

Guidelines

PeriOperative Quality Initiative consensus statement recommendations on the definitions, aims and delivery of shared decision-making for major surgery

Debra Leung,  Alf Collins, Jennifer Philip,  Michael P. W. Grocott,  Bernhard Riedel  and Denny Z. H. Levett,  on behalf of the PeriOperative Quality Initiative XVIII (POQI XVIII) Workgroup*

Summary

Introduction Shared decision-making is a collaborative process whereby clinicians and patients work together to decide on a treatment plan that is informed by evidence, clinical experience and individual patient characteristics and preferences. This process is particularly important for complex surgical decisions when the risks and benefits of treatment are finely balanced. However, shared decision-making has not been implemented consistently in peri-operative pathways and structured shared decision-making for patients requiring enhanced decisional support is not widely available. We aimed to develop clinical practice recommendations for peri-operative shared decision-making through an international consensus process.

Methods A modified nominal group technique was utilised, comprising seven stages. Idea generation (stages 1 and 2) was conducted online. Stages 3–7 occurred in person over 2.5 days and involved iterative rounds of deliberation, refinement and voting to develop consensus statements and recommendations. An international multidisciplinary group of 22 experts was purposively selected to represent diverse perspectives across healthcare settings and reflected relevant stakeholders in peri-operative shared decision-making. Three consumer advisors were also recruited who had lived experience of major surgery either as a patient or carer.

Results Consensus for recommendations was defined a priori as 75% of all faculty indicating agreement across successive rounds of anonymous voting. Universal consensus was obtained on 25 recommendations, which included a definition of 'universal shared decision-making' for all patients contemplating surgery and referral criteria for 'specialised shared decision-making services' for patients with higher decisional-support needs. The core components of shared decision-making services and priority areas for research were also identified.

Discussion This is the first consensus statement recommendations for peri-operative shared decision-making co-created by consumers and clinicians. It will support the implementation of shared decision-making for patients contemplating surgery.

.....
For full author affiliations, see end of article

Plain Language Summary is available on the journal website.

Correspondence to: Debra Leung

Email: debra.leung@petermac.org

Accepted: 19 February 2026

.....
Re-use of this article is permitted in accordance with the Creative Commons Deed, Attribution 2.5, which does not permit commercial exploitation.

Keywords: complex decision-making; decision support; peri-operative medicine; prehabilitation; shared decision-making

*The POQI XVIII Workgroup members are listed in online Supporting Information Appendix S1.

Why was this consensus statement written?

These recommendations were developed to address the growing need for a structured, operational model of peri-operative shared decision-making. As surgical care becomes increasingly complex, clinicians and patients require clear, practical guidance to support high-quality, values-aligned treatment decisions.

What guidelines currently exist?

While frameworks outline how shared decision-making can be delivered as a model of care; none are specific to the surgical setting [1–3]. Most focus on the clinical interactions between patients and clinicians, with less attention given to how shared decision-making can be integrated into existing broader care pathways (such as the peri-operative journey) where multiple teams, time-points and system factors are involved.

How does this consensus statement differ from existing guidelines?

To our knowledge, no existing consensus recommendations specifically address shared decision-making in the peri-operative setting. These recommendations were developed to fill that gap by combining the available evidence with expert clinical experience and the lived experience of patients. The result is a pragmatic implementable model of care tailored to patients contemplating surgery. This broad, integrative approach aligns with the evolving direction of shared decision-making research [4].

Introduction

Shared decision-making is a collaborative process through which patients and clinicians work together to determine treatment plans informed by evidence, clinical experience and patient preferences. Shared decision-making supports patients to be informed and, to their preferred extent, active participants in their care. While essential for many healthcare decisions, it is particularly important for high-stakes surgical treatment decisions, where the risk of serious adverse outcomes may be high and potentially outweigh the anticipated benefits. Such scenarios are

increasing, yet shared decision-making remains inconsistently embedded in peri-operative care pathways.

Postoperative complications have long-term impacts on function, quality of life and mortality. Rising rates of multimorbidity and frailty in the ageing surgical population, alongside more complex treatment options, contribute to the growing burden of peri-operative complications [5]. Consequently, patients require increased support to make informed surgical decisions [6]. Without sufficient support, patients risk receiving care that is low value, which may be unduly burdensome or misaligned with their goals. Shared decision-making mitigates this risk by improving patient knowledge, encouraging engagement and supporting the generation of informed preferences and realistic expectations of surgical treatment [7]. Thus, the development and implementation of structured decisional support frameworks within peri-operative pathways represent a critical opportunity for quality improvement in surgical care [8, 9].

Niche services have evolved organically to support complex peri-operative decision-making; these differ significantly in structure and approach, resulting in substantive clinical variation [10–12]. This variability reflects the absence of a standardised definition and delivery model for peri-operative shared decision-making, which has impeded broader implementation and research efforts.

Clinical practice guidelines based on systematic reviews support the development of standardised practice. However, in the absence of high-quality evidence, the National Institute for Health and Care Excellence (NICE), advocates using experts and structured consensus techniques to develop guidance that is nuanced and has utility in clinical practice [13]. Here, we describe consensus recommendations developed for peri-operative shared decision-making.

Methods

The PeriOperative Quality Initiative (POQI) is an international non-profit collaboration which convenes multidisciplinary consensus processes to produce clinical guidance recommendations on peri-operative topics [14–18]. Shared decision-making for adult patients considering major surgery was addressed by POQI XVIII.

While the primary focus was major surgery, the process also led to the development of broader recommendations intended to support shared decision-making for all patients contemplating surgical intervention. For this purpose, 'major surgery' was defined as surgery necessitating hospital admission and considered significant by either the patient or clinician. We adopted a person-centric definition recognising that surgery may be significant because of the technical complexity of the proposed procedure, patient multimorbidity (including frailty) and/or personal beliefs specific to the patient.

Building on previous POQI processes and Delphi methods, consensus was achieved through a modified nominal group technique [19–21]. This comprised iterative development of recommendations through alternating small group and plenary sessions. The modified nominal group technique utilised (online Supporting Information Figure S1) was modified from the original methodology described by Delbecq et al. [19]. The nominal group technique is a structured method of consensus seeking particularly suited to complex content areas with limited evidence, is highly adaptable and may be purposively adapted to the topic and expert group [20].

Participants (referred to as faculty) were purposively recruited to obtain international, multidisciplinary representation that reflected stakeholders in peri-operative shared decision-making. Represented disciplines included: surgery; palliative care; nursing; allied health; oncology; specialty medicine; intensive care; bioethics; academia; health service implementation; and anaesthesia. Faculty were drawn from public and private hospital sectors to capture diverse perspectives. Three consumer advisors with lived experience of major surgery either as a patient or carer – both positive and negative – were also recruited.

The following criteria were used to ensure sufficient clinical, academic and experiential knowledge conforming to the notion of 'expert': over 10 years of clinical/academic experience in their specialist area; or substantive investment in peri-operative shared decision-making delivery, implementation, policy development, research and healthcare communication skills.

The 25 faculty were divided into three groups, with each group assigned one of the following questions: "How do we understand shared decision-making in the peri-operative setting in terms of aims, components and intended service population?"; "What should a shared decision-making model of care for patients contemplating major surgery include in terms of structure, service delivery and training?"; and "How do we most effectively measure the process and effects of delivering shared

decision-making to this cohort of patients?" Each group was responsible for initial idea generation and drafting preliminary recommendations related to their assigned question. These draft outputs were then reviewed, debated and refined by the full faculty.

The consensus process comprised seven stages summarised in Fig. 1: stages 1 and 2 were conducted online and stages 3–7 took place in a face-to-face conference over 2.5 days in Melbourne, Australia in October 2024. All stages were chaired by two of the authors (MG and DL).

Before stage 1, a narrative review was conducted to support each of the three working groups. A structured search was executed in Ovid MEDLINE using combinations of terms related to surgery; the peri-operative period; and shared decision-making (online Supporting Information Table S1). To refine results for each of the predefined research questions, extra search concepts were added (e.g. 'decision support tools', 'communication skills', 'education'). The search was limited to English language publications from 2020 onwards. In addition, search results were used to construct a shared reference library for the working groups and participating experts were invited to nominate additional notable articles.

During stages 3–7, iterative rounds of idea generation, deliberation, refinement and voting occurred to develop consensus statements and recommendations. Outputs were organised according to the domains summarised in online Supporting Information Table S2. Consensus was defined a priori as 75% of all faculty indicating agreement (rankings of ≥ 6 on a 9-point Likert scale). Groups assigned a strength and indication of evidence quality to each recommendation utilising a structure consistent with NICE guidance (online Supporting Information Table S3) [24, 25].

Results

Outputs of the consensus process (online Supporting Information Table S4) are reported as either consensus statements or recommendations. Statements provide agreed-upon definitions or contextual clarifications underpinning our use of key terms, while recommendations outline actionable practice points. We report each recommendation with accompanying explanatory text to provide context to the recommendations and to safeguard against oversimplification or inadvertent misapplication. A recommended pathway integrating shared decision-making principles into patient care is summarised in Fig. 2 and the consensus structures and functions to deliver a shared decision-making service model effectively are outlined in Fig. 3. Together, both these serve as

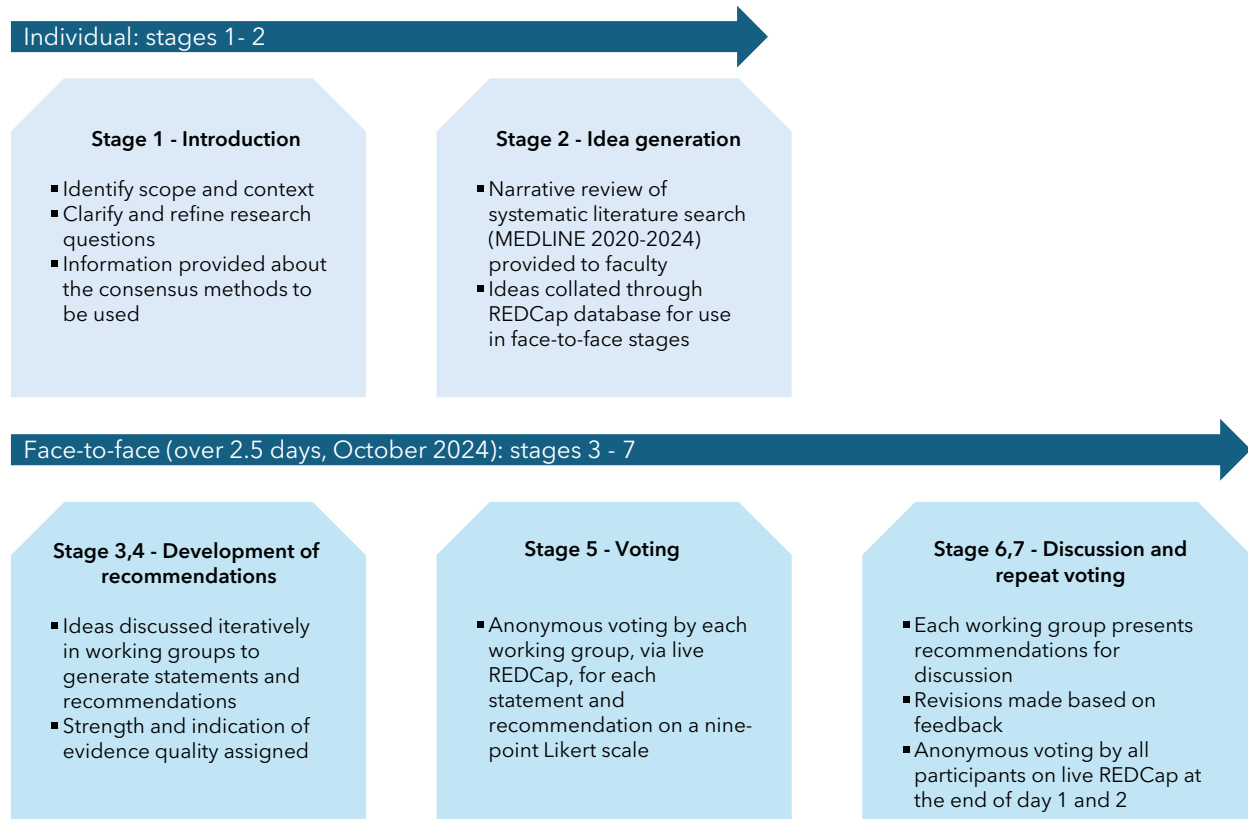


Figure 1 Summary of study protocol. All stages were chaired by DL and MG. Strength and indication of evidence quality for each recommendation assigned utilising a structure consistent with UK National Institute for Health and Care Excellence guidance [22, 23]. REDCap, Research Electronic Data Capture.

an executive summary of the statements and recommendations within this article.

There is no universally accepted definition for peri-operative shared decision-making. Moreover, publications often refer to shared decision-making without delineating the specific intervention encompassed by the term. Multidisciplinary discussions, peri-operative risk discussions and informed consent have all been referred to erroneously as shared decision-making. The lack of an accepted working definition has impeded research and implementation efforts. Hence, the faculty agreed that having a standardised definition of shared decision-making was critical in establishing shared decision-making as a complex intervention with core components and aims that can be replicated and evaluated. The consensus statements in Box 1 outline agreed definitions for peri-operative shared decision-making. We adopted the Australian Commission on Safety and Quality in Healthcare definition of shared decision-making due to its clear articulation of the concept's purpose, process and components [26]. However, to ensure applicability within the peri-operative setting, supplementary elements were included.

The overarching purpose of shared decision-making is to ensure that clinical care is congruent with the goals and preferences of patients. To translate this principle into actionable steps, the faculty identified specific aims, listed in Box 1, that could be mapped to measurable outcomes. The shared decision-making process should be tailored to each patient's desired level of involvement in decision-making, recognising that these preferences can evolve both within and across encounters. Shared decision-making aims to minimise decision regret related to surgery, thereby enhancing satisfaction. Decision regret is defined as negative emotions related to the perception that the outcome would have been better with a different choice. Postoperative regret appears higher in cancer and complex surgeries, and lower when patients are engaged and assume their desired decision-making role [27]. Notably, regret is reduced when patients receive care that is goal congruent [28].

The evidence that shared decision-making benefits peri-operative clinicians is limited but may be extrapolated from other contexts. Shared decision-making has been associated with improved clinician satisfaction and

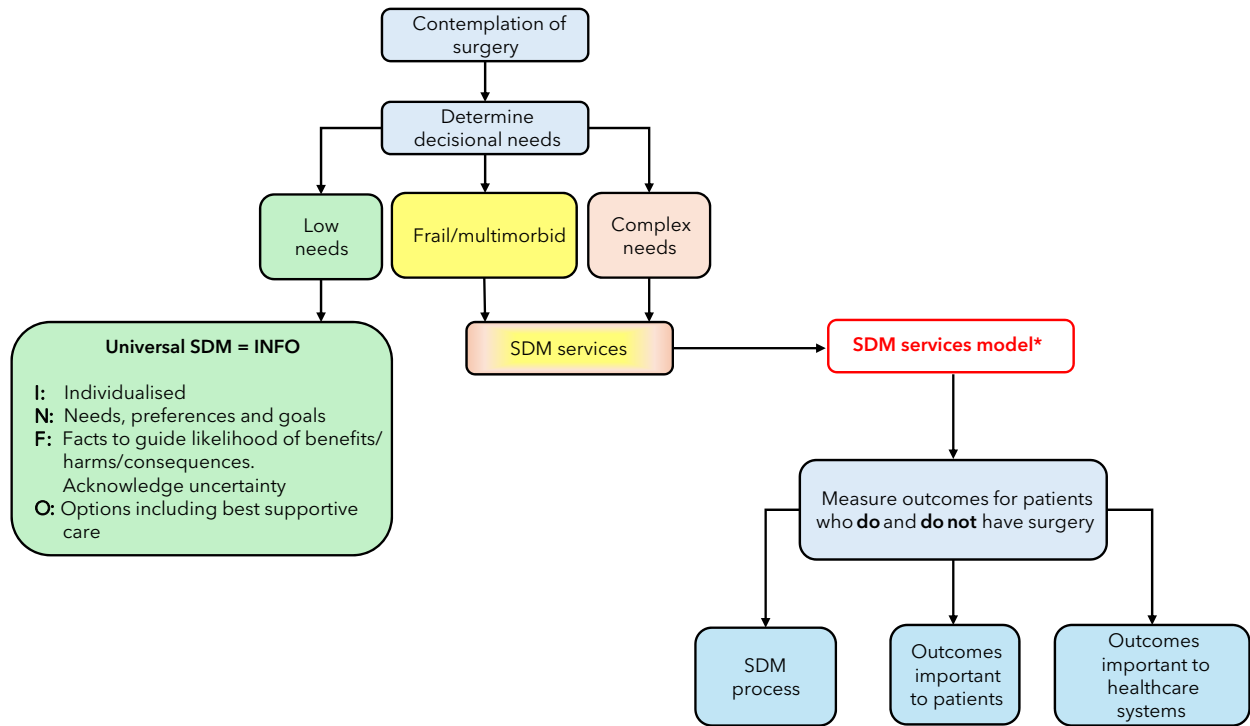


Figure 2 Consensus recommendations represented as a pathway of care for peri-operative shared decision-making. Patients contemplating surgery should have shared decision-making (SDM) principles underpin their care plans. Patients should be triaged according to their decisional needs, allowing resources to be apportioned accordingly. Those with lower decisional needs may be effectively supported by universal SDM, while those with higher needs may be more efficiently supported by dedicated SDM services. This resource-matched model aims to support efficient, equitable and goal-concordant care. The SDM services model is shown in Figure 3.

wellbeing [29]. Patients are also more likely to adhere to behaviour change advice if they perceive it aligns with their stated goals [30]:

- **We recommend that all patients receive ‘universal shared decision-making’ encapsulated in the acronym INFO: I = individualised (type and degree of information, and how much patients wish to be involved in discussions about care); N = needs, preferences and goals (for the future and for treatment); F = facts (best available evidence to guide likelihood of benefits, harms and consequences acknowledging uncertainties where these exist); and O = Options (which may be surgical or non-surgical treatments including watchful waiting or best supportive care) (good practice statement, strong recommendation).**

Although the guidance presented here focuses on major surgery, the development process underscored the need to define a consistent approach to shared decision-making applicable across all surgical contexts. As a result,

recommendation 1 above proposes the concept of ‘universal shared decision-making’ as a practical tool for all patients contemplating surgery. This novel term serves as an aide-mémoire (captured by the acronym INFO) to ensure consistent consideration of key elements when discussing surgery with any patient. Effective use of INFO requires tailoring communication to individual patients and avoiding jargon. This approach mirrors successful initiatives implementing shared decision-making across entire hospitals [31, 32] and health systems [33], showing its feasibility at scale; INFO is informed by this international experience, aiming to translate established principles into the surgical context.

While universal shared decision-making aims to support all patients, some will require greater decisional support. This increased need may stem from the complexity of the proposed surgery, concerns regarding the balance of peri-operative risks and benefits, or the patient’s psychosocial context (Fig. 4). Various models of care have evolved to provide enhanced support, including shared decision-making and complex decision-making services

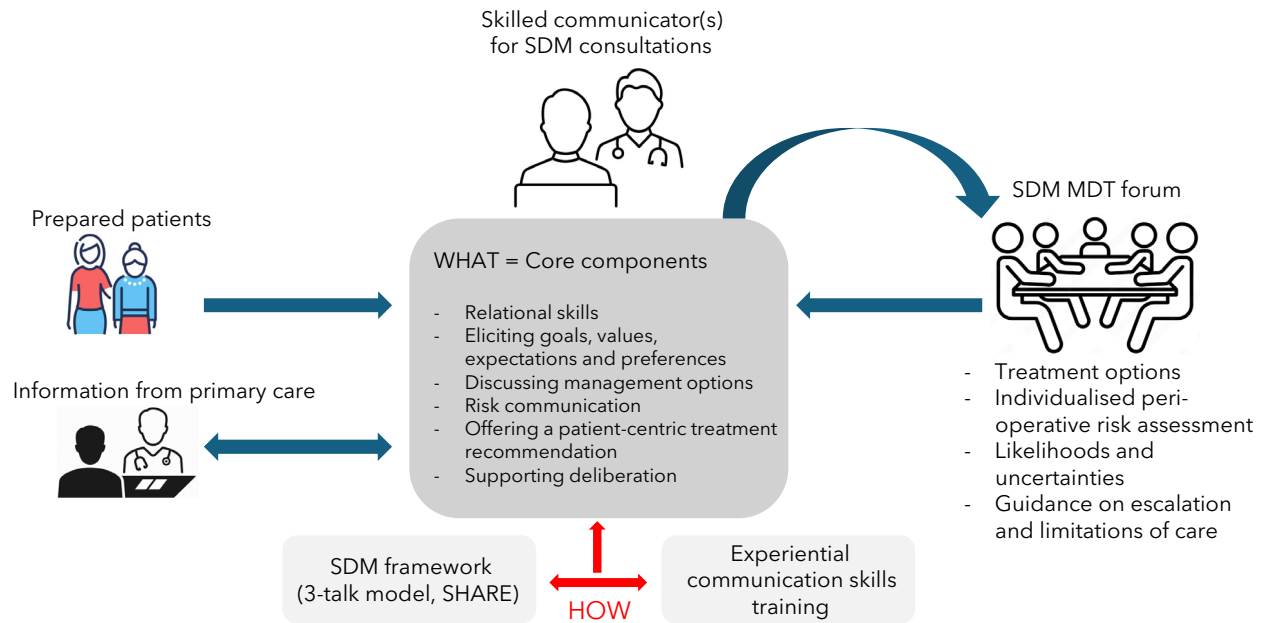


Figure 3 Shared decision-making services model. The consensus structure and function of dedicated shared decision-making (SDM) services should include some necessary inputs such as prepared patients and support persons; relevant information from primary and community care; a multidisciplinary team (MDT) forum for information exchange; and skilled communicators. It also defines the core components that should be addressed during the SDM consultation (what needs to be covered) and highlights the essential skills and frameworks required to effectively deliver the consultation (how it should be delivered).

and 'Perioperative care of the Older Person undergoing Surgery' clinics [34]. For the rest of this article we refer to these collectively as 'shared decision-making services', acknowledging their shared goal of providing enhanced decisional support. We recommend that:

- **All healthcare workers encountering patients in the peri-operative journey consider the need for enhanced decisional support and refer accordingly (good practice statement, strong recommendation).**
- **Peri-operative services have mechanisms to identify patients who may require enhanced decisional support (good practice statement, strong recommendation).**
- **A senior healthcare worker performs a secondary triage to prioritise referrals to ensure peri-operative shared decision-making resources are allocated efficiently (good practice statement, strong recommendation).**
- **First contact with peri-operative shared decision-making services (when appropriate) should be as early as possible after contemplation of surgery and repeated as often as needed (good practice statement, strong recommendation).**

There are no established criteria for identifying patients who may require greater decisional support. We propose

shared decision-making services develop locally tailored screening processes and referral criteria, incorporating patient-specific factors (e.g. comorbidities, patient concerns, health literacy) and surgical factors. To ensure timely referral, we recommend proactive screening of patients considering surgery to identify those with increased decisional support needs. To avoid overwhelming service capacity, we recommend referrals are triaged by a senior peri-operative clinician based on need, urgency and resources. This role is suited to a senior nurse or doctor who is knowledgeable about the surgical procedures undertaken in their institution and can liaise between peri-operative teams:

- **We recommend the following components are required for an effective peri-operative shared decision-making service: knowledge of patient values (i.e. their preferences, goals, how they like to be supported, how they like to make decisions); skilled (and trained) communicator(s) for patient conversations; access to long-term health information about the patient (e.g. from primary care or community-based services); an individualised peri-operative risk assessment; and knowledge of surgical and non-surgical treatment options including watchful waiting or symptom management (good practice statement, strong recommendation).**

Box 1 Agreed definitions for peri-operative shared decision-making

Shared decision-making is a consultation process where a clinician/s and patient jointly participate in making a health decision, having discussed the treatment options and the likelihood of benefits and harms, and having considered the patient's values, preferences and goals. Peri-operative shared decision-making focuses on decisions about surgery and alternatives, particularly where there is concern and/or where the anticipated harms may outweigh benefits.

The aims of peri-operative shared decision-making are shown below.

For the patient:

- Involvement in decision-making to the extent that they wish to be
- Formulation of a goal-congruent collaborative care plan that takes into account (potentially dynamic) personal values and preferences at the time of decision-making
- Satisfaction with decisions
- Reduced decision regret

For healthcare workers:

- Delivery of individualised evidence guided care
- Satisfaction with the decision-making process
- Reduced moral distress

For the health system:

- Promoting high value care

Effective communication between healthcare professionals underpins high quality peri-operative shared decision-making.

Our proposed framework of core components offers a flexible approach to developing shared decision-making services, acknowledging the need to adapt to specific patient populations and operational constraints. When establishing services, a needs assessment should be conducted to determine the necessary roles and staffing required to deliver these core components. Services should be led by invested clinicians who possess appropriate training, understanding of the peri-operative pathways and

the ability to engage stakeholders. Whilst the leadership and composition of services may differ with the clinical and institutional setting, the focus is on ensuring the core components are implemented effectively rather than prescribing a rigid model.

Delivery and systems

Shared decision-making aims to co-create care plans that unite clinicians' evidence-based knowledge of benefits, risks and harms with the patient's knowledge of their goals and preferences. As a prerequisite to shared decision-making discussions, clinicians must first collectively determine the available treatment options. This clinical decision-making process provides the foundation for subsequent shared decision-making discussions. We recommend that:

- **All healthcare professionals relevant to the peri-operative shared decision-making process are engaged to ensure evidence-based information is exchanged between them (good practice statement, strong recommendation).**
- **A multidisciplinary forum is established to collate information and consider all management options in order to inform the shared decision-making consultation with the patient (good practice statement, strong recommendation).**
- **Communication related to the shared decision-making process should include patient's circumstances and their goals, values and preferences (good practice statement, strong recommendation).**

Patients who require greater decisional support frequently have complex medical and psychosocial needs, requiring the input of multiple teams. This can lead to patients inadvertently receiving apparently contradictory information from different sources, exacerbating decisional conflict. Furthermore, presenting surgery as the 'best treatment' before assessing peri-operative risk can create confusion. To support effective decision-making, it is essential that this group of patients receive information about treatment options and their individualised risks and benefits, delivered through a single point of contact after discussions between clinicians.

We recommend that all specialties involved in the care of patients who require greater decisional support convene early after contemplation of surgery to discuss peri-operative risk; opportunities for risk modification; alternatives (including non-surgical and palliative-intent treatments); anticipated outcomes of each treatment option; and the trade-offs entailed by each. This should

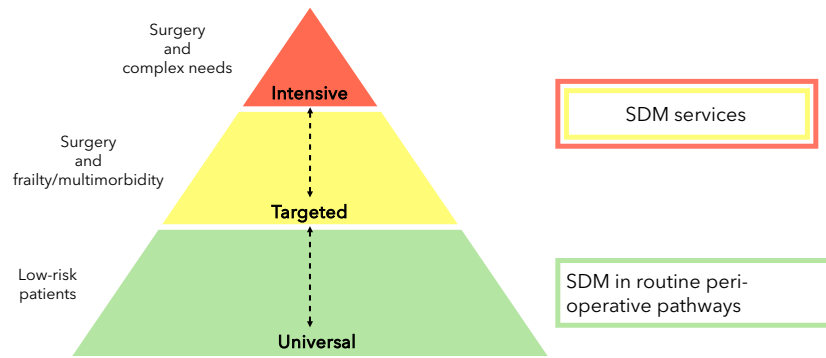


Figure 4 Tiered shared decision-making delivery (SDM). All patients contemplating surgery should receive SDM, with their decisional needs matched to the degree of decisional support required. All low-risk patients (green) considering surgery should receive universal SDM, delivered through routine peri-operative pathways. Although termed ‘universal’, SDM remains tailored to each patient’s needs and preferences. Patients requiring greater decisional support (yellow and red) may benefit from enhanced decisional support provided by dedicated SDM services with appropriate resourcing. Patients may move between tiers as their decisional support needs vary across time. (Adapted from NHS England – Comprehensive Model for Personalised Care [35]).

include clinicians outside acute care (e.g. primary care, community-based services). Where possible, we recommend this multidisciplinary forum precedes the shared decision-making consultation with the patient. This forum may be a formal shared decision-making multidisciplinary team meeting or may be informal with the shared decision-making clinician gathering various viewpoints. These discussions should be detailed in the patient’s medical record to inform subsequent shared decision-making consultations and avoid information loss from informal ‘corridor consultations’.

It is important to distinguish the shared decision-making forum from a prototypical surgical multidisciplinary team meeting. While surgical multidisciplinary teams focus on optimising disease outcomes, shared decision-making forums prioritise patient-centred outcomes. Critically, shared decision-making forums should not make decisions for patients. Following shared decision-making consultation(s) with the patient, the forum should reconvene to discuss the agreed-upon treatment and next steps. We recommend that:

- **Patients and support persons are informed about and prepared for shared decision-making consultations (good practice statement, strong recommendation).**
- **The patient is invited to involve support person(s) in shared decision-making appointments and processes (good practice statement, strong recommendation).**

Shared decision-making consultations require an appropriate setting and sufficient clinician time. Clinician

preparation includes gathering information and considering how to tailor the style and content of consultations to match linguistic, cultural and health literacy requirements [36, 37]. Validated tools such as the Control Preferences Scale may be used to evaluate the decision-making preferences of patients [38].

Patient engagement enhances the quality of shared decision-making. Therefore, patients should be provided with paper-based or digital information (videos/smartphone applications) to prepare them for the purpose and format of consultations [39]. Considering a patient’s preferred decision-making style includes recognising when they wish to involve support people and actively facilitating their inclusion where appropriate. Here, we have used the term ‘support persons’ to refer to family, friends, carers and others considered significant to the patient. Question prompt sheets which encourage patients to consider what is important to them ahead of time may be considered. However, evidence suggests they only improve engagement if used as a catalyst and not a replacement for discussions [40, 41].

Shared decision-making consultations can be challenging and therefore clinicians should undertake experiential training covering shared decision-making frameworks and the core skills required to operationalise them. Commonly adopted shared decision-making frameworks include the 3-Talk Model [42]; Ottawa Decision Support Framework [43]; SHARE model [44]; and 5-Q approach [26]. Although the core competencies of shared decision-making are debated [45], most models share commonalities, which we have condensed in the consensus statements in Box 2:

Box 2 Agreed core competencies of shared decision-making

Core skills underpinning shared decision-making include the following domains: relational skills (building trust, rapport and empathy); eliciting patient goals, values, expectations, preferences; discussing management options (including benefits, harms, consequences, risks, likelihoods and uncertainties/unknowns); risk communication; provision of a patient-centric treatment recommendation with a rationale; and supporting deliberation to a person-centred decision.

Core evidence-based communication skills are fundamental to the shared decision-making process and ensure effective communication with patients and support persons.

- **We recommend clinicians who are providing shared decision-making to patients who require greater decisional support participate in experiential skills training to develop core skills, using shared decision-making frameworks such as the 3-Talk model, SHARE model or 5-Q approach (high quality, strong recommendation).**

Individualising risk information and eliciting informed preferences present a challenge for all clinicians [46]. Rather than being purely rational, decisions can be influenced heavily by emotion, past experiences and informal representations of ‘gist’ [47]. Most shared decision-making workshops do not address the complexities and uncertainties encountered in real-world settings adequately [48]; nor do they focus sufficiently on communication skills. This may explain why, despite training improving clinician knowledge and confidence, this does not translate consistently to enhanced patient engagement in shared decision-making [48]. Therefore, we recommend experiential communication skills training focused on acquiring microskills that can be adapted flexibly to individual needs (Table 1).

Risk communication is a difficult but essential component of shared decision-making. Even patients with strong literacy skills struggle to grasp the nuances of risk [50]. This challenge is amplified for patients with low health literacy. To navigate these complexities, key principles include supplementing verbal communication with written materials; using natural frequencies (e.g. 1 in 10) rather than

percentages; and using visual representations of risk and icon arrays.

To be meaningful, risk needs to be individualised. Risk discussions should include anticipated harms, unintended consequences and temporary/permanent loss of function. Where it exists, uncertainty should also be acknowledged. Risk should be contextualised within a patient’s broader health trajectory. For some, the risk of dying from comorbidities may exceed the risk posed by the condition for which surgery is being considered. Outcomes which are considered unacceptable to the patient should also inform discussions about treatment limitations and when these should be re-evaluated:

- **We recommend decision aids which adhere to International Patient Decision Aid Standards should be used where available. However, for patients who require greater decisional support, stated benefit and harm likelihoods in decision aids are often inaccurate, and this should be communicated to patients. In this setting, they should only be used in conjunction with peri-operative shared decision-making processes (moderate quality, strong recommendation).**

Patient decision aids are evidence-based ‘tools that can be used to assist patients and clinicians to achieve shared decision-making’ [51]. They support patient-centred decision-making by incorporating patients’ preferences alongside information about the condition and available treatment options. They have been embraced for their ability to improve patient knowledge, reduce decisional conflict and improve decisional satisfaction [51, 52].

Decision aids are valuable tools but, used alone, do not constitute the provision of shared decision-making. Importantly, the population-based treatment risks presented in decision aids may not accurately reflect the risks faced by patients requiring greater decisional support. Therefore, they should be used with caution. Where used, we recommend that they adhere to International Patient Decision Aid Standards which provide an ‘evidence-informed framework to guide developers and researchers in their development, content, evaluation, and implementation’ [53]. We also recommend that:

- **Patients have access to a record of the peri-operative shared decision-making consultation (good practice statement, strong recommendation).**
- **The outcomes of peri-operative shared decision-making consultations are documented and**

Table 1 Peri-operative application of the Three Talk Model: tasks and illustrative phrases [42].

	Tasks	Example phrases
Team talk	Outline role of peri-operative shared decision-making	“We need to figure out the best way forward/treatment for you”
	Establish an early negotiated shared agenda and reinforce partnership using partnership language	“Our job is to support you in deciding which treatment is right for you”
	Individualisation	“Some people like to know all the details, while others prefer just the key points. What feels right for you?”
	Tailor the process for decision-making preferences	“How can I best support you working through this decision?” “Do you usually like to talk through decisions with family or friends, or do you prefer to think through things on your own first?”
	Identify goals for treatment and goals for the future	Values driven goals: “Before we think about treatment options, I'd like to know more about you” “What is a normal day like?” “What is a good day like?” “What brings you joy/ a smile to your face?” “What are you missing out on?”
	Identify unacceptable goals or trade-offs	Treatment oriented goals: “What would make you feel like the operation was a success?” “What's bothering you the most that you'd want the operation to address?” “What would you like to do more of, as a result of any treatment we might decide on?” “What do you need to be able to do in order to have what you consider an acceptable quality of life?” “What would worry you the most if you couldn't do it anymore?” “What outcome would make all of this not worth it?”
Option talk	Minimise bias	“Let's think through the options together”
	Defer closure	“As we think through each option in turn, let me know what thoughts come to mind”
	Attend to health literacy: chunk and check and consider teach back	“Having thought through all these options, are there any that you would rule out?”
	Communicate individualised peri-operative risk including acknowledging uncertainty	‘Best Case, Worst Case’ [49] “It may be helpful for me to paint a picture of what each of these treatment options may look like for you”
Decision talk	Invite informed preference construction	“How ready do you feel to make a decision? What would need to be in place to help you feel more ready?” “What other information do you think you would find helpful?” “Let's start thinking about the best option for you” “We've thought through the options; are there any that feel like the right course of action for you?” “If so, what led you to prefer that treatment?” “If so, what led you to rule out the other treatment?”
	If appropriate, offer a patient-centric treatment recommendation	“Based on what you have told me is important to you, we feel that X treatment may be most likely to help you achieve this. Let me talk you through why” “This is only a recommendation; the decision is still yours”
	Plan next steps together.	“Let's talk about what comes next”

accessible in a timely manner to clinicians and patients (good practice statement, strong recommendation).

- **The peri-operative shared decision-making process should be documented in a structured format with agreed upon minimum domains (good practice statement, strong recommendation).**

Peri-operative pathways increasingly involve multiple teams and depends on reliable information exchange. Informational loss during health setting transitions leads to increased risk for patients [54] and contributes to non-goal congruent care. Documenting the shared decision-making process is essential to mitigate these risks and ensure core

components are covered. Documentation should be easily locatable and adhere to a broadly standardised format to ensure consistent clear communication among clinicians. Minimum domains for documentation should be mapped to the core components shown in Box 2.

Measuring impact

Measuring the effectiveness of shared decision-making is challenging, as no consensus exists on the optimal outcome measures. The heterogeneity of outcome measures represented in the literature makes it challenging to compare and synthesise findings across studies, hindering a comprehensive understanding of the evidence [55, 56]. Identifying a standard outcome set should be a target for future research.

Recognising the importance of a coherent approach to evaluation, the faculty developed a consensus statement (Box 3) to anchor the development of a peri-operative shared decision-making measurement strategy. This statement serves as the basis for the subsequent recommendations on what and how to measure. When developing a measurement strategy, identify the core stakeholders and select measures suited to their purposes. A clinical team developing a new service may prioritise measures of the shared decision-making process to drive improvement, whereas an established service might focus on the impact on surgical activity and longer-term patient outcomes.

We recommend measuring, at minimum, a process measure of shared decision-making, a patient outcome measure and a health system outcome measure. Furthermore, we recommend collecting outcomes for patients who both do and do not proceed to surgery. Ideally, these should be repeated 6–12 months after the original decision.

For measuring the shared decision-making consultation, we recommend a standardised tool such as the SDM-Q9, Decisional Conflict Scale [57], SURE [58] or

CollaboRATE [59]. However, it is important to recognise that these tools have inherent limitations. Notably, many focus on temporally discrete decision points, which may not accurately reflect the more iterative and prolonged decision-making process common in peri-operative settings. Therefore, we recommend:

- **Institutions use standardised measures for capturing patient-reported measures (e.g. the SDM-Q9 or CollaboRATE for extent of involvement, or Decisional Conflict Scale or SURE for decisional conflict) at suitable intervals throughout the peri-operative period (moderate quality, strong recommendation).**
- **For patients, conduct patient-reported measures which capture multiple constructs, such as the extent to which the patient felt involved and informed in the shared decision-making process; decisional conflict and regret; treatment choice and preference; quality of life; and alignment of decision/outcomes with stated goals (moderate quality, strong recommendation).**

Given that traditional outcomes like mortality and morbidity may not fully reflect the impact of shared decision-making [2], we propose a shift to include patient-reported outcome measures. However, to avoid burdensome data collection, a selective approach to measurement is warranted:

- **For healthcare systems, we recommend measurements such as the effectiveness of peri-operative shared decision-making clinic triage of complex patients; shared decision-making clinic utilisation; uptake of non-surgical treatment options; and patient reported experience measures and patient reported outcome measures that reflect patient satisfaction and experience with overall care (moderate quality, strong recommendation).**
- **For healthcare systems examining the value proposition of shared decision-making, we recommend that measurements already captured by other processes may be useful for assessing shared decision-making outcomes and conducting cost-effectiveness analyses, including changes in postoperative complication rates; duration of hospital stay and readmission rates; and 30- and 90-day mortality (moderate quality, strong recommendation).**

When evaluating shared decision-making services, clinical and resource utilisation outcome measures should be mapped to an implementation science framework such

Box 3 Agreed approach to evaluating peri-operative shared decision-making measurement implementations

Processes and outcomes should be measured to assess the efficacy of shared decision-making for the patient and for the healthcare system, for patients that do, and do not, proceed to surgery.

as RE-AIM [60]. While financial stakeholders understandably seek to elucidate the economic implications of shared decision-making, it must remain primarily an end in itself, grounded in the ethical principles of autonomy, beneficence and justice, and driven by a commitment to high-quality, patient-centred care. Nevertheless, given resource limitations, the health economics of shared decision-making should be evaluated.

Concerns exist within the shared decision-making community that focusing on economic evaluation may shift the focus inadvertently away from patient-centeredness. Although evidence suggests shared decision-making can mean some patients choose less invasive treatments, a clear correlation with cost reduction is lacking. In the interim, until robust methods for economic evaluation are developed, routinely collected metrics such as duration of hospital stay, postoperative complication rates and unplanned ward/ICU admissions can offer valuable data for business cases and cost-effectiveness analyses.

Optimising reach

- **We recommend that cross-culturally informed and responsive universal shared decision-making is offered to all patients contemplating surgery as part of routine peri-operative practice (good practice statement, strong recommendation).**
- **We recommend engagement with marginal and vulnerable populations and representatives of diverse cultures to ensure the creation and adoption of a cross-culturally informed and responsive shared decision-making service (good practice statement, strong recommendation).**

Shared decision-making is easier to enact with patient populations who are educated, empowered and able to advocate for their needs, thereby inadvertently reinforcing existing health disparities [22]. Similarly, “*Western-oriented health care settings are built to support Western-oriented values and approaches to health...*” [23]. There is evidence to suggest that minority groups receive lower quality shared decision-making overall, but that culturally responsive shared decision-making approaches benefit those who experience disadvantage [22].

Building culturally responsive shared decision-making services requires buy-in from clinicians and organisations. Most shared decision-making models concentrate on the physician-patient interaction but the organisational context in which shared decision-making occurs is equally important in shaping how patients engage [61]. Organisational change that engenders trust and provides

culturally safe spaces for shared decision-making is likely to be transformational in creating sustainable shared decision-making services. Themes from the literature advocate partnering with priority populations and leveraging community-based assets to co-create high quality solutions-focused research [23]. For example, ‘Finding Your Way’, which is a culturally adapted shared decision-making resource for First Nations Peoples of Australia [62]. We recommend that:

- **Institutions undertaking major surgery or offering surgery to patients with complex health needs establish a dedicated peri-operative shared decision-making service (good practice statement, strong recommendation).**
- **The use of telehealth to maximise reach of shared decision-making services to regional and remote areas (good practice statement, strong recommendation).**

Most peri-operative pathways do not currently include a shared decision-making service. Having centres where expertise, training and resources are concentrated, may represent the most efficient and sustainable model of care. Such services could act as hubs with spokes out to regional and rural services. These spokes could assume the form of either direct provision of telehealth consultations or the provision of support and training to local clinicians:

- **We recommend that shared decision-making education is embedded in healthcare training curricula (high quality, strong recommendation).**

Currently, a theory-practice gap hinders the widespread adoption of shared decision-making. Thus, education initiatives that impart the attitudes, knowledge and skills essential for shared decision-making are recommended for clinicians, across disciplines and levels of seniority. Knowledge about shared decision-making frameworks should be complimented by parallel training in communication skills [63] and relational competencies which are those skills that create an environment which fosters communication and collaboration [45]. Universal training in this manner would embed shared decision-making as standard peri-operative care. Clinicians with a special interest could undertake advanced training to provide specialised shared decision-making for patients who require greater decisional support.

Discussion

Given the growing enthusiasm to embed shared decision-making into peri-operative pathways, the development of pragmatic, consensus-based recommendations is

necessary and timely. Recognising the limited evidence base in the surgical setting, we developed this guidance to promote an operational definition and replicable framework for peri-operative shared decision-making – one that can support both high-quality research and consistent clinical implementation.

The consensus methods employed here encouraged balanced participation and allowed the opinions of all participants to be voiced and considered in real time. Although the consensus threshold was pre-determined at 75%, all recommendations reached unanimous agreement, underscoring the strong alignment of the expert faculty around the final outputs. While efforts were made to ensure diverse multidisciplinary representation, the limited sample size reflects an inherent constraint of consensus-based methodologies. Involving consumers as part of our expert faculty helped to ensure that the guidance remains focused on the needs of the end-users.

Where high-quality evidence was lacking, recommendations were developed based on the clinical expertise of the faculty and extrapolated from shared decision-making research conducted in non-surgical settings. The evidence informing peri-operative shared decision-making is developing rapidly, and it is likely that these recommendations will require revision to reflect evolutions in practice and research.

It is important to acknowledge that the conceptual foundations of shared decision-making, including those

discussed in this project, are grounded in Western medical traditions. These traditions tend to emphasise individual autonomy, technically-oriented perceptions of risk and Western-aligned values and preferences – features that may inadvertently privilege patients who share these perspectives [64]. A growing body of work has highlighted the need for culturally responsive approaches to shared decision-making, particularly in non-Western settings where decision-making involves family, reflects culturally embedded belief systems or is shaped by systemic mistrust in healthcare institutions [65]. This is a vital and evolving area of research and, in recognition of this, our recommendations include the development of culturally responsive shared decision-making services. However, as a pragmatic first step, we have proposed a foundational model of peri-operative shared decision-making that can then be adapted and contextualised to better align with the cultural norms and expectations of diverse patient populations. Additional research opportunities identified by the faculty have been listed in Box 4.

The scope of this topic is substantial and, while we attempted to address key aspects of peri-operative shared decision-making, certain areas remain outside the remit of this guidance. In keeping with our focus on developing a model of care, we have not provided detailed recommendations on all the listed components. For example, while individualised peri-operative risk assessment is recognised as a critical element of

Box 4 Future research priorities for peri-operative shared decision-making

Design and adaptation of perioperative shared decision-making models of care:

- 1** Co-design models of care with consumers
- 2** Explore stakeholder perspectives on the acceptability, feasibility and perceived impact of models of care
- 3** Assess the role of primary care in supporting peri-operative shared decision-making across transitions of care

Implementation:

- 4** Conduct implementation studies of shared decision-making in the peri-operative setting
- 5** Develop decision aids, tailored to the surgical context, that support individualised risk communication
- 6** Evaluate the impact of experiential communication skills training on delivery of peri-operative shared decision-making

Evaluation and sustainability:

- 7** Develop a peri-operative shared decision-making core outcome set
- 8** Create a core outcome measurement set mapped to the core outcome set
- 9** Conduct economic evaluations of perioperative shared decision-making models of care, including cost-effectiveness
- 10** Develop funding and reimbursement models to support sustainable integration of shared decision-making services in peri-operative pathways

peri-operative shared decision-making – underpinning risk communication and shaping discussions about likely functional outcomes – we did not evaluate or endorse particular risk calculators or predictive tools.

This represents the first clinical practice guidance for peri-operative shared decision-making, co-produced by clinicians and patients. It aims to support the integration of universal shared decision-making into routine pathways, while also guiding the development of specialised shared decision-making services for patients with more complex decisional needs. By proposing a standardised model of care, it lays the groundwork for consistent practice and provides a platform for advancing future implementation research efforts.

Author affiliations

Debra Leung,¹ Alf Collins,^{2,3} Jennifer Philip,⁴ Michael P. W. Grocott,⁵ Bernhard Riedel,⁶ and Denny Z. H. Levett,⁷ on behalf of the PeriOperative Quality Initiative XVIII (POQI XVIII) Workgroup

1 Specialist Anaesthetist, 6 Director, Department of Anaesthesia, Pain and Perioperative Medicine, Peter MacCallum Cancer Centre, Melbourne, VIC, Australia
4 Professor, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Parkville, VIC, Australia

1 Senior Clinical Fellow, 6 Professor, Centre for Integrated Critical Care, Department of Medicine and Radiology, University of Melbourne, Parkville, VIC, Australia

1 PhD candidate, 6 Professor, Sir Peter MacCallum Department of Oncology, University of Melbourne, Parkville, VIC, Australia

2 Visiting Professor, Centre for Intelligent Healthcare, Coventry University, Coventry, UK

3 Trustee, The Patient's Association, UK

5,7 Professor, Perioperative and Critical Care Theme, NIHR Southampton Biomedical Research Centre, University Hospital Southampton/University of Southampton, Southampton, UK

Acknowledgements

MG, BR and DL contributed equally to this article as senior authors. AC is an independent contractor, supporting teams and organisations to implement shared decision-making. RK was supported by an Australian Government Research Training Program Scholarship. JF is a co-director in a peri-operative medical company where shared decision-making is implemented to help patients with surgical decision-making. IB was supported by an NHMRC Investigator Grant. MC is a contractor, supporting teams and organisations to

implement healthcare communication and person-centred care initiatives. No statistical code or data were generated. Open access publishing facilitated by The University of Melbourne, as part of the Wiley - The University of Melbourne agreement via the Council of Australasian University Librarians

References

1. Elwyn G, Gulbrandsen P, Leavitt H, et al. Shared decision-making. A primer for clinicians. *J Gen Intern Med* 2025; **40**: 3889–99. <https://doi.org/10.1007/s11606-025-09707-z>.
2. Montori VM, Ruisen MM, Hargraves IG, Brito JP, Kunneman M. Shared decision-making as a method of care. *BMJ Evid Based Med* 2023; **28**: 213–7. <https://doi.org/10.1136/bmjebm-2022-112068>.
3. Coulter A, Collins A, Edwards A, et al. Implementing shared decision-making in UK: Progress 2017–2022. *Z Evid Fortbild Qual Gesundhwes* 2022; **171**: 139–43. <https://doi.org/10.1016/j.zefq.2022.04.024>.
4. Hoffmann TC, McCaffery KJ, Légaré F, Bakhit M, Tracy M. From words to action: time for Australia to take shared decision making implementation seriously. *Med J Aust* 2025; **223**: 391–6. <https://doi.org/10.5694/mja2.70065>.
5. Nepogodiev D, Martin J, Biccard B, et al. Global burden of postoperative death. *Lancet* 2019; **393**: 401. [https://doi.org/10.1016/s0140-6736\(18\)33139-8](https://doi.org/10.1016/s0140-6736(18)33139-8).
6. Grocott MPW, Edwards M, Mythen MG, Aronson S. Peri-operative care pathways: re-engineering care to achieve the 'triple aim'. *Anaesthesia* 2019; **74**: 90–9. <https://doi.org/10.1111/anae.14513>.
7. Niburski K, Guadagno E, Abbasgholizadeh-Rahimi S, Poenaru D. Shared decision making in surgery: a meta-analysis of existing literature. *Patient Patient-Centered Outcomes Res* 2020; **13**: 667–81. <https://doi.org/10.1007/s40271-020-00443-6>.
8. Spatz ES, Krumholz HM, Moulton BW. Prime time for shared decision making. *JAMA* 2017; **317**: 1309–10. <https://doi.org/10.1001/jama.2017.0616>.
9. Ubbink DT. Shared decision-making should be a standard part of surgical care. *Br J Surg* 2022; **109**: znac291. <https://doi.org/10.1093/bjs/znac291>.
10. Pham CT, Gibb CL, Fitridge RA, Karnon J, Hoon E. Supporting surgeons in patient-centred complex decision-making: a qualitative analysis of the impact of a perioperative physician clinic. *BMJ Open* 2019; **9**: e033277. <https://doi.org/10.1136/bmjopen-2019-033277>.
11. Omundsen HC, Franklin RL, Higson VL, Omundsen MS, Rossak JL. Perioperative shared decision-making in the Bay of Plenty, New Zealand: audit results from a complex decision pathway quality improvement initiative using a structured communication tool. *Anaesth Intensive Care* 2020; **48**: 473–6. <https://doi.org/10.1177/0310057x20960734>.
12. Lal R, O'Halloran T, Santhirapala R, Dhese J, Partridge J. Implementing shared decision making according to the choosing wisely programme: perioperative medicine for older people undergoing surgery. *J Eval Clin Pract* 2023; **29**: 774–80. <https://doi.org/10.1111/jep.13827>.
13. Jackson A, Hettinga DM, Mead J, Mercer C. Using consensus methods in developing clinical guidelines for exercise in managing persistent low back pain. *Physiotherapy* 2009; **95**: 302–11. <https://doi.org/10.1016/j.physio.2009.08.001>.
14. Wischmeyer PE, Carli F, Evans DC, et al. American Society for Enhanced Recovery and Perioperative Quality Initiative Joint Consensus Statement on nutrition screening and therapy within a surgical enhanced recovery pathway. *Anesth Analg* 2018;

- 126:** 1883–95. <https://doi.org/10.1213/ane.0000000000002743>.
15. Hughes CG, Boncyk CS, Culley DJ, et al. American Society for Enhanced Recovery and Perioperative Quality Initiative Joint Consensus Statement on postoperative delirium prevention. *Anesth Analg* 2020; **130**: 1572–90. <https://doi.org/10.1213/ane.0000000000004641>.
 16. Ibekwe SO, Deschamps J, Grocott MPW, Liang Y, Shaw A, E. Perry T. Perioperative quality initiative (POQI) consensus statement on perioperative assessment of right ventricular function. *Perioper Med* 2023; **12**: 66. <https://doi.org/10.1186/s13741-023-00351-x>.
 17. Saugel B, Fletcher N, Gan TJ, et al. PeriOperative quality initiative (POQI) international consensus statement on perioperative arterial pressure management. *Br J Anaesth* 2024; **133**: 264–76. <https://doi.org/10.1016/j.bja.2024.04.046>.
 18. Sessler DI, Bloomstone JA, Aronson S, et al. Perioperative quality initiative consensus statement on intraoperative blood pressure, risk and outcomes for elective surgery. *Br J Anaesth* 2019; **122**: 563–74. <https://doi.org/10.1016/j.bja.2019.01.013>.
 19. Delbecq AL, Van de Ven AH. A group process model for problem identification and program planning. *J Appl Behav Sci* 1971; **7**: 466–92. <https://doi.org/10.1177/002188637100700404>.
 20. McMillan SS, King M, Tully MP. How to use the nominal group and Delphi techniques. *Int J Clin Pharmacol* 2016; **38**: 655–62. <https://doi.org/10.1007/s11096-016-0257-x>.
 21. Fisher RJ, Riley-Bennett F, Russell L, Lee C, Sturt R, Walker M, Sackley C. Nominal group technique to establish the core components of home-based rehabilitation for survivors of stroke with severe disability. *BMJ Open* 2021; **11**: e052593. <https://doi.org/10.1136/bmjopen-2021-052593>.
 22. Durand M-A, Carpenter L, Dolan H, Bravo P, Mann M, Bunn F, Elwyn G. Do interventions designed to support shared decision-making reduce health inequalities? A systematic review and meta-analysis. *PLoS One* 2014; **9**: e94670. <https://doi.org/10.1371/journal.pone.0094670>.
 23. Jull J, Fairman K, Oliver S, Hesmer B, Pullattayil AK. Interventions for Indigenous Peoples making health decisions: a systematic review. *Arch Public Health* 2023; **81**: 174. <https://doi.org/10.1186/s13690-023-01177-1>.
 24. Guyatt GH, Oxman AD, Vist GE, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ* 2008; **336**: 924–6. <https://doi.org/10.1136/bmj.39489.470347.ad>.
 25. Guyatt GH, Oxman AD, Kunz R, et al. Going from evidence to recommendations. *BMJ* 2008; **336**: 1049–51. <https://doi.org/10.1136/bmj.39493.646875.ae>.
 26. Hoffmann TC, Légaré F, Simmons MB, et al. Shared decision making: what do clinicians need to know and why should they bother? *Med J Aust* 2014; **201**: 35–9. <https://doi.org/10.5694/mja14.00002>.
 27. Wilson A, Ronnekleiv-Kelly SM, Pawlik TM. Regret in surgical decision making: a systematic review of patient and physician perspectives. *World J Surg* 2017; **41**: 1454–65. <https://doi.org/10.1007/s00268-017-3895-9>.
 28. Hargraves IG, Montori VM, Brito JP, et al. Purposeful SDM: a problem-based approach to caring for patients with shared decision making. *Patient Educ Couns* 2019; **102**: 1786–92. <https://doi.org/10.1016/j.pec.2019.07.020>.
 29. Bassette E, Salyer C, McCammon S, Brooks JV, Spoozak L. Value of hospice and palliative medicine fellowship after surgical training: bridging the gap for improved patient care. *Am J Hosp Palliat Med* 2023; **40**: 711–9. <https://doi.org/10.1177/10499091221128966>.
 30. Geta ET, Terefa DR, Hailu WB, et al. Effectiveness of shared decision-making for glycaemic control among type 2 diabetes mellitus adult patients: a systematic review and meta-analysis. *PLoS One* 2024; **19**: e0306296. <https://doi.org/10.1371/journal.pone.0306296>.
 31. Danner M, Geiger F, Wehkamp K, et al. Making shared decision-making (SDM) a reality: protocol of a large-scale long-term SDM implementation programme at a northern German university hospital. *BMJ Open* 2020; **10**: e037575. <https://doi.org/10.1136/bmjopen-2020-037575>.
 32. Steffensen KD, Hansen DG, Espersen K, et al. “SDM:HOSP”- a generic model for hospital-based implementation of shared decision making. *PLoS One* 2023; **18**: e0280547. <https://doi.org/10.1371/journal.pone.0280547>.
 33. van der Weijden T, van der Kraan J, Brand PLP, et al. Shared decision-making in The Netherlands: Progress is made, but not for all. Time to become inclusive to patients. *Z Evid Fortbild Qual Gesundheitswes* 2022; **171**: 98–104. <https://doi.org/10.1016/j.zefq.2022.04.029>.
 34. Thillainadesan J, Hilmer SN, Fleury AM, Naganathan V. New horizons in the perioperative care of older adults. *Age Ageing* 2022; **51**: afab245. <https://doi.org/10.1093/ageing/afab245>.
 35. NHS England. *Universal Personalised Care: Implementing the Comprehensive Model*: NHS England, 2019. <https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model> (accessed 19/02/2026).
 36. Seo J, Goodman MS, Politi M, Blanchard M, Kaphingst KA. Effect of health literacy on decision-making preferences among medically underserved patients. *Méd Decis Mak* 2015; **36**: 550–6. <https://doi.org/10.1177/0272989x16632197>.
 37. Goggins KM, Wallston KA, Nwosu S, et al. Health literacy, numeracy, and other characteristics associated with hospitalized patients’ preferences for involvement in decision making. *J Health Commun* 2014; **19**: 29–43. <https://doi.org/10.1080/10810730.2014.938841>.
 38. Shay LA, Lafata JE. Where is the evidence? A systematic review of shared decision making and patient outcomes. *Med Decis Mak* 2015; **35**: 114–31. <https://doi.org/10.1177/0272989x14551638>.
 39. Légaré F, Ratté S, Stacey D, et al. Interventions for improving the adoption of shared decision making by healthcare professionals. *Cochrane Database Syst Rev* 2010; **12**: CD006732. <https://doi.org/10.1002/14651858.cd006732.pub2>.
 40. Brandes K, Linn AJ, Butow PN, van Weert JCM. The characteristics and effectiveness of question prompt list interventions in oncology: a systematic review of the literature. *Psychooncology* 2015; **24**: 245–52. <https://doi.org/10.1002/pon.3637>.
 41. Pel-Littel RE, Buurman BM, van Pol MH, et al. Effects of a shared decision making intervention for older adults with multiple chronic conditions: the DICO study. *BMC Méd Inform Decis Mak* 2023; **23**: 42. <https://doi.org/10.1186/s12911-023-02099-2>.
 42. Elwyn G, Durand MA, Song J, et al. A three-talk model for shared decision making: multistage consultation process. *BMJ* 2017; **359**: j4891. <https://doi.org/10.1136/bmj.j4891>.
 43. Stacey D, Légaré F, Boland L, et al. 20th anniversary Ottawa decision support framework: part 3 overview of systematic reviews and updated framework. *Med Decis Mak* 2020; **40**: 379–98. <https://doi.org/10.1177/0272989x20911870>.
 44. Clayman ML, Scheibler F, Rüffer JU, Wehkamp K, Geiger F. The six steps of SDM: linking theory to practice, measurement and implementation. *BMJ Evid Based Med* 2024; **29**: 75–8. <https://doi.org/10.1136/bmjebm-2023-112289>.
 45. Légaré F, MoumjidFerdjaoui N, Drolet R, et al. Core competencies for shared decision making training programs: insights from an International, Interdisciplinary Working Group. *J Contin Educ Heal Prof* 2013; **33**: 267–73. <https://doi.org/10.1002/chp.21197>.
 46. Kunneman M, Griffioen IPM, Labrie NHM, Kristiansen M, Montori VM, van Beusekom MM. Making care fit manifesto.

- BMJ Evid Based Med* 2023; **28**: 5–6. <https://doi.org/10.1136/bmjebm-2021-111871>.
47. Brown SL, Salmon P. Reconciling the theory and reality of shared decision-making: a “matching” approach to practitioner leadership. *Health Expect* 2019; **22**: 275–83. <https://doi.org/10.1111/hex.12853>.
 48. Coates D, Clerke T. Training interventions to equip health care professionals with shared decision-making skills: a systematic scoping review. *J Contin Educ Heal Prof* 2020; **40**: 100–19. <https://doi.org/10.1097/ceh.0000000000000289>.
 49. Kruser JM, Taylor LJ, Campbell TC, et al. “Best case/worst case”: training surgeons to use a novel communication tool for high-risk acute surgical problems. *J Pain Symptom Manag* 2017; **53**: 711–719.e5.
 50. Visschers VHM, Meertens RM, Passchier WWF, de Vries NNK. Probability information in risk communication: a review of the research literature. *Risk Anal* 2009; **29**: 267–87. <https://doi.org/10.1111/j.1539-6924.2008.01137.x>.
 51. Hoffmann TC, Bakhit M, Durand M-A, Perestelo-Pérez L, Saunders C, Brito JP. Basing information on comprehensive, critically appraised, and up-to-date syntheses of the scientific evidence: an update from the international patient decision aid standards. *Med Decis Mak* 2021; **41**: 755–67. <https://doi.org/10.1177/0272989x21996622>.
 52. Stacey D, Trevena L. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2024; **1**: CD001431. <https://doi.org/10.1002/14651858.cd001431.pub6>.
 53. Stacey D, Volk RJ. The international patient decision aid standards (IPDAS) collaboration: evidence update 2.0. *Med Decis Mak* 2021; **41**: 729–33. <https://doi.org/10.1177/0272989x211035681>.
 54. Bougeard A-M, Watkins B. Transitions of care in the perioperative period – a review. *Clin Med* 2019; **19**: 446–9. <https://doi.org/10.7861/clinmed.2019.0235>.
 55. Barr PJ, Elwyn G. Measurement challenges in shared decision making: putting the ‘patient’ in patient-reported measures. *Health Expect* 2016; **19**: 993–1001. <https://doi.org/10.1111/hex.12380>.
 56. de Mik SML, Stubenrouch FE, Balm R, Ubbink DT. Systematic review of shared decision-making in surgery. *Br J Surg* 2018; **105**: 1721–30. <https://doi.org/10.1002/bjs.11009>.
 57. Garvelink MM, Boland L, Klein K, et al. Decisional conflict scale use over 20 years: the anniversary review. *Méd Decis Mak* 2018; **39**: 301–14. <https://doi.org/10.1177/0272989x19851345>.
 58. Parayre AF, Labrecque M, Rousseau M, Turcotte S, Légaré F. Validation of SURE, a four-item clinical checklist for detecting decisional conflict in patients. *Med Decis Mak* 2013; **34**: 54–62. <https://doi.org/10.1177/0272989x13491463>.
 59. Barr PJ, Thompson R, Walsh T, Grande SW, Ozanne EM, Elwyn G. The psychometric properties of CollaboRATE: a fast and frugal patient-reported measure of the shared decision-making process. *J Med Internet Res* 2014; **16**: e2. <https://doi.org/10.2196/jmir.3085>.
 60. Harden SM, Strayer TE, Smith ML, et al. National Working Group on the RE-AIM planning and evaluation framework: goals, resources, and future directions. *Front Public Health* 2020; **7**: 390. <https://doi.org/10.3389/fpubh.2019.00390>.
 61. DeMeester RH, Lopez FY, Moore JE, Cook SC, Chin MH. A model of organizational context and shared decision making: application to LGBT racial and ethnic minority patients. *J Gen Intern Med* 2016; **31**: 651–62. <https://doi.org/10.1007/s11606-016-3608-3>.
 62. Dimopoulos-Bick T, Follent D, Kostovski C, et al. Finding your way – a shared decision making resource developed by and for aboriginal people in Australia: perceived acceptability, usability, and feasibility. *Patient Educ Couns* 2023; **115**: 107920. <https://doi.org/10.1016/j.pec.2023.107920>.
 63. Osborne M, Truman C, Sheridan S. Perspectives: Tomorrow’s nursing education is here today: experiences of artificial intelligence and virtual reality technologies. *J Res Nurs* 2024; **29**: 191–8. <https://doi.org/10.1177/17449871241240728>.
 64. Alden DL, Friend J, Schapira M, Stiggelbout A. Cultural targeting and tailoring of shared decision making technology: a theoretical framework for improving the effectiveness of patient decision aids in culturally diverse groups. *Soc Sci Med* 2014; **105**: 1–8. <https://doi.org/10.1016/j.socscimed.2014.01.002>.
 65. Hawley ST, Morris AM. Cultural challenges to engaging patients in shared decision making. *Patient Educ Couns* 2017; **100**: 18–24. <https://doi.org/10.1016/j.pec.2016.07.008>.

Supporting Information

Additional supporting information may be found online via the journal website.

Appendix S1. Perioperative Quality Initiative XVIII Workgroup Members.

Figure S1. Modified nominal group technique utilised.

Table S1. Narrative review search strategy.

Table S2. Sub-questions used to assist organisation of responses

Table S3. Strength of recommendations and quality of evidence.

Table S4. Consensus recommendations for perioperative shared decision-making.