Research Q1 Evidence Profile (Quantitative)

Recommendation question 1: Should decision aids be recommended or not for use by health providers and people (to support shared decision making about treatment and care)?

Recommendation: The expert panel recommends that people are provided with decision aids to enhance participation in making decisions related to health screening and health-care treatment options.

Population: Health providers and people (adults) making decisions about their health screening and health-care treatment options
Intervention: The use of decision aids by health providers and people making health screening and health-care treatment decisions about their health
Comparison: No decision aids or the usual decision-making process
Outcomes (core): People's participation in their care (involvement in decision making and options); provider/people outcomes: provider satisfaction with care (or decision aid), people's knowledge (about benefits/harms) and people's selection of a treatment/screening option that reflected what was most important to them; provider care behaviors (establishing a therapeutic relationship respectful of person's preferences, culture etc.); organizational or system outcomes (satisfaction with overall care, length of stay, re-admission rates, adoption and sustainability (of decision aid use); harms (people/caregiver burden, provider burden); clinical (physiological) outcomes (not reported).

Setting: all healthcare settings

Bibliography: Stacey et al. (2024)

Table 1 – Quality details

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
Outcome: informed values – choice congruence[a] [congruence between the chosen option and the informed person's values] (outcome measured soon after exposure to decision aid)											
21[b]	Randomized control trials (RCT)	Not serious	Not serious[c]	Not serious	Not serious	Detected[d]	All studies: total events (# of times decision aid used) = 4,860 total events (congruence)= 2,199	All studies: total events (# of times comparator used) = 4,517 total events (congruence) = 1,247	Patient[e] decision aids were probably more effective than usual care for selecting an option that was congruent with the patient's informed values. Relative Risk [RR] (95% confidence interval [CI]) =1.75 (1.44, 2.13) I^2 =92% For every 100 people who use decision aids with a health provider, 20 more people will experience congruence between their chosen option and the informed person's values when making health screening or treatment decisions (the range is 12 more to 31 more).	⊕⊕⊕◯ Moderate	Stacey et al. (2024)

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
							Additional calculation with high risk of bias studies removed: total # of times decision aid used: 3,810 total events (congruent) = 1,797	Additional calculation with high risk of bias studies removed: total # of times comparator used: 3,372 total events (congruent) = 891	When 3 studies with a high risk of bias[f] were removed (n= 18 studies), the results were similar: RR [95% CI]: 1.96 [1.54, 2.50] I² =93% For every 100 people who use decision aids with a health provider, 23 more will experience congruence between their chosen option and the informed person's values when making health screening or treatment decisions (the range is from 13 more to 36 more).		
Outcome: knowledge[g] (person using the decision aid's knowledge about benefits/harms and supported the selection of a treatment/screening option that reflected what was most important to them) (outcome measured soon after exposure to decision aid)											
107	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies: n=12,851 participants After using the decision aid, the mean knowledge score was 70.9 out of 100 in the decision aid group (ranging from 10.60 to 13.19 higher). Additional calculation with high risk of bias	All studies: n= 12,641 participants After using the decision aid, the mean knowledge score was 58.61 out of 100 across comparator groups. Additional calculation with high risk	Patient decision aids were more effective than usual care on improving participant knowledge scores about benefits/harms and supported the selection of a treatment/screening option that reflected what was most important to them. Mean Difference [MD] (Inverse-Variance [IV], Random,95% CI): 11.90 [10.60, 13.19] I² = 92% When 12 studies with a high risk of bias studies were removed (n=95 studies), the results were similar[h].	⊕⊕⊕⊕ High	Stacey et al. (2024)

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
							studies removed: n= 11, 619 participants	of bias studies removed: n=11,414 participants	MD (IV, Random, 95% CI): 12.13 [10.74 to 13.52] I² = 93%		
Outcome: accurate risk perception[i] [person] (measured soon after exposure to the decision aid)											
25	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies: total events (# of times decision aid used) = 3,937 # of events (with accurate risk perception) = 1,810 Additional calculation with high risk of bias studies removed: total events (# of times decision aid used) = 3,126 # of events (accurate risk perception) 1,554	All studies: total events (# of times comparator used) = 3,859 # of events (with accurate risk perception) = 930 Additional calculation with high risk of bias studies removed: total events (# of times comparator used) = 3,026 # of events (accurate risk	Patient decision aids were more effective than usual care for achieving accurate risk perceptions. RR (95% CI): 1.94 (1.61 to 2.34) I² = 87% For every 100 people who use decision aids with a health provider, 23 more people will experience accurate risk perception when making health screening or treatment decisions (the range is 15 more to 32 more). When five studies with a high risk of bias studies removed (n=20 studies), the results were similar: RR (95% CI) = 1.99 (1.60 to 2.48) I² = 89% For every 100 people who use decision aids with a health provider, 26 more people will experience accurate risk perception when making health screening or treatment	⊕⊕⊕⊕ High	Stacey et al. (2024)

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
								perception) = 780	decisions (the range is 16 more to 38 more).		
Outcome: decisional conflict[j] (feels uninformed about options, benefits and harms subscale) (assessed soon after exposure to the decision aid)											
58	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies: n= 6,435 participants The mean scores for “feeling uninformed” were 20.9 out of 100 in the patient decision aid group. Additional calculation with high risk of bias studies removed: n= 5,296 participants	All studies: n= 5,669 participants The mean score for 'feeling uninformed’ was 31.6 out of 100 in the usual care group, with lower scores indicating feeling less uninformed. Additional calculation with high risk of bias studies removed: n= 4,686 participants	Patient decision aids were more effective than usual care on feeling uninformed scores. MD: (IV, Random, 95% CI): -10.02 out of 100, (95% CI -12.31 to -7.74) I^2 = 92% When seven studies with a high risk of bias were removed (n=51 studies), the results were similar[k]. MD (95% CI) = -11.18, 95% CI -13.82 to -8.54 I^2 = 92%	⨁⨁⨁⨁ High	Stacey et al. (2024)

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
Outcome: decisional conflict[l] (unclear about personal values subscale) (assessed soon after exposure to the decision aid)											
55	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies: n= 6,319 participants The mean score for the outcome ‘feeling unclear about personal values’ was 19.9 out of 100 in the patient decision aid group. Additional calculation with high risk of bias studies removed: n= 5,180 participants	All studies: n= 5,561 participants The mean for the outcome 'feeling unclear about personal values' was 28.8 for the comparator group, with lower scores indicating feeling less unclear about values. Additional calculation with high risk of bias studies removed: n= 4,578 participants	Patient decision aids were more effective than usual care on feeling unclear about personal values. MD: (IV, Random, 95% CI): -7.86 [-9.69, -6.02] I^2 = 88% When seven studies with a high risk of bias were removed the results were similar[m]: MD: (IV, Random, 95% CI): -8.60, [-10.73 to -6.47] (n= 48 studies). I^2 = 90%	⊕⊕⊕⊕ High	Stacey et al. (2024)
Outcome: participation in decision-making: clinician controlled[n] [passive role] (assessed soon after consultation with clinician)											
21	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies:	All studies: total events (# of times	Patient decision aids were more effective than usual care for reducing clinician-controlled or passive decision-making.	⊕⊕⊕⊕ High	Stacey et al. (2024)

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
							total events (# of times decision aid used) = 2,354 # of events (clinician-controlled use of decision aid) = 353 Additional calculation with high risk of bias studies removed: total events (# of times decision aid used) = 1,727 # of events (clinician-controlled) = 261	comparator used) = 1,994 # of events (shared decision-making using comparator) = 462 Additional calculation with high risk of bias studies removed: total events (# of times comparator used) = 1,522 # of events (clinician-controlled): 320	RR: (95% CI): 0.72 [0.59, 0.88] I² = 55% All studies: For every 100 people who use decision aids with a health provider, 6 fewer people will experience a clinician-controlled decision-making process when making health screening or treatment decisions (the range is 9 fewer to 3 fewer). When four studies with a high risk of bias were removed (n= 17 studies), the results were similar: RR (95% CI)= 0.81 [0.66 , 0.98] I² = 36% For every 100 people who use decision aids with a health provider, 4 fewer people will experience a clinician-controlled decision-making process when making health screening or treatment decisions (the range is 7 fewer to 0 fewer).		
Outcome: participation in decision-making: participant controlled[o] (active role) (assessed soon after consultation with clinician)											
20	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies: Total # of events (using decision aid): 2,021	All studies: Total # of events (using	Use of decision aids by participants and health providers were more effective than usual care for increasing participant-controlled decision-making.	⊕⊕⊕⊕ High	Stacey et al. (2024)

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
							# of events decision-making is (participant controlled) = 1,103 Additional calculation with high risk of bias studies removed: total events (# of times decision aid used) = 1,315 # of events (decision-making is participant controlled): 740	comparator): 1,694 # of events (participant controlled using comparator) = 754 Additional calculation with high risk of bias studies removed: total events (# of times comparator used) = 1,118 # of events (participant controlled using comparator): 500	RR (95% CI): 1.22 [1.05, 1.43] I^2 = 83% For every 100 people who use a decision aid with a health provider, 10 more people will experience participant-controlled participation in decision making when making health screening or treatment decisions (the range is 2 more to 24 more). When five studies with a high risk of bias were removed (n= 15 studies), the results were similar: RR (95% CI): 1.20 [0.99, 1.45] I^2 = 78% For every 100 people who use decision aids with a health provider, 9 more people will experience participant-controlled participation in decision making when making health screening or treatment decisions (the range is 1 more to 20 more).		
Outcome: participation in decision-making[p] (role shared between participant and clinician) (measured soon after consultation with clinician)											
23	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies:	All studies:	RR (95% CI): 0.98 [0.88, 1.09]	⊕⊕⊕⊕ High	Stacey et al. (2024)

Quality assessment							No. of participants		Effect	Certainty	Reference
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Intervention	Control			
							Total # of events (using decision aid): 2,131 # of events (a shared decision-making process) = 761 Additional calculation with high risk of bias studies removed: total # of events (using decision aid): 1,504 # of events (shared decision-making process) = 525	Total # of events (using comparator): 1,668 # of events (a shared decision-making process using comparator= 607 Additional calculation with high risk of bias studies removed: # of events (using comparator) = 1,196 # of events (shared decision-making process using comparator) = 440	I² = 0% There was no difference between patients in the patient decision aids groups compared to usual care groups on patients' perception of achieving shared decision-making with their clinician using the Collaborative role on the Control Preferences Scale. For every 100 people who use decision aids with a health provider, 1 more individual will experience participant-controlled participation in decision making when making health screening or treatment decisions (the range is 4 fewer to 3 more). When seven studies with a high risk of bias were removed (n= 16 studies), the results were similar: RR (95% CI): 0.96 [0.83, 1.10] I² = 55% For every 100 people who use decision aids with a health provider, 2 more people will experience participant-controlled participation in decision making when making health screening or treatment decisions (the range is 6 fewer to 4 more).		

Quality assessment							No. of participants		Effect	Certainty	Reference
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
Outcome: impact on health care system: consultation length[q] (measured in time [minutes])											
13	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	Decision aid used in preparation for consultation: n= 213 participants	Usual process used in preparation for consultation for comparator group: n= 207 participants	When a decision aid was used in preparation for consultation, there was little to no difference in consultation length compared to usual care. MD (IV, Random, 95% CI): -2.97 minutes, 95% CI -7.84 to 1.90; n= 5 studies I^2= 89%	⊕⊕⊕⊕ High	Stacey et al. (2024)
							When the decision aid was used during the consultation: n= 1,407 participants	When the usual process was used during the consultation in the comparator group: n= 1,295 participants	When the decision aid was used during the consultation, the consultation was 1.50 minutes longer compared to usual care. MD (IV, Random, 95% CI): MD 1.50 minutes, 95% CI 0.79 to 2.20; 8 studies) I^2= 98% Total results pooled (decision aids used in preparation for consultation and during the consultation with the health provider): MD (IV, Random, 95% CI): 0.73 minutes [0.05, 1.41] There were no studies with a high risk of bias when a decision aid was used in preparation for a consultation.		
							Additional calculation with high risk of bias studies removed: n= 769 participants	Additional calculation with high risk of bias studies removed: n=	When three studies assessed as high risk of bias were removed for the analysis that examined the impact on consultation time using a decision aid during the consultation, the findings were similar[r]:		

Quality assessment							No. of participants		Effect	Certainty	Reference
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
								682 participants	MD (IV, Random, 95% CI): 1.75 minutes [1.00, 2.50] (n=5 studies). I² = 99%		
Outcome: person satisfaction[s] with the decision-making process (measured post-consultation, not described, or 1 week follow-up)											
12	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies: n=: 1,041 participants average (mean) scores: 79.4 out of 100 in the patient decision aid group Additional calculation with high risk of bias studies removed: n= 691 participants	All studies: n= 1,025 participants average (mean) scores: 76.4 out of 100 for the usual care group Additional calculation with high risk of bias studies removed: n= 703 participants	Patient decision aids were more effective than usual care for improving patient satisfaction with the decision-making process. MD [95%CI]: 3.33 [1.18,5.48] I² = 57% When four studies with a high risk of bias studies were removed, the results were similar[t]: MD [95%CI]: 3.90 [1.71, 6.09] (n=8 studies). I² = 39%	⊕⊕⊕⊕ High	Stacey et al. (2024)
Outcome: decision regret[u] (**adverse event**) (measured 6 to 24 months after the decision is made)											
22	RCTs	Not serious	Not serious	Not serious	Not serious	Undetected	All studies: n= 1,825 participants the mean regret score in the intervention groups was not different.	All studies: n= 1,882 participants the mean regret score was 15.6% across control	There was no difference in decisional regret scores in participants exposed to patient decision aids as compared to those exposed to the comparator.	⊕⊕⊕⊕ High	Stacey et al. (2024)

Quality assessment							**No. of participants**		**Effect**	**Certainty**	**Reference**
№ of studies	**Study design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication bias**	**Intervention**	**Control**			
							Additional calculation with high risk of bias studies removed: n= 1,344 participants	groups, ranging from 6.4% to 27.0%. Additional calculation with high risk of bias studies removed: n= 1,296 participants	MD (IV, Random, 95% CI): -1.23, 95% CI -3.05 to 0.59 I^2 = 80% When five studies with a high risk of bias were removed the results were similar[v]: MD: -2.58, 95% CI -5.16 to -0.01 (n= 17 studies) I^2 = 83%		
Outcome: clinical (physiological) outcomes (not measured)											
N/A											

Acronyms

CI = confidence interval

I^2 = measure of the heterogeneity (percentage of variation that occurs, rather than by chance) across the primary studies

IV=inverse-variance

MD = mean difference (this value reflects the absolute difference between the mean value of an outcome measure in two difference groups (intervention group vs. the comparator group, before and after receiving an intervention])

RCT= randomized controlled trial

RR= relative risk

SD = standard deviation

SR = systematic review

Tools used to measure outcomes

Informed values – choice congruence: congruence (yes/no) between informed values and choice outcome and based on the proportion of participants who made a decision that aligned with what was most important to them.

Participant knowledge: knowledge scores from primary studies were standardized on a scale from 0 (no knowledge) to 100 (perfect knowledge).

Accurate risk perception: Based on the accuracy of perceived outcome probabilities according to the percentage of individuals whose judgments corresponded to the scientific evidence.

Decisional conflict - uninformed subscale of the Decisional Conflict Scale: measures the degree to which the participants 'feels uninformed' about their options, benefits, harms; standardized on a scale from 0 (informed) to 100 (uninformed).

Common instruments include the Control Preferences Scale (Degner 1992) and COMRADE (Edwards 2003). Other studies may use similar researcher-developed response statements to measure perceived involvement.

Decisional conflict – unclear about personal values subscale of the Decisional Conflict Scale: Standardized on a scale from 0 (clear) to 100 (unclear). Scores less than or equal to 25 are associated with follow-through decisions; and scores > 38 are associated with delay in decision-making. Common instruments include the Control Preferences Scale (Degner 1992) and COMRADE (Edwards 2003).

Participation in decision-making; clinician-controlled decision-making: conducted using the groupings in the Control Preference Scale; measures the role that the patient and the physician can assume in decision making, ranging from the patient selecting its own treatment through a collaborative model to a scenario where the physician alone makes the decision.

Participation in decision-making: participant-controlled: conducted using the groups in the Control Preference Scale.

Participation in decision-making; shared role in decision-making: conducted using the groupings in the Control Preferences Scale.

Decisional regret: measured using the five-item Decisional Regret scale. Scores range from 0-100. Higher decisional regret scores were associated with lower satisfaction with the decision.

Consultation length: measured in time (minutes) prior to (decision aid used before consultation) or when the decision aid was used during the consultation with the health provider.

Patient satisfaction: multiple scales were used to report this outcome such as the Satisfaction with the Decision-Making Process (SDMP), a 12-item scale (Barry 1997), or ‘‘How satisfied were you with this consultation?”, with response scale 0 to 10 (Bozic 2013). Likert scoring ranged from 0 or 1 for strongly disagree to 5 for strongly agree. Satisfaction with the information-sharing approach (proportion who would recommend to others) or satisfied with process.

Table 2 – Individual Systematic Review Details

Reference	Study Design	Country	Intervention Group Details	Control Group Details	Reported Effects/Outcomes	Risk of bias
Outcomes reported: informed values – choice congruence; person knowledge; accurate risk perception; decisional conflict [feels uninformed and unclear about personal values]; participation in decision making [provider controlled, person controlled and shared]; decision regret; person satisfaction with the decision-making process and consultation length.						
Stacey et al. (2024)	Systematic (Cochrane) review (104 new RCTs captured in this update, for a cumulative total of 209 primary RCTs [175 RCTs; 34 cluster RCTs]) Update of previous systematic reviews conducted in 2003 and 2017.	19 countries (including nine new countries as indicated by *): USA (n= 106), Canada (n = 23), United Kingdom (n = 21), Australia (n = 17),the Netherlands (n = 10), Germany (n = 8), China (n = 7), Spain (n= 6), Denmark* (n = 2), Finland (n = 2), France* (n = 2), Japan* (n =2), Greece* (n = 1), Italy* (n = 1), Malaysia* (n = 1), New Zealand* (n= 1), Sweden (n = 1), Switzerland* (n = 1), Turkey* (n = 1), and four studies that were conducted in two countries.	Use of decision aid: evidence-based tool to improve knowledge and create accurate perceptions of options, benefits, and harms regarding the decision and choices they're required to make. Decision aids can be paper-based, web or computer program-based. The aid can include audio and visual presentation of content. Decision aids are an evidence-based tool to help people make choices about medical treatment and care options that align with their informed values. Decision aids across the included studies used different formats, including 89 (43%) paper-based, 70 (33%) web-based or computer program, 33 (16%) including combinations of audio, video, web/computer based, and paper-based, 15 (7%) video, and two (1%) scripts read aloud. The most common decisions were about cardiovascular treatment (n = 22 studies), cancer screening (n = 17 studies on colorectal, 15 on prostate, 12 on breast screening), cancer treatment (e.g. 15 breast, 11 prostate), mental health (n = 10 studies), and joint replacement surgery (n = 9 studies). The most common new treatment decision topics are in obstetrics (n = 4 studies), cardiovascular disease (n = 2 studies), kidney disease (n = 4 studies), obstructive sleep apnea (n = 3 studies), lung cancer screening (n = 2 studies), and upper extremity conditions (n = 3 studies).	Comparator groups across the 209 studies offered: usual care consisted of various types of controls (e.g. usual care, general information, risk assessment, clinical practice guideline summaries for health consumers, placebo intervention (e.g. information on another non-relevant topic such as use of seat belts), or no intervention.	All data reported above, including statistical analyses performed.	Systematic review: LOW

References:

Stacey D, Lewis KB, Smith M, Carley M, Volk R, Douglas EE, Pacheco-Brousseau L, Finderup J, Gunderson J, Barry MJ, Bennett CL, Bravo P, Steffensen K, Gogovor A, Graham ID, Kelly SE, Légaré F, Sondergaard H, Thomson R, Trenaman L, Trevena L. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews 2024, Issue 1. Art. No.: CD001431. DOI: 10.1002/14651858.CD001431.pub6.

Explanations:

[a] The informed values – choice congruence outcome aligns with the core outcome of person participation in their care (co-designed people-centred care where people and families feel respected, preferences are heard and at the centre of care of the care partnership).
[b] The number reported in this column reflects the number of primary studies reporting each outcome from the total 209 primary studies captured in the systematic review and meta-analysis results reported for each outcome. 157 studies randomized individual patients, and 34 studies randomized clusters (Stacey et al., 2024).
[c] The authors of the systematic review did not downgrade for inconsistency (related to heterogeneity) across all outcomes despite the variability in the effect sizes in the individual studies and given the generally consistent direction of effects across the individual studies for the decision aid groups compared to the usual care groups. Authors focused on the direction of the variability in effect and not the variability in the size of the effects. The rationale for this is that decision aids are complex, multi-component interventions, the comparator is usual care and there is variability in how the people using the decision aid interact with clinicians (clinician only or interprofessional team) across the included studies (Stacey et al., 2024).
[d] Downgraded for GRADE certainty by Stacey et al. (2024) as publication bias was detected during meta-analysis through visual assessment of funnel plot asymmetry of the primary studies.
[e] The term "patient" in patient decision aids refers to a person, individual or groups of people who are participating in shared decision-making with a health provider for the purpose of making decisions about health screening or treatment and care. RNAO has moved away from using the term "patient" to acknowledge and address negative connotations associated with use of this widely used term.
[f] Where meta-analysis results included some primary studies that were quality appraised with a high risk of bias, a sub-analysis was re-calculated by the SR authors, removing the data from studies with a high risk of bias, to assess whether risk of bias from methodological limitations in those primary studies may have influenced the overall statistical results.
[g] The knowledge outcome aligns with the core outcome of provider/person outcomes and measures the person using the decision aid's knowledge about benefits/harms and supported the selection of a treatment/screening option that reflected what was most important to them.
[h] The mean knowledge scores in the intervention and comparator groups from the remaining 95 studies without a high risk of bias were not available: with authors reporting the MD [95%CI] for this analysis.
[i] The accurate risk perceptions outcome aligns with the core outcome of person/provider outcomes and measures the accuracy of perceived outcome probabilities according to the percentage of individuals whose judgments corresponded to the scientific evidence about the chances of an outcome for similar people.
[j] The decisional conflict outcome aligns with the core outcome of person/provider outcomes and measures the first construct: feeling uninformed after using the decision aid.
[k] The mean decision conflict (feels uninformed) scores in the intervention and comparator groups from the remaining 51 studies without a high risk of bias were not available: with authors reporting the MD [95%CI] for this analysis only
[l] The decisional conflict outcome aligns with the core outcome of person/provider outcomes and measures the second construct: having unclear values after using the decision aid.
[m] The mean decisional conflict (unclear about personal values) scores in the intervention and comparator from the remaining 48 studies without a high risk of bias were not available: with authors reporting the MD [95% CI] for this analysis.
[n] The participation in decision making outcome aligns with the person participation in their care core outcome. This outcome measures clinician controlled (passive decision-making role for the person) decision making about screening or treatment.
[o] The participation in decision making outcome aligns with the person participation in their care core outcome. This outcome measures participant/person controlled (active participation) decision-making about screening or treatment
[p] The participation in decision making outcome aligns with the person participation in their care core outcome. This outcome measures shared decision making (both clinician and the person participates in the decision-making process) about screening or treatment.
[q] The consultation length outcome aligns with the organizational or health system core outcome. The outcome measures the length of a consultation with a health provider where decision aids are used by the person when making a decision about screening or treatment prior to the consultation or during the consultation.
[r] The mean consultation time (when a decision aid is used during the consultation) scores in the intervention and compactor for the remaining 5 studies without a high risk of bias were not available: with authors reporting the MD [95% CI] for this analysis.
[s] The person satisfaction outcome represents person satisfaction with the decision-making process about screening or treatment options.
[t] The mean person satisfaction scores in the intervention and comparator groups from the remaining 8 studies without a high risk of bias were not available: with authors reporting the MD [95%CI] for this analysis only.
[u] The decision regret outcome (adverse event) outcome aligns with the provider/person burden core outcome. This outcome measures the amount of regret an individual experiences regarding a decision they make about screening or treatment.
[v] The mean decision regret scores in the intervention and comparator groups from the remaining 17 studies without a high risk of bias were not available: with authors reporting the MD [95%CI] for this analysis only.