How can shared decision making impact on evidence-based practice?

Paul Glasziou,
Bond University, Australia
Evidence-based medicine: Does it imply SDM?

“Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values”

- Dave Sackett

Patient Concerns

Clinical Expertise

Best Research
# GRADE Evidence & Recommendations

## Quality of evidence
- High quality
- Moderate quality
- Low quality
- Very low quality

## Strength of recommendation
- Strong recommendation for using an intervention
- Weak recommendation for using an intervention
- Weak recommendation against using an intervention
- Strong recommendation against using an intervention

- High quality: 4 or A
- Moderate quality: 3 or B
- Low quality: 2 or C
- Very low quality: 1 or D
What SDM do GPs use?

Development and Evaluation of a Shared Decision Making Training Workshop for Health Care Professionals in Primary Care in Malaysia

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Participants of the training workshop:

No. of participants:

- Family Medicine Specialist: 4
- Medical Officer: 28
- General Practitioner: 4
- Nurse: 19
- Pharmacist: 6
- Others: 18

Percentage (%):

- Family Medicine Specialist: 20%
- Medical Officer: 56%
- General Practitioner: 20%
- Nurse: 19%
- Pharmacist: 6%
- Others: 18%

Comments to improve the workshop:

- Duration of workshop: A session which can be a bit longer for more information needed.
- Staff Nurse: Maybe can organize one day (full) workshop.
- Medical Officers: Timing of delivery: Good that the booklet has been given earlier for the Medical Officers to go through. Should do role play among participants.
- Family Medicine Specialists: Insulin initiation training: Most of the general practitioners are not comfortable to start insulin in the first place. Way be discuss with expert healthcare provider before the workshop may boost up their confidence in using insulin with their patients.
- Medical Officer: Information: More PDA scenarios.

Feedback: Content of workshop:

- Average: Good, Excellent
- Average: Good, Excellent

Discussion:

Health professionals training programs in SDM very widely in how and what they deliver. There is little evidence about which programs are most effective and why [2]. This unfortunately gives health professionals very little evidence on which to base their decision making.
Modes of shared decisions

1. In-consultation tools
   - CVD risk tools; acute otitis media handout

2. “Homework” tools
   - Choice of Contraception
   - PSA decision sheet

3. Shared decision process; no patient tools
   - Irwigs’ 4 step process (Smart Health Choices)
So the tests confirm our diagnosis. We need to decide the best course of action for you.

1. What would happen if I do nothing?
2. What treatments can you suggest?
3. Which might be best for me?
4. What are the likely benefits? Are there any downsides for me?
Tennis Elbow
What happens if I do nothing?

Success (cure)
1. Median time to?
2. % at 6 months
3. % at 1 year
“As no two faces, so no two cases are alike in all respects, and unfortunately it is not only the disease itself which is so varied, but the subjects themselves have peculiarities which modify its action.”

William Osler
Which treatments are worthwhile for this patient with a history of TIA?

81 year old male with:
1. **Transient ischemic attacks (TIA)**
2. Non-H. pylori ulcers & Severe GERD
3. NSAID intolerance
4. Chronic neck pain

- CT scan shows small infarcts
- Cholesterol “normal” 5.8mmol/l
- BP is 125/80

Should he take Rothwell triple therapy: aspirin? Antihypertensive? statin?
A general model for treatment decisions

- Higher risk patients (usually) have higher benefits
- Lower risk patients (usually) have lower benefits

Glasziou, Irwig BMJ, 1995
The “half-life” of knowledge

Of 100 systematic reviews:
Median time to a change that would effect clinical decisions was 5.5 years.
7 out of date when published

Figure 2. Overall survival time (95% CI) free of signals for updating.

The immediate decrease in survival at time zero reflects the 7 systematic reviews for which signals for updating had already occurred at the time of publication. The low number of reviews at risk after 10 years reflects the fact that the sample spanned 1995 to 2005 and censoring occurred on 1 September 2006. Thus, only reviews published before September 1996 and having no signals for updating could have more than 10 years of observation.
Many “Leaks” from research & practice

If 80% achieved at each stage then
0.8 x 0.8 x 0.8 x 0.8 x 0.8 x 0.8 x 0.8 = 0.21
Many “Leaks” from SDM tool to practice

Appropriate  Usable  Up To Date  Patient fit
Modes of shared decisions

1. **Shared decision process; no patient tools**
   - Irwigs’ 4 step process (Smart Health Choices)

2. **In-consultation tools**
   - CVD risk tools; acute otitis media handout; acne options

3. **“Homework” tools**
   - Choice of Contraception
   - PSA decision sheet