How can Shared Decision Making impact on overdiagnosis?

Ray Moynihan
Senior Research Fellow
Bond University
What is Overdiagnosis?

Good question

Two related answers

1. Narrowly defined – it means diagnosing someone with a disease that would not harm them – e.g. via prostate cancer screening

2. More broadly – it encompasses overmedicalisation, widening disease definitions, lowering diagnostic thresholds - so people with milder problems or at low risk are labelled, and for some, the label may do more harm than good
There is an overlap in recent histories of concerns about overdiagnosis \(^{(1)}\) and drive for shared decision making \(^{(2)}\). Both areas of research flow in some way from the data on unreasonable variations in practise/utilisation – and a desire to reduce unnecessary care, in line with people’s values.

“Numerous randomized trials indicate that [decision aids] improve decision quality and prevent overuse of options that informed patients do not value.” O’Connor 2004 \(^{(2)}\)

What we already know

Stacey et. al. Decision aids for people facing health treatment or screening decisions, *Cochrane Review 2011*

- Decision aids reduce choice of major elective invasive surgery in favour of conservative options
- Decision aids reduce choice of PSA screening
- When detailed compared to simple decision aids were used, they reduce choice of menopausal hormones
What we already know?

Quick explicit Scopus searches of ‘Shared Decision Making’, ‘Decision Aids’, coupled with terms ‘overdiagnosis’, ‘overtreatment’, ‘medicalisation’ and variants produced only a small number of articles – almost all were commentaries or recommendations...

• Many were about PSA - Prostate Cancer Screening.....including how SDM might help inform patients of benefits of PSA-screening (1)

But also........

• Breast Cancer Screening.....call for use of Decision Aids to include overdiagnosis (2)
• Lung cancer screening.....encouraging SDM and benefits of surgery for high-risk (3)
• Bipolar in kids.....small study suggests decision aid may decrease overdiagnosis (4)
• Dialysis in frail elderly.....need for SDM (5)
• Hypertension in very old.....need for SDM about treatment (6)
• Study showing that having ‘choice’ may help treatment effectiveness (7)
• Need for quaternary prevention (of iatrogenia) and SDM in mental health (8)
• How some SDM lenses might contribute to the ‘medicalization of involvement’ (9)

What do we need to know?

Seems to be a need for more of both empirical data and theoretical debate on how Shared Decision Making might impact – help or hinder - the problem of overdiagnosis and overtreatment
Terminology/Labelling is critically important

“Tests confirm you have cancer, so let's discuss what your options are and what you might like to do”

Is different from...

“Tests show a small potential abnormality that is relatively common and likely not to cause you any trouble, so let's discuss what your options are and what you might like to do”
Terminology/labelling is critically important

“Tests confirm you have a disease called osteoporosis – sometimes known as a silent killer because there are no symptoms – so let’s discuss…”

Is different from...

“Your risk of fracture can tend to increase as you get older, so let’s discuss....”
What do we need to know?

1. More explicit scientific debate/commentary about how SDM might inform people about - and ultimately reduce - the risk of overdiagnosis/overtreatment

2. Develop and evaluate more decision aids which incorporate evidence on risk of overdiagnosis – both from screening and from widening of disease definitions/lowering of thresholds

3. Develop strategies for how best to inform the wider public about the potential benefits of SDM – including how it might help reduce unnecessary medical labelling and treatments

4. Explore potential difference between “patient” verses “citizen” voice in development of materials to aid SDM
What do we need to know?

Along with sharing decisions about testing, screening, treatment or non-treatment options........

........ can Shared Decision Making include decision making about whether, in certain situations, a diagnostic label is necessary, and if so, what is the most appropriate terminology?

Can notions of ‘informed consent’ extend from our consent to tests or treatments, to our consent to whether or not we want to medicalise/label a health risk or life experience?

How to operationalize research on these questions?
Thanks for a great day of debate