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Introduction

In the last decades, researchers, governments and public campaigns have increased awareness about healthcare overuse.[1] Low-value care is described as care unlikely to benefit the patient given the harms, costs or available alternatives.[2] Clinical practice guidelines with 'do-not-do' recommendations and other de-implementation strategies were promoted to reduce it.[1] One of these strategies is shared decision making (SDM).[3] SDM was traditionally described as an approach to enhance patient involvement in healthcare decisions by communicating evidence-based information about options, their pros and cons, and eliciting patients' preferences to support them to deliberate about those options.[4] Currently, some authors consider SDM as a broader concept, a method that adapts to a wider range of situations where patients and clinicians make decisions together using different approaches (not only limited to cases with a fine balance between benefits and harms, where practitioners help to weigh pros and cons with patients' values and preferences).[5]

Different studies showed that when patients are better informed about the benefits and harms of interventions (eg, surgeries, screening tests, medications), they tend to decline low-value care.[3 6 7] These findings might explain why SDM has been promoted to reduce low-value care.[3 6–9]

Focusing on the conversations between patients, caregivers and clinicians during the clinical encounter, we reflect on why using SDM for de-implementation of low-value care can be paradoxical.

When it is problematic to use SDM for low-value care de-implementation

Both de-implementation of low-value care and SDM are informed by new evidence that contradicts current practice, that is medical reversal,[10] but have different purposes and pursue different outcomes (see table 1). De-implementation strategies aim at removing, replacing, reducing or restricting low-value care to solve problems of rising healthcare costs and harms. SDM aims to respond to patients' problems to find the care that best fits the patients' and their families' unique context, aligned with their needs and preferences.[11]

We can pragmatically classify low-value care in practices with high-quality or low-quality evidence, with stronger or more conditional recommendations. In the first category, we can find low-value care practices with high-quality evidence and a 'strong recommendation against' because the practice has harms that always outweigh benefits and needs to be discontinued (eg, do not perform vaginal ultrasound for ovarian cancer screening) or because it has proven ineffective or harmful for some situations but proven beneficial for others and needs to be limited to a specific population (do not perform a percutaneous coronary intervention in patients with stable chronic angina without risk factors that are well controlled with medication or do not prescribe antibiotics for viral upper respiratory infections without specific criteria).[10 12 13] In the second category, low-value care practices might have low-quality evidence or a tight balance between benefits and harms and a conditional recommendation (eg, do not routinely

Table 1 Fundamental differences between shared decision making (SDM) and low-value care de-implementation in the clinical encounter

	SDM	Low-value care de-implementation
Purpose	Solving individual patient problems*	Solving healthcare problems, primarily focused on reducing costs and harms
Focuses on	Individual patient	Healthcare system
Starting point	The patient's problem informed by relevant evidence	New evidence showing that a practice is ineffective, inefficient or harmful
In which situation?	In most non-life-threatening situations when there is time to make a decision†	When care is unlikely to benefit the patient given the harms, costs or available alternatives
Expected outcome	Make a decision according to what matters most to the patient	Limit or reduce the low-value care practice

*Problems or healthcare situations that require SDM were traditionally conceived as situations in which more than one option is acceptable, and each one has a balance of pros and cons that can be valued differently by each patient.[4] Recently, other authors have expanded the situations in which an SDM approach might be helpful, which is not only to help deliberate in situations with a tight balance between benefits and harms (what is best for me?) but also situations with intrapersonal or interpersonal conflict (what do I want?), intellectual, practical and emotional incoherence (how do we manage?), or existential transition (what really matters?).[5] Readers can refer to Hargraves *et al* to expand on the 'Purposeful SDM' approach.
†Except for harmful tests and treatments (ie, 'strong recommendations against').

prescribe antipsychotics as a first-line treatment for behavioural symptoms in patients with dementia).[14]

For the first low-value care category, when there is a 'strong recommendation against', SDM is not warranted. If a patient mentions the need for a vaginal ultrasound for ovarian cancer screening or asks for antibiotics for a common cold, healthcare professionals should actively discourage it rather than present it as a valid option using SDM, as it has proven net harm.[12 13 15] The bioethical principle of non-maleficence (ie, do not harm) overcomes autonomy.[16] We discourage the practice; hence we do not apply SDM. Moreover, delayed antibiotic prescription for uncomplicated otitis media has shown to be superior to immediate prescription, which should only be used if risk factors are present.[13]

For the second low-value care category, where the recommendation is conditional with a tight balance between benefits and harms, SDM and de-implementation strategies are at odds due to the different views about what constitutes low-value care from the perspective of policy decision makers, clinicians and patients.[17] After all, costs, benefits and harms may vary across stakeholders in the healthcare system, where low-value care has different meanings. While policy-level stakeholders may think it is about the balance of benefits and harms for the population and the (cost) effectiveness of care delivery, clinicians may consider net clinical benefits, and patients the sum of treatment benefits relative to their preferences, context or costs for themselves. Moreover, they pursue different outcomes. De-implementation limits low-value care by removing, replacing, reducing or restricting the practice from a healthcare perspective.[18] In contrast, SDM aims at making an informed decision that matters most to the patient. With the same uncertainty or low-quality evidence, patients can value each option differently and decide on different courses of action, which might not be declining low-value care if it helps solve their problems and fits best in their context. Even though it includes providing evidence-based information (facilitated by decision aids), SDM is not equivalent to a patient education de-implementation strategy. The purpose of SDM should not be to inform the patient to convince or expect them to pursue a specific course of action, measured as the adherence to the 'do-not-do' recommendation.[19] See box 1 for an example of how applying a de-implementation strategy or SDM for conditional recommendations has different purposes and leads to different courses of action.

The relevance of SDM to reducing low-value care

Although SDM is not appropriate for de-implementing low-value care as defined from a healthcare system perspective, it is suitable to reduce it when it is defined from a patient perspective. In the clinical encounter, patients might consider that we provide 'low-value' care when our response: (1) Does not correspond to their view of the problem (it is generic), or (2) It is not adapted to their particular contextual characteristics or cannot improve their situation according to their goals and desires (ie, when it is ineffective, causes new problems, is unaffordable, is unfeasible or requires a lot of effort and attention). By adopting SDM, the clinician and the patient participate in co-creating a desirable, feasible and effective response that suits that patient in particular.[5]

How to approach low-value care in the clinical encounter

As mentioned before, when we have good quality evidence that care provides more harm than benefits (ie, a 'strong recommendation against'), healthcare professionals should actively discourage it. Based on Thériault *et al*, we recommend to 'align, acknowledge and refocus' instead.[20] This means understanding the patient's rationale for requesting the low-value care practice, validating their concerns and explaining why it is not recommended. For all other situations where there are conditional recommendations or the evidence about its low value is inconclusive, clinicians should apply SDM and be ready to discuss the issue if the patient brings it up, communicating the available evidence and co-creating a solution with the patient.[5 11 21 22] As mentioned before, by applying SDM in the clinical encounter, we are reducing low-value care from an individual patient perspective. SDM is not focused on solving healthcare system problems but on solving patients' problems.

It is important to acknowledge that many drivers of overuse play a role in the clinical encounter, such as the cultural belief that 'more is always better', patient demands or defensive practice.

Box 1 Clinical vignette contrasting de-implementation and SDM approaches[1]

An 85-year-old patient with moderate dementia comes to your office with her daughter (the substitute decision maker). She was recently widowed and moved in with her daughter and son-in-law. The reason for the visit is that your patient started accusing her son-in-law of stealing things from her. At first, they got along very well, but now that the mother began with delusions and paranoia, she doesn't want him or anybody that is not the daughter to help her. The daughter feels exhausted trying to calm her mother and help her get along with her son-in-law.

From a de-implementation perspective, antipsychotics are discouraged as the first choice to treat behavioural and psychological symptoms of dementia as they can increase the incidence of stroke and death and provide limited benefit for agitation and anxiety. Choosing Wisely Canada's recommendation is to limit its use to cases where 'non-pharmacological measures have failed, and patients pose an imminent threat to themselves or others',[14] which is not strictly the case in this scenario. You provide this information and explain to the daughter that the best first approach is to use non-pharmacological measures and how to implement them, scheduling a follow-up in 2 weeks.

From an SDM perspective, you explore how non-pharmacological measures fit in your patient's and caregivers' context. The daughter feels regretful she cannot help during the week because she gets home late after work, her mother rejects any help from the son-in-law, and they cannot afford another caregiver. You mention the benefits and harms of antipsychotics. While the daughter is concerned about the harms, she values the possibility of reducing her mother's anxiety more, as she thinks the delusions are more detrimental to her mother's care right now. The option of 'only non-pharmacological measures first' does not fit in this context. You decide together to try the medication and schedule a follow-up in 2 weeks.

This is an illustrative clinical case created by the authors based on their clinical practice but not on an individual patient.

Clinicians tend to keep offering ineffective or inefficient practices to reduce their perceived legal risks or to avoid losing patients' trust and damaging the clinician-patient relationship by ordering fewer tests rather than advancing patient care.[23] Prescribing low-value care practices without having conversations about the evidence behind them feeds a vicious cycle in which people keep thinking that these are high-value and, in turn, request more tests. Supportive organisational cultures of practice are needed to address uncertainties about the consequences of providing fewer tests and treatments and to create conditions in which clinicians feel confident in avoiding defensive practice and resisting patient pressures for harmful low-value care practices. Some examples of de-implementation strategies that could help are strategic reframing of non-medical approaches, documenting the decision process not to perform a test or treatment, and clinician education and training in communication skills.[17] Moreover, without disregarding the challenge of addressing these conversations in the clinical encounter, we believe that clinicians should work closely with patients to delineate the problem and co-create a suitable solution rather than assuming a generic demand for more tests or interventions and giving a generic response by prescribing them.

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References

1 **Wolfson D**, Santa J, Slass L. Engaging physicians and consumers in conversations about treatment overuse and waste: a short history of the choosing wisely campaign. *Acad Med* 2014;89:990–5.
2 **Verkerk EW**, Tanke MAC, Kool RB, *et al*. Limit, lean or listen? A typology of low-value care that gives direction in de-implementation. *Int J Qual Health Care* 2018;30:736–9.
3 **Sypes EE**, de Grood C, Whalen-Browne L, *et al*. Engaging patients in de-implementation interventions to reduce low-value clinical care: a systematic review and meta-analysis. *BMC Med* 2020;18:116.
4 **Elwyn G**, Frosch D, Thomson R, *et al*. Shared decision making: a model for clinical practice. *J Gen Intern Med* 2012;27:1361–7.
5 **Hargraves IG**, Montori VM, Brito JP, *et al*. Purposeful SDM: a problem-based approach to caring for patients with shared decision making. *Patient Educ Couns* 2019;102:1786–92.
6 **Décary S**, Zadro JR, O'Keeffe M, *et al*. Overcoming overuse Part 5: is shared decision making our excalibur? *J Orthop Sports Phys Ther* 2021;51:53–6.
7 **Coxeter P**, Del Mar CB, McGregor L, *et al*. Interventions to facilitate shared decision making to address antibiotic use for acute respiratory infections in primary care. *Cochrane Database Syst Rev* 2015;2015:CD010907.
8 **Born KB**, Levinson W. Choosing wisely campaigns globally: a shared approach to tackling the problem of overuse in healthcare. *J Gen Fam Med* 2019;20:9–12.
9 **Hoffmann TC**, Jones M, Glasziou P, *et al*. A brief shared decision-making intervention for acute respiratory infections on antibiotic dispensing rates in primary care: a cluster randomized trial. *Ann Fam Med* 2022;20:35–41.
10 **Prasad V**, Cifu A. Medical reversal: why we must raise the bar before adopting new technologies. *Yale J Biol Med* 2011;84:471–8.
11 **Kunneman M**, Griffioen IPM, Labrie NHM, *et al*. Making care fit manifesto. *BMJ Evid Based Med* 2023;28:5–6.
12 **Grossman DC**, Curry SJ, *et al*, **US Preventive Services Task Force**. Screening for ovarian cancer: US preventive services task force recommendation statement. *JAMA* 2018;319:588–94.
13 **Using Antibiotics Wisely in Primary Care**. Choosing wisely Canada. 2021. Available: https://choosingwiselycanada.org/primary-care/antibiotics/ [Accessed 23 Jan 2023].
14 **Canadian Geriatrics Society**. Geriatrics. five tests and treatments to question. Choosing Wisely Canada; 2021. Available: https://choosingwiselycanada.org/recommendation/geriatrics/ [Accessed 24 Sep 2022].
15 **Thompson R**, Muscat DM, Jansen J, *et al*. Promise and perils of patient decision AIDS for reducing low-value care. *BMJ Qual Saf* 2020:bmjqs-2020-012312.
16 **Garcia D**. *Fundamentos de bioética*. Madrid: Tricastela, 2007.
17 **van Bodegom-Vos L**, Marang-van de Mheen P. Reducing low-value care: uncertainty as crucial cross-cutting theme comment on "key factors that promote low-value care: views of experts from the United States, Canada, and the Netherlands." *Int J Health Policy Manag* 2022;11:1964–6.
18 **Norton WE**, Chambers DA. Unpacking the complexities of de-implementing inappropriate health interventions. *Implement Sci* 2020;15:2.
19 **McCormack J**, Elwyn G. Shared decision is the only outcome that matters when it comes to evaluating evidence-based practice. *BMJ Evid Based Med* 2018;23:137–9.
20 **Thériault G**, Grad R, Dickinson JA, *et al*. To share or not to share: when is shared decision making the best option? *Can Fam Physician* 2020;66:327–31.
21 **Davidson KW**, Mangione CM, *et al*, **US Preventive Services Task Force**. Collaboration and shared decision-making between patients and clinicians in preventive health care decisions and US preventive services task force recommendations. *JAMA* 2022;327:1171–6.
22 **Elwyn G**, Price A, Franco JVA, *et al*. The limits of shared decision making. *BMJ Evid Based Med* 2022:bmjebm-2022-112089.
23 **Ries NM**, Jansen J. Physicians' views and experiences of defensive medicine: an international review of empirical research. *Health Policy* 2021;125:634–42.