

Shared Decision Making

An Efficient Use of Time or Another Exercise is Futility

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A concerned doctor

PSA Screening Recommendations of Major Societies

Organization	Who To Screen	Screening Interval
USPSTF, 2012	“D” Recommendation. Should not be offered, consider shared decision making (SDM)	na
USPSTF, 2017	“C” Recommendation for 55 – 69, “D” for all others. SDM	Not mentioned
AUA, 2013	55-69 y or ≥ 70 with 10 to 15 y life expectancy, use SDM; < 55 y individualize approach	Consider 2 y interval over annual; may individualize depending on initial level
ASCO, 2012	Men with life expectancy > 10 y, SDM	none
ACS, 2010	>50 y at average risk with 10 y life expectancy use SDM; 45 y high risk, 40 y very high risk	Annual if ≥ 2.5 ng/m; biannual if < 2.5 ng/ml Biopsy if > 4 ng/dl, individualize 2.5-4 ng/ml
ACP, 2013	>50 y at average risk with 10 y life expectancy use SDM; 45 y high risk, 40 y very high risk	Consider longer intervals than yearly
EAU, 2013	Baseline PSA ≥ 40 – 45 y	2-4 y with PSA > $1\mu\text{g/L}$ at 45-59 y and up to 8 y if PSA < $1\mu\text{g/L}$

Tenets of Shared Decision Making

- Provision of information
 - Balanced and evidence based
 - Harms and benefits of each option
- Elicitation of patient's perspective
 - Asking about prior experiences
 - Understanding and discussing concerns
 - Delineating preferences regarding screening options
- Guiding final decision making (without directing)

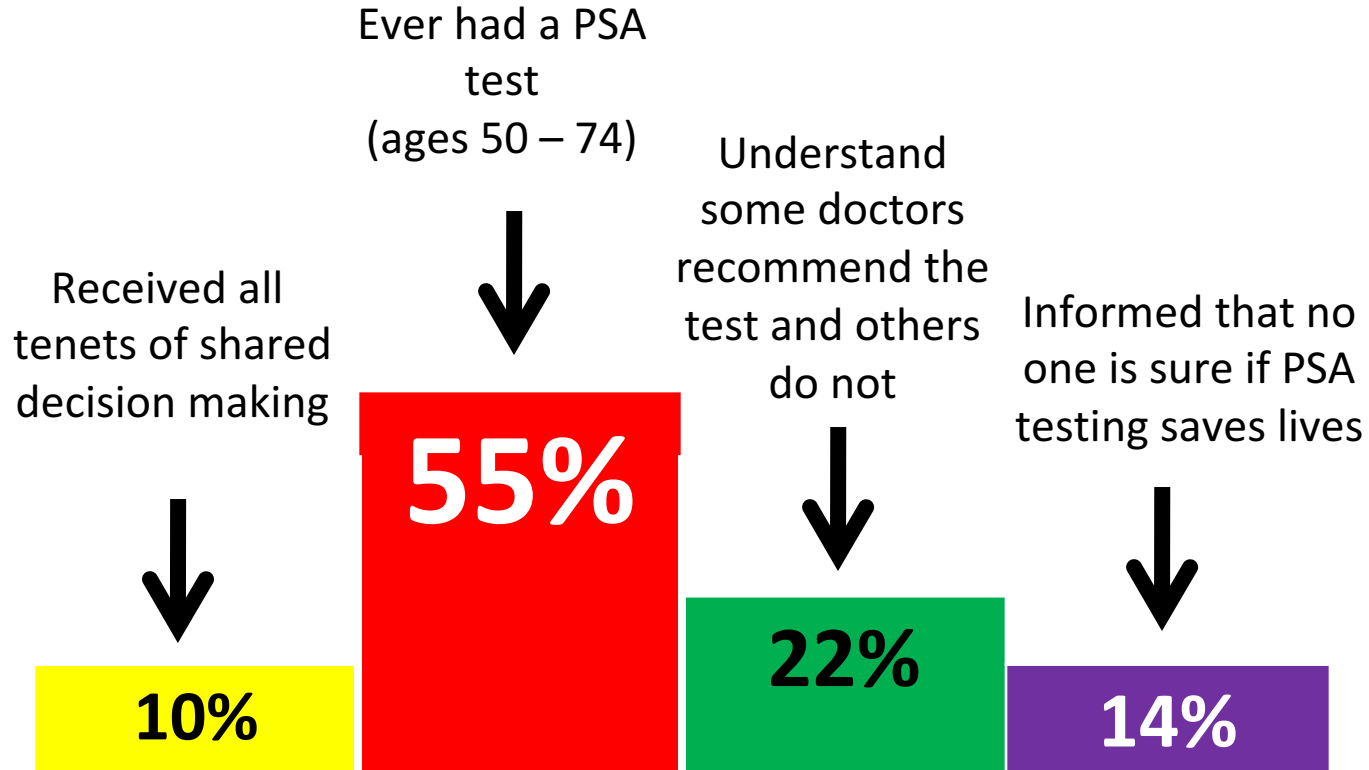
Who is Ordering PSA tests?

Specialty	Percent
Internal Medicine	64.9
Family Medicine	23.7
Urology	6.1
Hem/Onc	1.3

The Implementation of Shared Decision Making Has Failed in Other Diseases as Well

Variable	Breast CA	Colorectal (W)	Colorectal (M)	Prostate CA
Discussed reasons to have test (pros)				
Not at all/little	47	41	33	48
Some/a lot	53	59	67	51
Discussed reasons not to have test (cons)				
Not at all/little	92	87	87	93
Some/ a lot	8	13	14	7

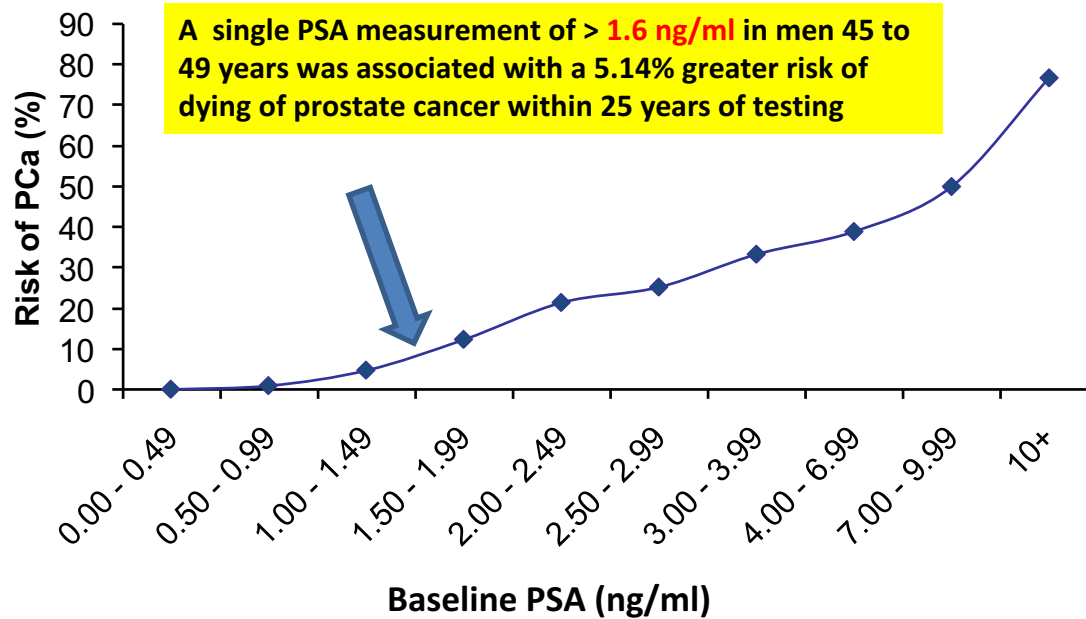
Shared Decision Making and PSA Testing: Results from a National Survey



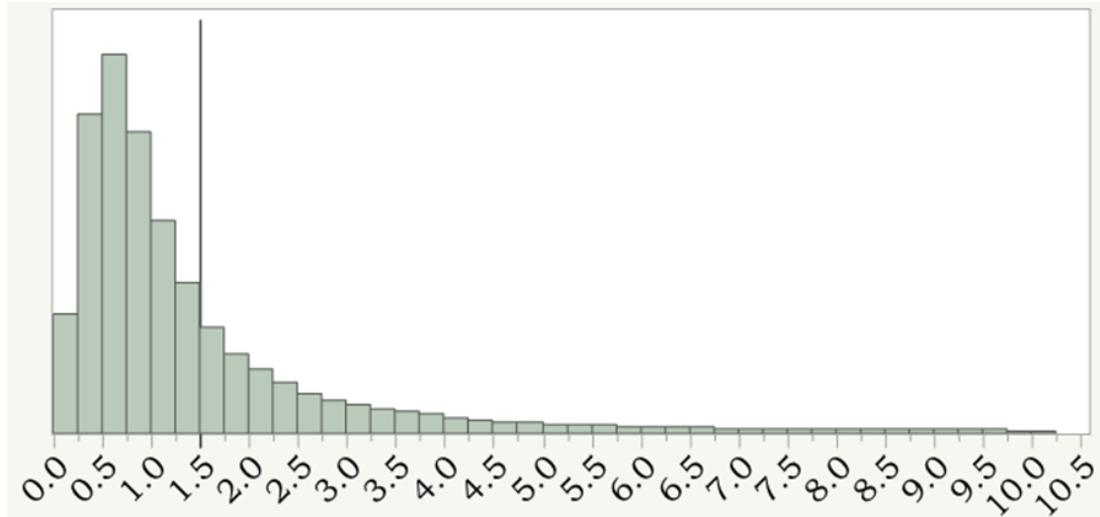
A Simple Schema?

- Information for patient must be based on evidence and be beyond dispute
- Patient should be presented with a clear framework for a decision
- Schema should be appropriate for primary care
 - Should not assume provider has detailed knowledge of disease
 - Should not require more than a few minutes

Using PSA as a predictor

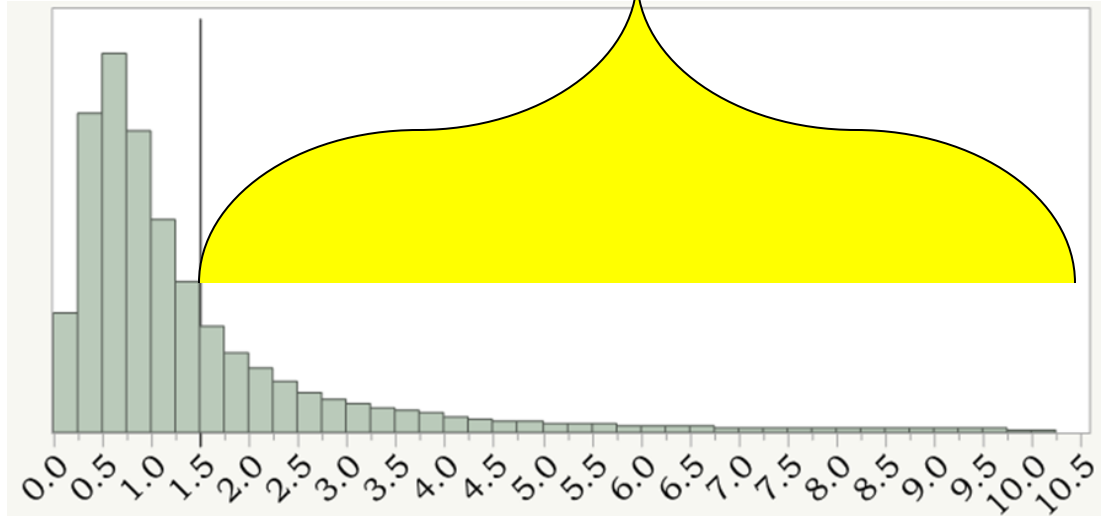


Result Distribution

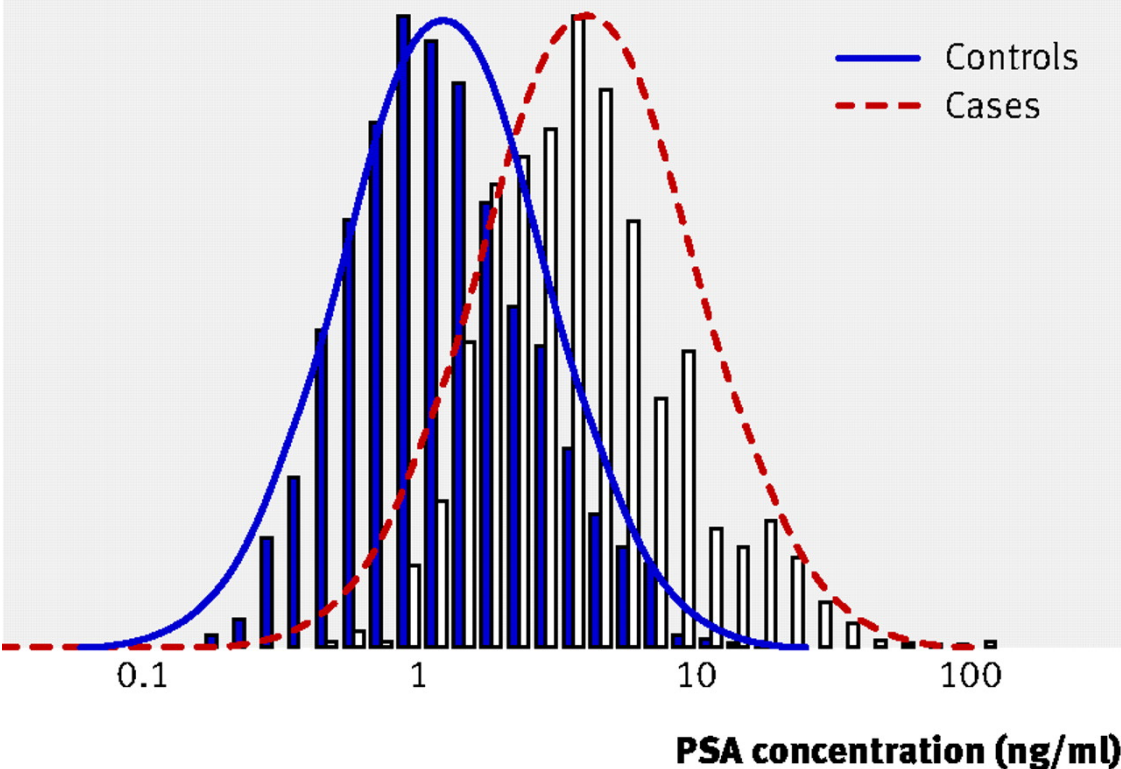


Result Distribution

27%



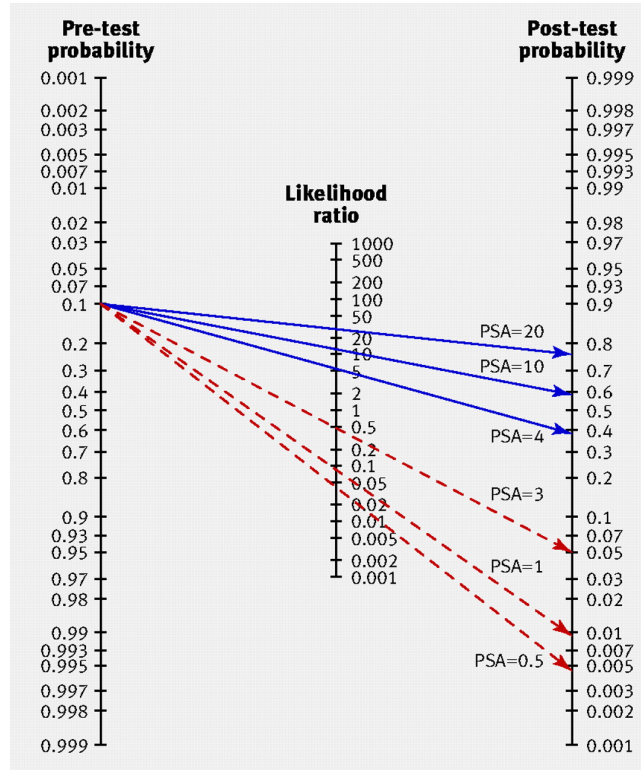
Using PSA More Intelligently



Benny Holmström et al. BMJ 2009;339:bmj.b3537

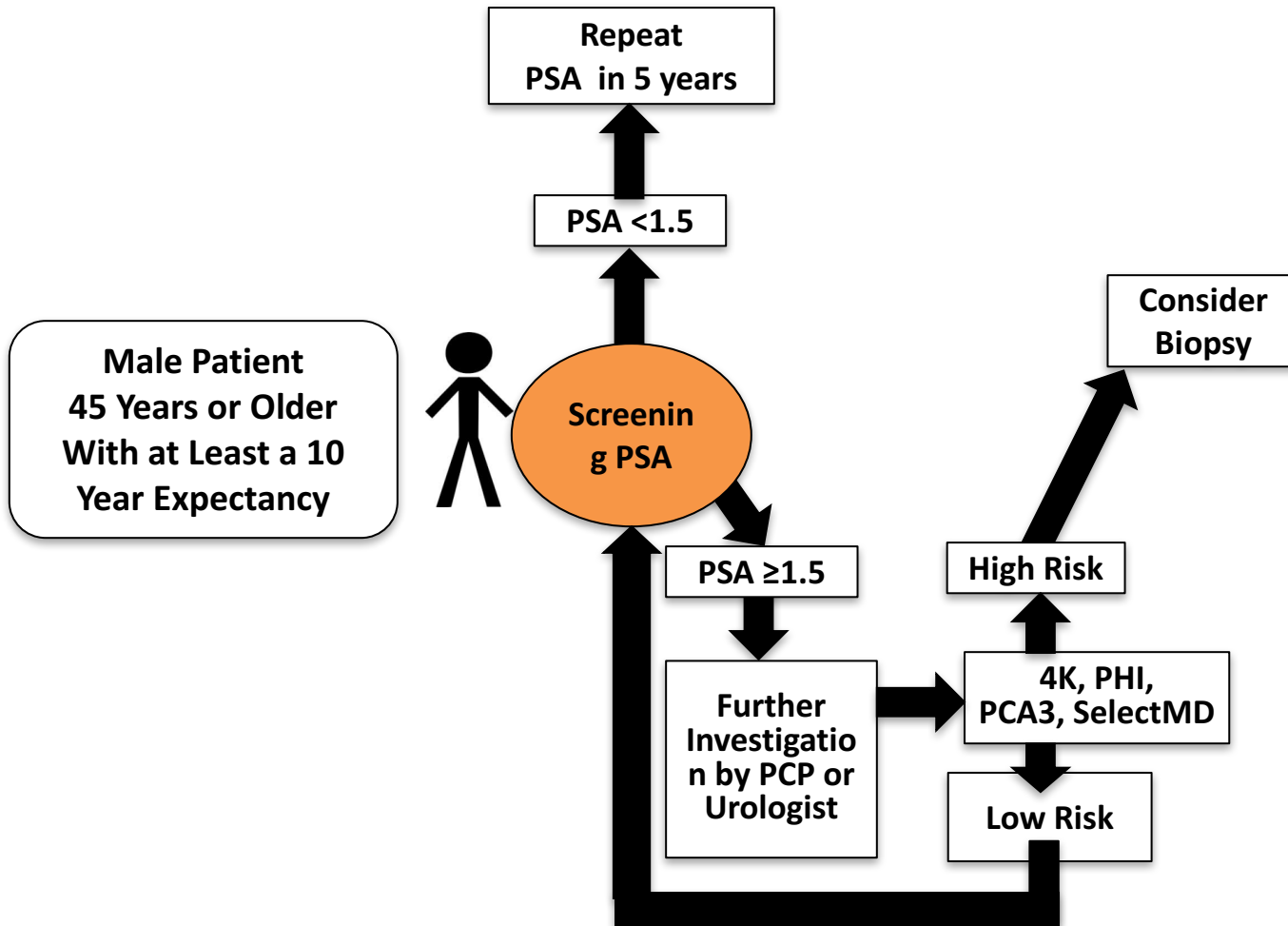


Initial PSA Predicts Future Risk



Benny Holmström et al. BMJ 2009;339:bmj.b3537





There is a better way to screen for prostate cancer

- PSA is valuable, as a first line test
- Suspicious PSA values (those 1.5 ng/dl) should be then be followed by shared decision making

Make Intelligent and Personalized Decisions

- Avoid PSA tests in men with little to no gain, as suggested in the AUA guidelines
 - Focus on age
 - Focus on health
 - Focus on quality measures
- Referral to high volume centers
- Do not treat those who do not need treatment
 - We (primary care) need a risk calculator?

Jackson Experience

Questions