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[Intervention Review]

Interventions for increasing the use of shared decision making by healthcare professionals

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Editorial group: Cochrane Effective Practice and Organisation of Care Group. **Publication status and date:** New search for studies and content updated (no change to conclusions), published in Issue 7, 2018.

Citation: Légaré F, Adekpedjou R, Stacey D, Turcotte S, Kryworuchko J, Graham ID, Lyddiatt A, Politi MC, Thomson R, Elwyn G, Donner-Banzhoff N. Interventions for increasing the use of shared decision making by healthcare professionals. *Cochrane Database of Systematic Reviews* 2018, Issue 7. Art. No.: CD006732. DOI: 10.1002/14651858.CD006732.pub4.

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ABSTRACT

Background

Shared decision making (SDM) is a process by which a healthcare choice is made by the patient, significant others, or both with one or more healthcare professionals. However, it has not yet been widely adopted in practice. This is the second update of this Cochrane review.

Objectives

To determine the effectiveness of interventions for increasing the use of SDM by healthcare professionals. We considered interventions targeting patients, interventions targeting healthcare professionals, and interventions targeting both.

Search methods

We searched CENTRAL, MEDLINE, Embase and five other databases on 15 June 2017. We also searched two clinical trials registries and proceedings of relevant conferences. We checked reference lists and contacted study authors to identify additional studies.

Selection criteria

Randomized and non-randomized trials, controlled before-after studies and interrupted time series studies evaluating interventions for increasing the use of SDM in which the primary outcomes were evaluated using observer-based or patient-reported measures.

Data collection and analysis

We used standard methodological procedures expected by Cochrane.

We used GRADE to assess the certainty of the evidence.

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Main results

We included 87 studies (45,641 patients and 3113 healthcare professionals) conducted mainly in the USA, Germany, Canada and the Netherlands. Risk of bias was high or unclear for protection against contamination, low for differences in the baseline characteristics of patients, and unclear for other domains.

Forty-four studies evaluated interventions targeting patients. They included decision aids, patient activation, question prompt lists and training for patients among others and were administered alone (single intervention) or in combination (multifaceted intervention). The certainty of the evidence was very low. It is uncertain if interventions targeting patients when compared with usual care increase SDM whether measured by observation (standardized mean difference (SMD) 0.54, 95% confidence interval (CI) -0.13 to 1.22; 4 studies; N = 424) or reported by patients (SMD 0.32, 95% CI 0.16 to 0.48; 9 studies; N = 1386; risk difference (RD) -0.09, 95% CI -0.19 to 0.01; 6 studies; N = 754), reduce decision regret (SMD -0.10, 95% CI -0.39 to 0.19; 1 study; N = 212), improve physical (SMD 0.00, 95% CI -0.36 to 0.36; 1 study; N = 116) or mental health-related quality of life (QOL) (SMD 0.10, 95% CI -0.26 to 0.46; 1 study; N = 116), affect consultation length (SMD 0.10, 95% CI -0.39 to 0.58; 2 studies; N = 224) or cost (SMD 0.82, 95% CI 0.42 to 1.22; 1 study; N = 105).

It is uncertain if interventions targeting patients when compared with interventions of the same type increase SDM whether measured by observation (SMD 0.88, 95% CI 0.39 to 1.37; 3 studies; N = 271) or reported by patients (SMD 0.03, 95% CI -0.18 to 0.24; 11 studies; N = 1906); (RD 0.03, 95% CI -0.02 to 0.08; 10 studies; N = 2272); affect consultation length (SMD -0.65, 95% CI -1.29 to -0.00; 1 study; N = 39) or costs. No data were reported for decision regret, physical or mental health-related QOL.

Fifteen studies evaluated interventions targeting healthcare professionals. They included educational meetings, educational material, educational outreach visits and reminders among others. The certainty of evidence is very low. It is uncertain if these interventions when compared with usual care increase SDM whether measured by observation (SMD 0.70, 95% CI 0.21 to 1.19; 6 studies; N = 479) or reported by patients (SMD 0.03, 95% CI -0.15 to 0.20; 5 studies; N = 5772); (RD 0.01, 95%C: -0.03 to 0.06; 2 studies; N = 6303); reduce decision regret (SMD 0.29, 95% CI 0.07 to 0.51; 1 study; N = 326), affect consultation length (SMD 0.51, 95% CI 0.21 to 0.81; 1 study, N = 175), cost (no data available) or physical health-related QOL (SMD 0.16, 95% CI -0.05 to 0.36; 1 study; N = 359). Mental health-related QOL may slightly improve (SMD 0.28, 95% CI 0.07 to 0.49; 1 study, N = 359; low-certainty evidence).

It is uncertain if interventions targeting healthcare professionals compared to interventions of the same type increase SDM whether measured by observation (SMD -0.30, 95% CI -1.19 to 0.59; 1 study; N = 20) or reported by patients (SMD 0.24, 95% CI -0.10 to 0.58; 2 studies; N = 1459) as the certainty of the evidence is very low. There was insufficient information to determine the effect on decision regret, physical or mental health-related QOL, consultation length or costs.

Twenty-eight studies targeted both patients and healthcare professionals. The interventions used a combination of patient-mediated and healthcare professional directed interventions. Based on low certainty evidence, it is uncertain whether these interventions, when compared with usual care, increase SDM whether measured by observation (SMD 1.10, 95% CI 0.42 to 1.79; 6 studies; N = 1270) or reported by patients (SMD 0.13, 95% CI -0.02 to 0.28; 7 studies; N = 1479); (RD -0.01, 95% CI -0.20 to 0.19; 2 studies; N = 266); improve physical (SMD 0.08, -0.37 to 0.54; 1 study; N = 75) or mental health-related QOL (SMD 0.01, -0.44 to 0.46; 1 study; N = 75), affect consultation length (SMD 3.72, 95% CI 3.44 to 4.01; 1 study; N = 36) or costs (no data available) and may make little or no difference to decision regret (SMD 0.13, 95% CI -0.08 to 0.33; 1 study; low-certainty evidence).

It is uncertain whether interventions targeting both patients and healthcare professionals compared to interventions of the same type increase SDM whether measured by observation (SMD -0.29, 95% CI -1.17 to 0.60; 1 study; N = 20); (RD -0.04, 95% CI -0.13 to 0.04; 1 study; N = 134) or reported by patients (SMD 0.00, 95% CI -0.32 to 0.32; 1 study; N = 150) as the certainty of the evidence was very low. There was insuffient information to determine the effects on decision regret, physical or mental health-related quality of life, or consultation length or costs.

Authors' conclusions

It is uncertain whether any interventions for increasing the use of SDM by healthcare professionals are effective because the certainty of the evidence is low or very low.

PLAIN LANGUAGE SUMMARY

A review of activities to help healthcare professionals share decisions about care with their patients

What is the aim of this review?

Healthcare professionals often do not involve their patients in decision making about their care. With shared decision making, healthcare professionals inform patients about their choices and invite them to choose the option that reflects what is important to them, including the option not to proceed with treatment. Shared decision making is said to be desirable because patient involvement is accepted as a right and patients in general want more information about their health condition and prefer to take an active role in decisions about their health. The aim of this review was to find out if activities to increase shared decision making by healthcare professionals are effective or not. Examples of these activities are training programs, giving out leaflets, or email reminders. Cochrane researchers collected and analyzed all relevant studies to answer this question, and found 87 studies.



Key messages

A great variety of activities exist to increase shared decision making by healthcare professionals, but we cannot be confident about which of these activities work best because the certainty (or the confidence) of the evidence has been assessed as very low.

What was studied in the review?

Our review examined the 87 studies that tested what kind of activities work best to help healthcare professionals involve their patients more in decision making about their care. We also examined the effect of these activities on decision regret, physical or mental health-related quality of life, length of the consultation, and cost.

The studies were so different that these activities were difficult to compare.

First, we divided the studies into ones that used outside observers to measure shared decision making and ones that used patients to measure shared decision making.

We then divided studies into ones that looked at activities a) for healthcare professionals only (e.g. training), b) for patients only (e.g. giving them a decision aid, which is a pamphlet explaining options and inviting them to think about their values and preferences), and c) for both healthcare professionals and patients (e.g. training plus a decision aid).

Finally, we subdivided each of these three categories into studies that compared the activity with usual care and studies that compared the activity with another activity.

We also looked at how certain the evidence was for our primary outcome (the extent to which healthcare professionals involve their patients more in decision making about their care) and secondary outcomes (decision regret, physical or mental health-related quality of life, length of the consultation, and cost) of interest.

What are the main results of the review?

Forty-four studies looked at activities for patients only, while 28 studies looked at activities for both healthcare professionals and patients, and 15 studies looked at activities for healthcare professionals only.

While studies in all three categories had tested many different activities to increase shared decision making by healthcare professionals, overall we cannot be confident in the effectiveness of these activities because the certainty of the evidence was weak. This is because there were many possible sources of error (e.g. not making sure the tested activities were not also provided to the comparison groups), and often poor reporting of results (i.e. not providing enough information to judge the quality of the evidence).

Although it was hard to come to any firm conclusions, we can say that compared to no activity at all, activities for healthcare professionals may slightly improve mental health-related quality of life, but make little or no difference to physical health-related quality of life (two studies). We can also say that activities targeting both healthcare professionals and patients may make little or no difference to decision regret (one study).

How up-to-date is this review?

We searched for studies published up to June 2017.