

VIEWPOINT

The Value of Sharing Treatment Decision Making With Patients Expecting Too Much?

Steven J. Katz, MD, MPH

Departments of Medicine and Health Management and Policy, University of Michigan, Ann Arbor.

Sarah Hawley, PhD

Departments of Medicine and Health Management and Policy, University of Michigan, Ann Arbor.



Author Reading at jama.com

The growing emphasis on patient-centered care is increasing the demand on physicians' time and effort to more fully engage patients and their families in treatment decision making. Thus, it is important to understand the potential effects of shared decision making (SDM) with patients on the outcomes of clinical encounters. Shared decision making is being strongly promoted for several reasons. First, it is the ethical responsibility of clinicians to facilitate patient involvement in treatment decision making because patients and their families are ultimately subjected to the outcomes of these decisions. Second, there is evidence that more engaged patients are more informed, more likely to fully deliberate about the risks and benefits between different treatment options, and ultimately more satisfied with the clinical encounter.¹ The objectives of SDM are to fully inform patients and their families about treatment options, including the trade-offs between risk and benefits, and to incorporate patient values and preferences into treatment decisions.

More recently, SDM has also been promoted as a strategy to reduce overtreatment and costs,^{2,3} a rationale grounded in the belief that better-informed patients may be less likely to choose a treatment strategy more

practice setting, and features of the interventions. Importantly, only 5 of 14 studies showed a reduction in the more extensive treatment option, and several of these positive studies could not disentangle patient- vs clinician-level effects of the intervention on utilization. Despite these limitations, the review has been cited in a number of recent commentaries and research articles supporting the potential role of SDM in reducing overtreatment.

Two studies frequently cited in support of the role of SDM in reducing costs are additional examples of the lack of clarity about patient vs clinician influences on utilization. One study examined the effect of a telephone-based patient management program on costs in 7 employer insurance plans.⁴ The study found that the more enhanced telephone management strategy intervention was associated with cost savings attributable to lower rates of hospitalizations. Although the authors suggested that the lower hospitalization rates in the intervention group were due to more patient involvement in decision making, no measures of communication during encounters were presented. In fact, it is more plausible that savings in hospitalizations were due to the influences of clinician-directed decisions such as better medication management and greater intensity and continuity of outpatient care.

A recently published implementation study evaluated the dissemination of a mailed patient-directed hip and knee replacement decision aid to surgeons and patients in a large integrated health plan.⁵ All surgeons and their staff were required to watch the decision aid, at-

Despite some well-documented benefits of SDM, the literature does not support its potential to reduce overtreatment and costs.

tent meetings explaining the rollout, and review monthly reports of both decision aid delivery and surgical volume. During the study, an order for the decision aid was made for only one-third of surgery patients, and there was no information about whether patients received or used it. The authors suggested that the substantial decrease in hip and knee surgery observed during the study period was due to the influence of the intervention on patient preferences for treatment. However, it is more plausible that any effect of the intervention on surgery rates was largely due to physician-level influences such as the monitoring and feedback to surgeons regarding surgical treatment patterns.

A second weakness in the evidence supporting the role of SDM in reducing overtreatment and excessive medical costs is inadequate consideration of the complexity of how patients construct and express their preferences. First, inadequate attention has been paid to disentangling patient- vs clinician-level effects in studies of interventions aimed at evaluating the influence of SDM on utilization. An updated Cochrane review of decision aids for patients facing treatment or screening decisions suggested that "there was a reduction in the choice of major elective surgery in the group receiving the decision aid compared to usual care."¹ The conclusion was based on a summary analysis of 14 studies published between 1995 and 2009 that were very diverse in terms of the clinical decision context,

extensive than that recommended by their clinicians. The increasing expectations about the role of SDM in clinical and health policy warrant closer scrutiny of the evidence. Despite some well-documented benefits of SDM, the literature does not support its potential to reduce overtreatment and costs.

Corresponding

Author: Steven J. Katz, MD, MPH, Departments of Medicine and Health Management and Policy, University of Michigan, 2800 Plymouth Rd, North Campus Research Complex, Bldg 16, Room 430W, Ann Arbor, MI 48109-2800 (skatz@umich.edu).

erences for treatment. Indeed, a key objective of SDM is ensuring that patient values about the benefits and risks of different treatment options are elicited, explicitly understood, and incorporated into decisions. Yet the construction of preferences is a complex interplay between intuitive and deliberative mental processes. Furthermore, little is known about the stability of values and preferences in individual patients confronting different treatment experiences over time. Importantly, there is no evidence that patient preferences would inherently favor less extensive treatments than recommendations made by their physicians. Indeed, some studies have suggested that many patients have unrealistically high expectations about medical treatments^{6,7} and that more patient influence on decisions may result in more extensive treatment.⁸

A third limitation is an oversimplistic view of the clinical encounter. Blanket assumptions about which health conditions or treatments are more or less sensitive to patient preferences (often called "preference-sensitive conditions") do not fully consider the wide variability in the context of the clinical management. For example, breast cancer surgery has been frequently characterized as a preference-sensitive condition. Yet up to 20% of patients may ultimately have a clinical contraindication to breast-conserving surgery,⁹ which is the most frequent reason why women undergo mastectomy in the United States. Another important complexity of clinical encounters is the variation in the evaluative test strategy, which is a major determinant of receipt of treatment. For example, variations in the use of imaging studies such as magnetic resonance imaging or positron-emission tomography to evaluate extent of disease in breast cancer may influence clinician recommendations for more or less ex-

tensive treatment. Yet there is little research about the role of patient preferences in the selection of evaluative tests.

There is increasing demand on clinicians to improve communication and the quality of the patient experience. Research supports the value of SDM to improve patient knowledge about treatments and management plans and also to improve satisfaction with the clinical encounter. There are many challenges to achieving the goals of SDM. Patients' preferences for involvement in decisions vary widely, and little is known about how to incorporate desire for different levels of involvement into decision making. Indeed, there is evidence that some patients may be burdened by the increasing complexity of evaluative and management strategies and desire more navigation during clinical encounters.¹⁰ The brevity of visits constrains the opportunities to address these elements of SDM. Furthermore, clinicians are not adequately trained to facilitate SDM, especially eliciting patient values and preferences for treatment.

However, the promotion of SDM as a strategy to stem potential overtreatment and rising health care costs may impede initiatives to address these challenges. Tying SDM to promises of lower utilization and costs may divert attention from more effective efforts aimed at physician and organizational levels. Furthermore, "overselling" SDM may inhibit its adoption if expectations are too high and the expected outcomes are not achieved. Although these uncertainties are strong motivation for more research, they underscore that too little is known about SDM and its outcomes to support its role in addressing the increasing concern about overtreatment and medical cost inflation.

ARTICLE INFORMATION

Published Online: September 23, 2013.
doi:10.1001/jama.2013.278944.

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

REFERENCES

1. Stacey D, Bennett CL, Barry MJ, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev*. 2011;(10):CD001431.
2. Oshima Lee E, Emanuel EJ. Shared decision making to improve care and reduce costs. *N Engl J Med*. 2013;368(1):6-8.
3. Wennberg JE. Time to tackle unwarranted variations in practice. *BMJ*. 2011;342:d1513.
4. Wennberg DE, Marr A, Lang L, O'Malley S, Bennett G. A randomized trial of a telephone care-management strategy. *N Engl J Med*. 2010;363(13):1245-1255.
5. Arterburn D, Wellman R, Westbrook E, et al. Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. *Health Aff (Millwood)*. 2012;31(9):2094-2104.
6. Weeks JC, Catalano PJ, Cronin A, et al. Patients' expectations about effects of chemotherapy for advanced cancer. *N Engl J Med*. 2012;367(17):1616-1625.
7. Rosenberg SM, Tracy MS, Meyer ME, et al. Perceptions, knowledge, and satisfaction with contralateral prophylactic mastectomy among young women with breast cancer: a cross-sectional survey. *Ann Intern Med*. 2013;159(6):373-381.
8. Hawley ST, Griggs JJ, Hamilton AS, et al. Decision involvement and receipt of mastectomy among racially and ethnically diverse breast cancer patients. *J Natl Cancer Inst*. 2009;101(19):1337-1347.
9. Morrow M, Jagsi R, Alderman AK, et al. Surgeon recommendations and receipt of mastectomy for treatment of breast cancer. *JAMA*. 2009;302(14):1551-1556.
10. Livaudais JC, Franco R, Fei K, Bickell NA. Breast cancer treatment decision-making: are we asking too much of patients? *J Gen Intern Med*. 2013;28(5):630-636.