves informing a patient (or surrogate) that there is a choice, discussing available options, and eliciting and exploring patient goals and preferences regarding the options, there is a striking lack of consensus on much else. Areas of SDM currently in dispute include what components fully constitute it, when it should be used, and how it should be implemented.

The result has been a paradox of perspectives on SDM. On one hand, it is recognized as an essential component of patient-centered care. The Centers for Medicare and Medicaid Services has required SDM since 2018 for certain clinical scenarios, and decision aids to support SDM in clinical encounters have proliferated.[1] At the same time, it is also recognized that SDM is in need of a thoughtful re-examination. In 2016, the Agency for Healthcare Research and Quality (AHRQ) initiated investments in research on the concept, process, and measurement of SDM after acknowledging that "it is unclear what leads patients and providers to believe a decision was shared or how to measure that construct.".[2]

There may be no issue more illustrative of this crossroads than SDM's relationship with the concept of equipoise. Equipoise has been a common element of SDM models[3] and considered by some to be a prerequisite[4] or core competency[5] for SDM. This is based on the view that SDM is most appropriately applied in decision situations with more than one option and no clear answer about which option is best. Yet, there remains little consensus on what equipoise actually means in the context of SDM, creating confusion about when SDM is and is not indicated.[6] Here, we argue that equipoise is neither a necessary nor sufficient criterion in determining the need for SDM. Moreover, we suggest that what is needed to move the field of SDM forward is a shift away from focusing on when SDM is needed to instead focusing on how best to accomplish SDM across a variety of contexts. Advancing the science of SDM implementation by developing and refining core skills and tools adaptable to a range of clinical settings will help patients participate in and clinicians deliver context-appropriate SDM that accounts for time pressures, clinician burnout, and administrative burdens.

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DE-EMPHASIZING EQUIPOISE IN SDM

Outside the medical context, equipoise has been defined as "a situation in which things are perfectly balanced."[7] This broad concept is simple but problematically ambiguous: which things exactly are in balance? and according to whom? These questions have, in fact, plagued the application of equipoise in SDM.[6] As a result, equipoise remains a conceptually vague term with multiple different definitions that vary in both content and orientation. Definitions of equipoise in the context of SDM have included "uncertainty of the potential benefits and disadvantages of the options,"[8] "the doctor has no clear preference about the treatment choice,"[5] "when health professionals and patients…agree conceptually that individual preferences are acceptable arbitrators of choice,"[9] and "patients have freedom to choose."[10] If equipoise is indeed a prerequisite for SDM, the discrepancies between these definitions—such as a focus on evidentiary uncertainty in some definitions and a focus on preference sensitivity in others—would yield different interpretations of when SDM is indicated.

The term clinical equipoise, originally proposed in the context of clinical research to justify random assignment in the context of clinical trials[11] and now used by some scholars in SDM,[6] illuminates some of these problems applying equipoise to SDM. Clinical equipoise is defined as "a state of uncertainty about the relative merits of treatments A and B in population P."[11] In this way, clinical equipoise describes a situation of evidentiary uncertainty among experts in the field, i.e., a situation where there is conflicting or inadequate evidence regarding the relative merits of available options. Manuscripts and clinical guideline statements addressing clinical decisions where such a state of uncertainty exists often conclude that it is in these situations that SDM is particularly important.[12,13]

Using clinical equipoise as a justification or prerequisite for SDM is problematic because it positions SDM as a solution to an evidence problem rather than as an approach to integrating patients' values and preferences into decisions. In fact, situations of evidentiary uncertainty may be where SDM processes are least effective because clinicians lack the requisite information to support patients in making high-quality decisions. Rather, it is situations where evidence behind multiple options is well-known—where there is *not* evidentiary uncertainty but where options involve distinct trade-offs that implicate values and preferences—that SDM is perhaps most useful.

We therefore reject clinical equipoise as a necessary condition or competency for SDM. Given the lack of clarity and consensus around other definitions of equipoise, we also propose there be less reliance on equipoise generally in SDM. Doing so makes questions about *when* to do SDM less salient and highlights the importance of focusing on *how* to do SDM and *assessing* its quality.

LEARNING BY DOING

Shifting the focus toward how best to execute SDM across a range of clinical contexts helps to acknowledge that SDM is not a monolithic practice that just needs to be integrated into clinical medicine in a scaled way. Rather, the SDM process must be highly context-appropriate and implemented intentionally, with rigorous evaluation of whether it is achieving the goals intended. In this way, there is value in learning by doing: shifting focus toward how best to execute SDM can help clarify and refine SDM that will aid its integration into practice.

One area in need of evaluation is the communication skills and tools for implementing SDM. Decision aids have been widely used, but they represent just one approach and are limited in scope, and it is not fully understood how best to integrate these tools into clinical workflows to promote effective SDM. Indeed, the communication skills for implementing SDM are highly contextual. In some cases, the most important skill is effective elicitation and clarification of the patient's goals, values, or preferences. In others, it is to effectively communicate probabilistic outcomes associated with various options. In still others, it is helping patients understand or anticipate the lived experience of various choices or outcomes. The latter may be especially important in cases where evidence suggests that experiences differ from patients' baseline intuitions. There is thus a profound need for guidance on how to effectively apply each of these communication skills and to integrate existing tools—and develop new ones—to facilitate their implementation.

There is particularly little understanding of what clinicians do now to perform essential SDM skills like elicitation and clarification of the patient's values, goals, and preferences, and how those current practices affect outcomes. Preliminary work has revealed that there is wide variation in what clinicians do when they believe they are doing SDM.[14] For example, some clinicians elicit and explore patient preferences by trying to understand what matters to patients and then integrate what they learn into the conversation. Others consider it sufficient to engage patient preferences by seeking to obtain patient agreement with the option the clinician prefers. These different strategies— "What do you think you would like to do given these options?" versus "Let's do this option, sound ok?"—reveal substantial contextual variations in implementing SDM. They may yield different perceptions of how shared the decision-making process is, and may yield very different decisions and patient outcomes. Characterizing how clinicians operationalize these and other elements of SDM, how these manifestations influence outcomes, and which strategies are most consistent with the role SDM is expected to play in specific contexts will help optimize its implementation.

We believe there are two particularly important areas where progress in the implementation of SDM is needed. First, the relationship of SDM to related processes of

informed decision-making, informed consent, and patient-centered care is poorly understood and can be blurred.[15–18] For instance, it has been proposed that SDM is an instrumental component of patient-centered care but distinguishable because patient-centered care represents a practice ideal that encompasses more than decision-making.[19,20] Where these two concepts begin and end in relation to each other is unclear. Similarly, SDM has origins in informed consent, with the 1982 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research—a body largely accredited with introducing the concept of SDM—even equating the two, stating that "ethically valid consent is a process of shared decision making based upon mutual respect and participation."[21] While clearly related—one group recently posited that "the culmination of shared-decision making is that the patient consents to the mutually agreed procedures to be performed or not performed"[22]—informed consent can also be distinguished from SDM by being more narrowly rooted in a clinician's obligation to promote patient autonomy by disclosing information and obtaining permission before certain types of action. SDM is a broader decision process model that also promotes patient autonomy, not just through disclosure of information and obtaining permission, but also through strategies such as active elicitation of patient preferences and helping patients align those preferences with available options.[23,24] To advance SDM implementation, we not only need to better differentiate SDM communication skills and processes from those used to obtain informed consent or practice patient-centered care but also better understand how these concepts fit together.

A second area in which progress is needed is how to implement SDM across heterogeneous care contexts. It is clear that SDM has a role in many different clinical situations. Recent models examine how SDM should work differently in the context of decisions with varying features.[25] For instance, decisions vary by their acuity, stakes, and recurrence (i.e., one-time versus longitudinal decisions) and have different relational contexts (e.g., a decision in the context of a long-standing relationship between the clinician and patient versus a decision complicated by a series of longitudinal conversations started with one clinician at the start of a patient's hospitalization but continued by different clinicians during the patient's hospital stay). Patients themselves also differ in ways that importantly impact decision-making processes and power dynamics. For example, in what ways do processes of SDM mitigate or perpetuate power imbalance, injustice, and bias or structural racism?[26] We need to ensure SDM optimizes shared engagement and understanding of probabilities, outcomes, and preferences among patients with low literacy and patients from marginalized communities whose engagement and empowerment in the health care setting is dismissed, discouraged, or actively deterred.

In addition, there is a need to understand how to deliver high-quality SDM across diverse healthcare settings with varying time and administrative constraints. This may be the most significant barrier to implementation of SDM, and therefore needs to be addressed if SDM is to be adopted broadly and done well. Many tools to support the SDM process have not been ideally constructed for delivery and use in typical clinical workflows. Versions of SDM that can be implemented in health care encounters that are brief, virtual, and mediated by tools, such as EHR-embedded patient portals, are critical if its adoption is to become more widespread.

CONCLUSION

SDM has an important role in a wide range of clinical situations, but it is especially important in situations where the evidence behind multiple options is well-known yet options involve distinct trade-offs that matter to patients. Embracing this role for SDM helps highlight why the field of SDM should pivot to a focus on implementation across a clinical spectrum and diverse patient population. Tethering SDM to situations characterized by equipoise has kept attention on when to do SDM for far too long, stymieing progress in how best to do SDM.

To navigate this crossroads, the field's focus needs to not just be on improving adoption of SDM. It is especially critical to address barriers to implementation, to identify and develop the skills that enable its effective use, and to clarify how it can be appropriately adapted to various contexts. Addressing these persistent implementation challenges should define the research agenda for SDM going forward.

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