Practice Guidelines

Shared Decision-Making: Guidelines From the National Institute for Health and Care Excellence

Key Points for Practice

- Shared decision-making can be optimized when organizations provide resources and establish a supportive culture.
- Offer patients resources to prepare for important discussions and prompt goal consideration and questions for the clinician.
- Ask patients to teach back concepts to check their understanding.
- Document decisions and underlying reasons and share details with the patient and health care team.

From the *AFP* Editors

Shared decision-making between physicians and patients is a vital component of effective health care. Shared decision-making can improve patient experience and satisfaction, increase trust, and improve understanding of the risks and benefits of available options. The National Institute for Health and Care Excellence (NICE) published guidelines to offer practical advice for incorporating shared decision-making into everyday encounters.

An Organizational Change

Shared decision-making is an ongoing process that includes multicomponent interventions, which are more effective than single encounters.

Qualitative studies and expert opinion encourage strong organizational leadership to positively influence the use of shared decision-making through available resources and organizational culture. The use of influencers or champions within teams should be considered to enhance implementation in a practice. A shared decision-making implementation checklist provides an effective framework for champions to influence change at their institution (https://www.england.nhs.uk/publication/shared-decision-making-summary-guide).

Implementation

Family physicians can engage patients in shared decision-making throughout stages of care by using specific techniques in conversations before, during, and after medical discussions.

BEFORE THE VISIT

Physicians should encourage shared decision-making with patients before the encounter. Studies showed an increase in patient knowledge and satisfaction from offering patients resources in advance of encounters to prepare for important discussions. This might include prompting to consider their goals for care and for the discussion, and questions for the physician.

Some patients benefit from the support and presence of another person during the health care visit, such as a family member, friend, or caregiver. These people can serve as advocates who can reinforce understanding, empower participation in shared decision-making, and provide reassurance. Although not every patient will wish to participate in decision-making or to have decisions made with or by family members, every patient should be given the opportunity to choose the degree to which they would like to participate.

DURING THE VISIT

NICE recommends the use of evidence-based models to enhance shared decision-making in clinical practice. The three-talk model is a shared decision-making framework with strong supporting evidence for all of the components. Specifically, the stages include team talk, option talk,

Coverage of guidelines from other organizations does not imply endorsement by *AFP* or the AAFP.

This series is coordinated by Michael J. Arnold, MD, contributing editor.

A collection of Practice Guidelines published in *AFP* is available at https://www.aafp.org/afp/practguide.

CME This clinical content conforms to AAFP criteria for CME. See CME Quiz on page 126.

Author disclosure: No relevant financial relationships.

TABLE 1

Recommendations for Presenting Numerical Data During Shared Decision-Making

Recommendation	Discussion points
Use a mixture of numbers and pictures	Numerical rates with pictograms or icon arrays Positive and negative framing at the same time
Use numerical data to describe risks	Terms such as risk, rare, unusual, and common can be interpreted in different ways
Use absolute risk rather than relative risk	Risk of an event increases from 1 in 1,000 to 2 in 1,000, rather than the risk of the event doubles
Use natural frequencies	Use numerals (10 in 100) rather than percentages (10%)
Be consistent when using data; use the same denominator comparing risk	7 in 100 for one risk and 20 in 100 for another, rather than 1 in 14 and 1 in 5
Present risk over a defined period of time (months or years)	If 100 people have treatment for one year, 10 will experience this adverse effect
Use positive and negative framing	Treatment will be successful for 97 out of 100 people, and it will be unsuccessful for 3 out of 100 people

and decision talk, and they help clinicians structure the shared decision-making process during the visit.

Team Talk. Team talk occurs at the opening of a discussion when patient autonomy and preference are introduced and collaboration between the patient and physician is emphasized. Team talk establishes a supportive environment where the patient can express what matters most to them and share their preferences and goals of care.

Best practices during team talk include agreeing on an agenda at the beginning of the visit to prioritize topics and include how long the discussion will last. During team talk, time should be set aside to answer questions following the discussion.

Option Talk. In option talk, treatment options are compared based on the risks, benefits, and consequences. Discussions should consider the context of the patient's preferences and goals. The option of no treatment should be addressed routinely. During the discussion, the clinician should ensure that the patient's treatment goals are understood by all, and that any misconceptions are addressed.

If available, numerical data should be used to describe risks and benefits when available instead of terms such as rare, common, or uncommon. Risks and benefits shoud be framed positively and negatively, such as "This adverse effect occurs in one out of 10 people, so nine out of 10 people do not experience this effect." *Table 1* lists recommendations for effectively communicating risks and benefits. Risks can be presented using infographics containing numbers and pictures to display positive and negative effects together. Patient decision tools reliably enhance patient understanding if they are quality-assured and relevant. Quality clinical support tools are discussed in a standards framework from NICE (https://www.nice.org.uk/corporate/ecd8).

Patient understanding should be verified regularly when sharing options. Teach back, or asking patients to explain concepts discussed, confirms that they understand the information being discussed. The chunk and check technique provides smaller chunks of information and confirms patient comprehension before moving on.

Decision Talk. Decision talk includes making a joint decision and a timeline for when the plan will be reviewed next. The physician should clearly state what has been decided, what the next steps will be, and that the patient may review their decision earlier or change their mind at any time if desired. The decision should be documented in the medical record, including what the patient valued as important factors involved in making that decision. Sharing these

details with the patient in writing in a post-visit letter or secure message may be helpful.

FOLLOWING THE DISCUSSION

Patients shoud be given resources to review after the discussion. These could include information about the diagnosis, options for treatment, and a summary of the conclusion of the discussion. Physicians should provide links to high-quality online resources and inform patients whom to contact for other questions after the visit. In addition, sending a letter summarizing the details of the discussion to the patient and other physicians involved in the patient's care is helpful.

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Army, Uniformed Services University of the Health Sciences, U.S. Department of Defense, or the U.S. government.

Editor's Note: Shared decision-making is recommended by nearly every clinical practice guideline, yet it is rarely explained in any detail. Although we understand shared decision-making as respecting patient autonomy, this is the first evidence-based guideline addressing techniques. This NICE guideline is proposed as a roadmap for the British National Health Service and suggests a path for our own health care organizations.–Michael J. Arnold, MD, Contributing Editor

Guideline source: National Institute for Health and Care Excellence

Evidence rating system used? No

Systematic literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? Yes

Recommendations based on patient-oriented outcomes? No

Published source: Shared decision making. London: National Institute for Health and Care Excellence (NICE); June 17, 2021

Available at: https://www.nice.org.uk/guidance/ng197

Meghan F. Raleigh, MD
Carl R. Darnall Army Medical Center
Fort Hood, Tex.

Madalyn D. Nelson, MD
Carl R. Darnall Army Medicine Center
Fort Hood, Tex.

Dana R. Nguyen, MD
Uniformed Services University of the Health Sciences
Bethesda, Md.
Email: dana.nguyen@usuhs.edu ■