Shared decision-making: an updated three-talk model for the clinical consultation

The three-talk model for shared decision-making (SDM) has been updated in a development process that involved SDM experts and clinicians. The revised model portrays SDM as a fluid transition between different kinds of ‘talk’ (consultation components) by providing a visual model depicting three easy-to-remember conversational steps. NICE guidance fully supports SDM and person-centred care, and the revised three-talk model may help health professionals embed SDM in their practice.

Overview and current advice

Shared decision-making (SDM) is a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients’ informed preferences (Coulter et al. 2011).

All NICE guidelines and technology appraisals state in their prefaces that professionals should take into account the individual needs, preferences and values of their patients or the people using their service, alongside the guidance recommendations. Several guidelines explicitly recommend ensuring that patients and service users (and their carers, guardians and relatives as appropriate) are as involved in decisions about their care as they wish and are able to be:

- Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence (January 2009)
- Service-user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (December 2011)
- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services (February 2012)
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (March 2015)
- Multimorbidity: clinical assessment and management (September 2016)

Quality standards associated with these guidelines set out the priority areas for quality improvement in health and social care and can help regulators, commissioners, providers and healthcare professionals define, identify, commission and provide high quality care. Several condition-specific guidelines and associated quality standards also make recommendations about SDM. NICE has
produced a number of patient decision aids to help SDM, and is involved in several developments in this field.

New evidence

A ‘three-talk model’ for SDM consultations was published in 2012. This has been updated through a development and consultation process (Elwyn et al. 2017). The first step involved discussion by a small group of experts including the authors of the original model (n= 30, 19 responded with comments). This was followed by an online survey sent to several communities of interest (n=92 to 1500 [some overlapping membership is likely], 171 responses). The third and final step involved a review by doctors in 6 specialties in the UK and USA (orthopaedics; urology; obstetrics and gynaecology; internal medicine; family medicine; paediatrics: 1470 invitations sent, 316 responses).

The final model is described in a figure:

Figure: Three-talk model of shared decision making, Elwyn et al. 2017.

Notable differences from the original three-talk model are:

- A move away from a linear model to one that reflects the need to view SDM as a fluid transition between different kinds of ‘talk’, while also indicating a logical sequence
- The explicit addition of the need for active listening as well as deliberation
- Inclusion of brief descriptions of each ‘talk’ domain in the graphic and addition of suggested scripts
- The replacement of the term ‘choice talk’ with ‘team talk’.

The authors state that the term ‘team talk’ received the most comments and alternative suggestions, mainly because the intended interpretation of partnership formation was unclear. However, after considering alternatives, and with the additions of brief descriptions and suggested scripts, they felt this term best signalled the need to provide support and explore goals together.
Commentary

Commentary provided by NICE

Understanding patients’ ideas, concerns and expectations has long been seen as a key component of the consultation and this is reflected in much undergraduate and postgraduate training for healthcare professionals. SDM builds on this by exploring the person’s goals, their attitude to risk and their preferences, and then coming to a joint decision about what option is best.

The previous three-talk model was widely used in training programmes and presentations on SDM; the revised tool may prove even more helpful in encouraging and supporting healthcare professionals tackle the ‘how to do it’ challenges of SDM. The authors state that they plan to assess its ability to support skill development, with and without additional training, and with and without the use of encounter-based patient decision aids. This would provide very valuable insights for educators and those promoting adoption of SDM into practice.

This tool should be seen in the context of the lessons from the MAGIC (Making Good Decisions in Collaboration) programme (Joseph-Williams et al. 2017). That programme was commissioned by the Health Foundation to design, test, and identify the best ways to embed SDM into routine NHS primary and secondary care using quality improvement methods. Five challenges were identified:

- ‘We do it already’; to which a response could be ‘Great! Let’s see how we can do it even better’.
- ‘We don’t have the right tools’; to which a response could be to explain that tools may support the SDM process but do not replace communication skills.
- ‘Patients don’t want SDM’: this might be the case for some people, and in fact desired levels of involvement are likely to differ from person to person and one situation to another. Many patients feel unable rather than unwilling to share in decision making. But even if the clinician is the sole and final decision-maker, at least having better understood the person’s goals, preferences and attitude to risk the clinician will be better able to make a decision congruent with them.
- ‘How can we measure it?’ There are a number of challenges in measuring the extent of SDM, but tools such as the short, simple, three-item CollaboRATE tool offer potential.
- ‘We have too many other demands and priorities’. Organisational buy-in and support are essential, so that SDM is not seen as just one more burden placed upon very busy professionals. Looking carefully at care pathways, exploring which professional is best placed to do what aspects of SDM, and thinking what other loads can be lightened are all important.

The updated three-talk model may well be very useful in providing a conceptual framework for SDM and helping develop professionals’ skills, to be used alongside decision support tools where these are available. It should be remembered, though, that a key learning point from the MAGIC programme was that ‘skills trump tools, but attitudes trump everything’.

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References


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