Editor's Page

Do We Need Shared Decision Making When Prescribing Guideline-Directed Medical Therapy?

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Shared decision making is a process of communication in which clinicians and patients work together to make optimal health care decisions that align with what matters most to patients. The importance of shared decision making has become increasingly recognized in the HF community, with much of the focus on device implantation such as left ventricular assist devices and implantable cardioverter-defibrillators.[1] Indeed, the American Heart Association released a scientific statement on shared decision making in advanced HF in 2012,[2] and the Center for Medicare and Medicaid recently introduced a requirement for clinicians to use shared decision making when considering primary prevention implantable cardioverter-defibrillators.[3] Interestingly, despite the attendant risks of cardiovascular medications, which account for a significant number of adverse drug events leading to emergency room visits in the United States,[4] shared decision making has not been explicitly emphasized in the setting of prescribing guideline-directed medical therapy (GDMT) for adults with HF.

Why might this be? One explanation is that there are now mandates in place that promote the initiation and titration of GDMT given its substantial population-based benefits; the use of GDMT has become a quality metric linked to hospital reimbursement in the United States. This seems logical, as GDMT has been hailed as perhaps the single most important strategy to improve the population-level health of adults with HF, with robust evidence showing that it reduces the substantial morbidity and mortality associated with HF.

Given the mandates for GDMT in HF, one might infer that there is little uncertainty regarding the role of GDMT for patients with HF. However, this inference is not entirely accurate, as there are still several gaps in the evidence for GDMT. First, older adults, who comprise the majority of patients with HF, have largely been excluded from the major clinical trials that produced the evidence underlying the benefits (and risks) of GDMT.[5] Large observational cohort studies have shown that older adults derive similar benefit, but these are far from definitive. Accordingly, the degree to which older adults benefit (and/or potentially experience harm) is not known. Second, the impact of GDMT on patient-reported outcomes is not well-characterized. This is an important limitation because older adults vary in their health priorities,[6] with some prioritizing quality of life and/or preservation of function over traditional outcomes like mortality. Accordingly, without high-quality data on these patient-reported outcomes, it is difficult to determine the utility of GDMT for many older adults. Third, the inherent limitations of RCTs is that they produce average treatment effects, which obscure clinically relevant differences between individuals and limit their applicability to any single individual.[7] For a number-needed-to-treat of 50, there is no good way to discern which patient will benefit and which 49 patients will not. This is compounded by treatment heterogeneity—the notion that treatment has a differential effect on individuals with different characteristics—which is particularly relevant for older adults with HF, a highly complex and heterogeneous population.

The uncertainty resulting from these limitations creates a challenging scenario for clinicians. On the one hand, some might argue that, in the absence of data to suggest harm, clinicians should defer to clinical practice guidelines and prescribe GDMT given its substantial population-based benefits. A more patient-centered approach might be to engage in shared decision making by incorporating the best scientific evidence available, acknowledging the limitations of the evidence and resulting uncertainty, and outlining the potential risks and benefits of GDMT in the context of the patient's values and preferences.

But is it practical to engage in shared decision making for GDMT? Clinicians caring for adults with HF already have several tasks that must be completed during an office visit; these include but are not limited to conducting a history and physical, performing medication reconciliation, counseling

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on diet and exercise, and discussing prognosis. The resulting time constraints of a routine office visit can hamper an exploration of health priorities and preclude a detailed discussion about the risks and potential benefits of the many pharmacologic therapies available to adults with HF. This can lead to medical decisions that incorporate less information and fewer tradeoffs, and engender increased dependence on preconceived notions and biases.[8] There are also challenges related to patients' abilities to process the information exchanged during the shared decision making process—patients often struggle with interpreting quantitative and probabilistic information; experience cognitive overload in the setting of uncertainty which can lead to decision avoidance and/or impair decision-making; and experience low self-efficacy due to their perceived lack of knowledge.[8] Taken together, shared decision making for GDMT, or any treatment for that matter, may not be so simple.

So what is a clinician to do? Clearly, there are gaps in knowledge with regard to GDMT, suggesting a potential role for shared decision making; but engaging in shared decision making may be easier said than done. We therefore need to generate more convincing evidence for real-world adults with HF, including those who have multi-morbidity, cognitive impairment, and/or frailty—the reality is that these are common in real-world patients with HF. In addition, we need to incorporate patient-reported outcomes into RCTs more routinely, an effort that has already begun. We also need tools that can assist clinicians in determining the applicability of RCTs to individual patients, and tools that can better quantify treatment heterogeneity. Lastly, we need to develop new strategies that can facilitate shared decision making for GDMT. Most will agree that incorporating the patient and their caregivers into the decision making process is important. The problem is that it is not exactly clear how best to engage in a process of shared decision making within the time constraints of a traditional office visit without overwhelming patients and their families. Decision aids have been developed and studied, but challenges to their broad uptake remain.[9] To move forward, we will need to start thinking more creatively and invest in new ideas (and reimbursement strategies); this is the only way forward to ensure that we are providing patient-centered care to each individual patient.

"Note from the Editor-in-Chief: Dr. Goyal is the JCF Mentee for the current academic year."

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