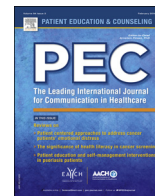




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Review article

Shared decision-making and outcomes in type 2 diabetes: A systematic review and meta-analysis

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ABSTRACT

Objective: Type 2 diabetes is a chronic disease which necessitates the development of a therapeutic alliance between patient and provider. This review systematically examines the association between treatment shared decision-making (SDM) and outcomes in diabetes.

Methods: A range of bibliographic databases and gray literature sources was searched. Included studies were subjected to dual data extraction and quality assessment. Outcomes were synthesized using meta-analyses where reporting was sufficiently homogenous or alternatively synthesized in narrative fashion.

Results: The search retrieved 4592 records, which were screened by title, abstract, and full text to identify 16 studies with a range of study designs and populations. We found evidence of an association between SDM and improved decision quality, patient knowledge and patient risk perception. We found little evidence of an association between SDM and glycemic control, patient satisfaction, quality of life, medication adherence or trust in physician.

Conclusions: This work elucidates the potential clinical utility of SDM interventions in the management of Type 2 Diabetes and helps inform future research on the topic.

Practice implications: A more complete understanding of the associations between SDM and outcomes will guide and motivate efforts aimed at improving uptake of the SDM paradigm.

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1. Introduction

Clinical decision-making is beset by competing demands. Clinicians must uphold patient autonomy while acting in patients’ best interest. There is a knowledge gap in both directions: While physicians usually have access to more clinical knowledge, patients know more about the ways decisions are likely to interact with their values, preferences and resources.

Shared decision-making (SDM) is an approach to clinical decision-making in which patients and practitioners jointly consider clinical factors and patient preferences to arrive at a decision based on mutual agreement [1,2]. The approach aims to bridge the information gap between patients and clinicians while upholding the ethical imperative toward patient autonomy. SDM was promoted by the influential Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, [3] and has since gained wide acceptance as an indispensable component of patient-centered care [4]. Charles et al. offered the first and most influential framework for SDM. They defined the construct in relation to four criteria: 1. Involvement of at least two parties, 2. Mutual contribution to treatment deliberation, 3. Bilateral information exchange, 4. Mutual agreement [2]. In practice, however, most measures and interventions relating to SDM have focused on the second element of the Charles et al. definition – mutual participation of the patient and clinician in the decision process.

SDM interventions have taken a number of approaches – including decision aids that present different options, video-based tools that address specific decisions or overall disease management and directly administered workshops that educate and empower patients to engage in decision-making [4–6]. These diverse approaches are united by a shared goal of increasing patient participation in the decision-making process.

1.1. SDM in diabetes

Type 2 diabetes has a prevalence of 9.3% in the United States and is among the leading causes of mortality and morbidity [7]. In most cases, the disease requires lifelong management and simultaneous pharmacologic, behavioral and lifestyle interventions. Therefore, an understanding of the patient’s values, preferences and life context is of great relevance [8]. The earliest antecedents of SDM – centered on the concept of mutual participation – recognized the unique synergies between the paradigm and the care of chronic diseases [9]. SDM interventions have been associated with increased patient knowledge, greater patient decision satisfaction,

improved communication, less patient indecision, better congruence between patient values and decisions, improved patient risk perception, and improved decision quality in clinical care for a variety of conditions [10]. Moreover, SDM has been specifically linked with better diabetes self-management behaviors [11].

The evidence supporting approaches to diabetes treatment is sparse and of poor quality. One study has estimated that 40% of the diabetes guidelines espoused by the Endocrine Society are backed by low quality evidence [12]. Moreover, nearly 80% of patients with diabetes are estimated to suffer from at least one comorbid condition [13]. The evidence surrounding diabetes management is uncertain and treatment plans will need to account for individual patient co-morbidities. These factors create opportunities for decision-making paradigms that attempt to capture patient factors and preferences. There is empirical evidence that patients differ from clinicians in their priorities regarding diabetes care [14]. This means that even robust guideline recommendations are complicated by individual patient needs, suggesting that personalized management approaches are necessary. The most recent guidelines from the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) recognize this relevance and endorse a patient-centered approach to the condition [15].

There have been several attempts to summarize the literature examining the impact of SDM in diabetes [16–18]. However, these studies limit SDM to decision aids and include only randomized trials. The broader shared decision-making literature has reached a consensus that SDM is not limited to decision aids alone; the construct can be operationalized using a variety of approaches and tools. These include video and instruction-based tools that build generic decisional self-efficacy, without addressing the specific decision scenarios addressed in decision aids [19,20]. Further, we believe that limiting a review to RCTs fails to include much relevant information from observational studies. These studies can contribute to causality claims regarding SDM and diabetes outcomes. Evidence can be derived from many methodologies, and for a complicated area such as the application of SDM to diabetes care, studies of many designs are potentially relevant.

This review aims to summarize and, where possible, quantitatively synthesize the evidence examining the association between SDM and outcomes in diabetes, examining both observational and experimental designs and summarizing evidence relevant to both process of care and clinical outcomes. Our goal is a comprehensive assessment of the impact of SDM in diabetes care to better

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