GP preferences for discussing statin deprescribing: a discrete choice experiment

Running title: GP preferences for discussing statin deprescribing

Article category: Health services research

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Key messages

- Statin deprescribing may be considered among some older persons
- Guidelines suggest shared decisions, carefully discussed with patients
- It is unknown how GPs prefer to discuss statin deprescribing
- GPs prefer to discuss statin deprescribing in brief
- There is much heterogeneity in what GPs consider important to discuss
- Communication tools and education should incorporate these preferences
Abstract

Background
Deprescribing (planned, supervised discontinuation) of statins may be considered in some older persons. This should be carefully discussed between patients and general practitioners (GPs).

Methods
We examined GPs’ preferences for discussing statin deprescribing by conducting a discrete choice experiment (DCE) sent to a stratified random sample of 500 Danish GPs. Attributes were discussion topics (goals of therapy, evidence on statin use in older persons, adverse effects, uncertainty) and levels were the depth of the discussion topics (none, brief, detailed). We used mixed logistic regression for analysis.

Results
A total of 90 GPs (mean age 48, 54% female, mean 11 years in practice) completed the DCE. There was substantial variability in which topics GPs felt were most important to discuss; however, GPs generally preferred a brief discussion of topics to detailed ones. The most important discussion topic appeared to be goals of therapy. GPs felt a brief discussion of evidence was important but not a detailed one, while adverse effects and uncertainty were felt to be less important to discuss.

Conclusion
GPs prefer brief discussions on a range of topics when discussing statin deprescribing but have differing views on which topics are most important. For deprescribing communication tools to be useful to GPs in clinical practice, they may need to focus on brief coverage of the range of relevant topics. Future work should evaluate patient preferences, and opportunities for education and training for GPs on deprescribing communication.

Keywords: communication, deprescribing, general practice, oldest old, shared decision-making, statins
Introduction

Statins are medications that reduce risk of cardiovascular disease, and are commonly used among older persons.\(^1,2\) For some older people, health and functional status may deteriorate with time, potentially shifting the balance of benefits and harms of statins such that the harms outweigh the benefits.\(^3-5\) Further, healthcare goals and treatment preferences may shift with increasing age.\(^6,7\) Therefore, it is important to re-evaluate ongoing statin use in older persons, and to consider whether deprescribing may be appropriate.\(^4\) The decision to continue a statin or consider deprescribing should be shared between patients and clinicians (often a general practitioner [GP]).\(^3,8,9\) GPs play a central role in managing medication use and chronic diseases for older persons in Denmark, and are responsible for most ongoing prescribing.\(^10,11\) They are reimbursed via public funds and are remunerated through a mixture of capitation and fee-for-service.\(^10\) Patients appear to be open to discussing statin deprescribing if their GP thinks it is a good idea.\(^12,13\) However, there is currently little understanding of how GPs discuss deprescribing in routine care, including for preventive medications such as statins. Since GPs will often be leading the discussion around statin deprescribing,\(^14-17\) it would be helpful to identify which topics GPs perceive should be included in discussions, and to identify their relative importance to GPs. This will provide insight into designing deprescribing tools and interventions and identify useful areas for training and education initiatives. The aim of this study was to examine GPs preferences for topics to include in discussions around statin deprescribing in older patients.
Methods

We conducted a discrete choice experiment (DCE) among Danish GPs. The DCE is a method that can be used to determine individuals’ preferences among different options or scenarios in healthcare\textsuperscript{18-20} including GPs.\textsuperscript{21,22} In a DCE, participants are asked to choose between two or more alternatives (a choice set).\textsuperscript{23} Participants complete several choice sets.\textsuperscript{23} The alternatives in each choice set are characterized by a number of factors (attributes) that systematically differ in their levels.\textsuperscript{23} This allows researchers to identify which attributes and levels are most important to participants in making decisions. Our DCE explored the relative importance of topics included in statin deprescribing discussions with patients.

Development of DCE

Identifying attributes and levels

To inform the design of our DCE, we carried out semi-structured interviews with 11 Danish GPs (mean age = 46 years, 55\% female, mean years practicing = 9).\textsuperscript{14} We used this information to identify possible discussion topics (attributes) and obtain knowledge on the varying depth these topics can be discussed by GPs in consultations (levels).\textsuperscript{24,25}

Preliminary choice set design

We framed our DCE around a case scenario (Supplementary Box 1), where statin use came up when reviewing an older patient’s medication list during a hypertension consultation. We asked GPs to imagine that they were discussing the decision to continue or deprescribe a statin with this patient. The
following discussion topics were included in the design with the levels in parentheses (see Supplementary Table 1):

- Goals of statin treatment (e.g. long-term risk reduction versus maximize quality of life) (no discussion, brief discussion, detailed discussion)
- Evidence surrounding statin use in older persons (no discussion, brief discussion, detailed discussion)
- Possible adverse effects of statins in older persons (no discussion, brief discussion)
- Uncertainty for individual patients; that it is not possible to know with certainty whether a patient will have a heart attack whether they continue taking a statin or not (no discussion, brief discussion, detailed discussion)

Thus, there were four attributes—three attributes with three levels and one with two levels. The adverse effects attribute only had two levels, since our qualitative work suggested GPs would not engage in detailed discussions about this in cases like our scenario. To evaluate the relative importance of the discussion topics, we provided GPs with choice sets consisting of two alternative discussions, as well as the alternative to opt-out of having a discussion. GPs had to choose which discussion, if any, they would prefer to have with the patient. An example of a choice set is in Table 1.

**Cognitive interviews and pilot testing**

We generated choice sets using a fractional factorial efficient experimental design approach, which aims to minimize standard errors around parameter estimates while achieving some degree of utility balance. We split the DCE into two versions and participants were randomly assigned to complete one version consisting of six choice sets. We created an online version of our DCE in REDCap. Respondents completed one choice set per page and could go back and change answers. The research
team carried out a series of reviews to optimize the wording, formatting, and instructions for the DCE (including an instructional video). We then conducted cognitive interviews with six GPs using the think-aloud method\textsuperscript{28} to evaluate whether our case scenario was realistic, the tasks and choice sets were understandable, and the instructions were clear. We further refined the instructions and format of the DCE. We then conducted a pilot test of our DCE with a convenience sample of eight GPs. We analyzed the pilot data using conditional logistic regression.\textsuperscript{29} This analysis informed the Bayesian efficient experimental design of the final DCE. Our final design required a minimum sample size of 82 participants. Further details around experimental design, pilot testing and cognitive interviews are in Supplementary Box S2.

**Study population**

The final DCE was delivered to a stratified random sample of 500 practicing GPs in Denmark (approximately 14\% of all Danish GPs). The sample was stratified based on sex, years practicing (<10 years, 10 or more years), region, and practice type (singlehanded or partnership practice), to ensure the sample was representative of the current population of Danish GPs. There were no exclusion criteria for the GPs except that the GPs involved in development and pilot testing of the DCE were not invited to complete the DCE.

**Administration of DCE**

The DCE was completed electronically in REDCap via a link sent in an email (a unique survey link was emailed to each potential respondent). It was open for four weeks in September to October 2020, and GPs were sent a reminder at two weeks. When GPs completed the DCE they self-reported: age (continuous), sex, years practicing (continuous), practice type, whether they were part of a collaborative
practice (collaboration between several single-handed or partnership practices) and whether their practice is involved in teaching/training. We compared self-reported data from respondents to publicly available data on non-respondents. At the end of the DCE, we asked two additional questions to examine the validity of our DCE. Firstly, we asked respondents to select their ideal discussion around statin deprescribing among the available topics and levels. They were able to freely select which depth of each discussion topic they would prefer. Secondly, we asked respondents to rank the importance of each discussion topic, where 1 was the most important topic and 4 was the least important topic. GPs were reimbursed for 20 minutes of their time.

Analysis

We described respondent characteristics using descriptive statistics. To analyze the DCE, we used a mixed logit model where the opt out was held fixed and attributes were assumed to vary over a normal distribution.29 We analyzed main effects only.30 We generated coefficients representing the perceived importance of each depth of discussion topic relative to one another. The coefficients were considered statistically significant at the 5% significance level and tests of significance for the coefficients were two-sided. We also calculated the relative importance of each topic, by first calculating the difference between the biggest and smallest coefficient of an attribute, and dividing this by the sum of the differences for every attribute.31 We also calculated the probability of choosing one type of discussion over another (every topic in detail versus no discussion, every topic in brief versus no discussion, and every topic in brief versus every topic in detail) from individual specific coefficients. Probabilities were generated using the mixed logit formula.32 We used the mixlogit and mixlbeta commands in Stata 16 for analysis. Only completed DCEs were analyzed.
Approvals

Ethics approval was not required for this study as per Danish regulations (Act on Research Ethics Review of Health Research Projects section 14.2). The study was registered and approved for data processing with the University of Southern Denmark (record 10.573). All study data was stored on a secure server.
Results

A total of 90 GPs responded to our DCE (response rate 18%; 44 respondents for Block 1 and 46 respondents for Block 2). The mean age of respondents was 48 years (standard deviation [SD] = 8), 54% were women, and the mean number of years practicing was 11 (SD = 9). Most respondents were part of partnership practices (86%) and were training practices (89%), while 7% were part of collaborative practices. The characteristics of respondents are presented in Table 2. Respondents were slightly younger (48 years [SD = 8] versus 52 years [SD = 9]) and had slightly fewer years in practice (11 years [SD = 8] versus 14 years [SD = 8]) compared to non-respondents (see Supplementary Table 2 for further details).

The coefficients are displayed in Figure 1 and Table 3. All discussion topics and depths were considered important, except for a detailed discussion of statin evidence in older persons (coefficient 0.58, 95% CI 0.17 to 1.32). A brief discussion of goals of statin treatment had the highest coefficient (coefficient 2.19, 95% CI 1.38 to 2.99). The topic of goals of statin treatment had the highest relative importance (Table 3). A brief discussion of evidence had the second highest coefficient (1.76, 95% CI 1.03 to 2.49), while the topic of evidence ranked second in relative importance. However, the relative importance was similar for the discussion topics of evidence, adverse effects, and uncertainty. Among topics considered important, the magnitude of coefficients was lowest for a brief (coefficient 1.38, 95% CI 0.69 to 2.07) and detailed (coefficient 1.02, 95% CI 0.28 to 1.77) discussion of uncertainty. There was substantial heterogeneity in the perceived importance of discussion topics, as demonstrated by wide 95% confidence intervals around the standard deviations for the coefficients (Table 3). Out of 540 total choice sets, the opt-out option was selected in 79 (15%).
The probability that GPs would choose a detailed discussion of all topics compared to no discussion of any topics was 80% (95% CI 74 to 86), while the probability that GPs would choose a brief discussion of all topics over no discussion of any topics was 96% (95% CI 94 to 98). The probability that GPs would choose to discuss all topics in brief over all topics in detail was 76% (95% CI 70 to 82).

Table 4 and Supplementary Table 3 show the results of our supplementary questions used to establish the validity of our DCE findings. Table 4 highlights GPs’ choices when they were able to freely select their ideal level of discussion for each topic. For all topics, the proportion was highest for a brief level of discussion. When asked to rank the importance of the discussion topics, GPs ranked the topic of goals as the most important to discuss (mean 2.14, SD 1.07) (Supplementary Table 3). The mean GP ranking for the other topics was similar, ranging from 2.57 to 2.68. These findings are consistent with the relative importance results from the DCE.
Discussion

Our results suggest that GPs prefer to cover a range of topics when discussing statin deprescribing; however, they would generally prefer to engage in each topic briefly rather than engaging in more detailed discussions. While GPs seemed to acknowledge the investigated topics as important, the relative importance of the topics was less clear. A brief discussion of goals of therapy appeared to be the most important discussion topic. However, given the substantial heterogeneity we observed based on the 95% confidence intervals of the standard deviations, it appears that different GPs have different preferences when it comes to prioritizing which topics to cover in statin deprescribing discussions.

Strengths and limitations

Our DCE was rigorously developed using qualitative research, cognitive interviews, and pilot testing. This ensured that the process aimed to produce a case scenario that was realistic, and that the instructions and tasks that were clear and understandable. The DCE methodology is a well-established approach for evaluating preferences, and has a strong theoretical foundation.\textsuperscript{18,19} We further confirmed the validity of our DCE findings through supplementary questions. We closed the survey when our target sample size was met and thereby obtained a lower response rate than the average rate of approximately 30% in DCE studies.\textsuperscript{33} There were small differences in age, sex, years in practice, and the location of respondents compared to non-respondents, but the characteristics of respondents were still broadly similar to the sample we invited. We only assessed the relative importance of the four discussion topics that were identified by our qualitative work and may have missed other relevant topics. However, GPs participating in cognitive interviews suggested the case and scenarios were realistic and did not identify additional discussion topics. We included qualitative descriptions of the depth of discussion (“brief” or “detailed”). It is possible that GPs interpreted these levels differently from one another. We did not assess what the GPs would actually say (e.g. language, terminology).
when discussing these topics. Hence, we were only able to evaluate importance of the topics themselves rather than the content of the discussion. We only examined the preferences of GPs and it is unclear whether our findings are generalizable to other physicians (e.g., cardiologists, geriatricians) or pharmacists, both of whom may also have deprescribing discussions with patients. Similarly, since we only examined preferences around statin deprescribing, it is uncertain whether our findings may reflect GPs’ approach to discussing deprescribing of other medication classes, though it is possible that there would be overlap in discussion topics for deprescribing of other cardiovascular preventive medications such as antihypertensives. Since our study was conducted among GPs in Denmark, our results may not be generalizable to GPs practicing in other countries, though the results may be comparable among GPs practicing in countries with similar reimbursement structures and healthcare systems. Finally, we used a fixed case with specific patient characteristics. It is possible that GP preferences for discussions would vary in different clinical circumstances (e.g. patient age, health status).

Comparison to existing literature

Factors such as limited estimated benefit of statins, patient preference, and adverse effects, have previously been reported as factors leading GPs to consider statin deprescribing. We found variability in preferences for discussing statin deprescribing, which is consistent with existing qualitative evidence. An Australian qualitative study found large variation in which factors GPs consider when making statin decisions in older persons and how they weigh/interpret these factors. Further, in our qualitative study performed prior to our DCE work we found differences between GPs around which topics they would choose to discuss, and how in depth they would discuss them.

GPs appeared to favour brief discussions over detailed discussions. This may be due to the fact that statin deprescribing discussions often come up as one of many issues considered during a consultation. It may also be that if several aspects are deemed important, they must be covered briefly
to be able to discuss them all, or that GPs perceive that some patients will not want to discuss these issues in depth.\(^{14}\) Lack of time has previously been highlighted as a barrier to both deprescribing and shared decision-making in older persons, suggesting shorter discussions would be favoured.\(^{36,37}\)

Although brief discussions are favoured, our study shows that GPs acknowledge the discussion as important, since they clearly preferred a brief discussion over none at all. Another reason that detailed discussions could be less preferred is that GPs may perceive that patients do not want to discuss topics such as evidence, uncertainty, or goals of care, or may feel these are challenging to discuss or weigh.\(^{14,37–39}\)

GPs may also prefer to begin with a brief discussion, and expand the discussion based on patient wishes or revisit the topic at a subsequent consultation.\(^{14}\) Both for deprescribing and in general, uncertainty is viewed by GPs as difficult to navigate and communicate.\(^{39–41}\) It is possible GPs would therefore be less keen on bringing it up, because they find it challenging to discuss\(^{14}\) or fear patient response.\(^{39}\)

Although there was wide variability in the perceived importance of topics, a discussion of goals of statin therapy appeared particularly important in our study. This is encouraging, as patient goals and preferences are critical when it comes to shared medication decisions in older persons.\(^{5,8,42}\) GPs have previously acknowledged the importance of goals and preferences in the context of statin decisions in qualitative studies and surveys.\(^{14,34,35,43}\) It is, however, not clear whether these stated attitudes are reflected in clinical practice. There are few studies examining actual GP behaviour during consultations. One Australian study of recorded conversations, found that shared decision-making approaches (i.e. discussing goals and preferences) were generally not used in medication decisions.\(^{44}\)

**Implications**

Statin use is common among older persons, and thus consideration of statin discontinuation is routinely encountered by GPs.\(^{45}\) Since GPs will generally be the ones leading deprescribing discussions,
their preferences are important in designing effective and useful deprescribing interventions and tools, and structuring training and education related to deprescribing. Our finding that GPs prefer brief discussions, but preferences around which topic is most important vary, suggests that discussion guides, decision aids, and tools related to statin deprescribing should prioritize brief coverage of the range of topics. This would allow for flexibility in discussions and accommodate different preferences among GPs as well as patients. Since goals of statin therapy are viewed as a particularly important consideration to GPs, tools or interventions should include explicit and structured mechanisms for discussing this topic. Future research should examine what patients think is most important to discuss and examine language/methods used by GPs to explain topics.46

Conclusion

In general, the GPs in our study preferred to have brief discussions of topics related to statin continuation or deprescribing, rather than detailed ones. There was substantial variability around which topics GPs considered important; however, goals of therapy was a particularly important topic for GPs. Future deprescribing communication tools and interventions should accommodate heterogeneity in GP preferences for discussions.

Declarations

Funding: no sources of funding

Ethical approval: not required as per Danish regulations (Act on Research Ethics Review of Health Research Projects section 14.2). The study was registered and approved for data processing with the University of Southern Denmark (record 10.573).

Competing interests: the authors have no competing interests to report

Data availability: The data underlying this article cannot be shared, for the privacy of the individuals who participated in the study.
References


Figure legend

Figure 1. Relative importance of discussion topics and depth. *

Goals = discuss goals of statin therapy; Evidence = discuss limited evidence for statin use in older persons; Adverse effects = discuss possible adverse effects of statins; Uncertainty = discuss uncertainty around what will happen to individual patient regardless of decision; all topic depths compared to the reference category of “no discussion.”

* Relative importance represented by coefficients for each depth of discussion topic from the mixed logit model, displayed as dots, with lines representing the 95% confidence intervals. The magnitude of the coefficient represents how important that depth of discussion topic is to GPs in a discussion of statin deprescribing relative to not discussing the topic.
Tables
Table 1. Example of a choice set.

Which discussion would you prefer?

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion A</th>
<th>Discussion B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals of statin treatment (e.g. prolong life, maximize quality of life)</td>
<td>You briefly discuss Margrethe’s goals for statin treatment</td>
<td>You don’t discuss Margrethe’s goals for statin treatment</td>
</tr>
<tr>
<td>Evidence for statin treatment in older persons (GP interpretation of statin evidence in older persons)</td>
<td>You don’t discuss about evidence for statin treatment in older persons</td>
<td>You discuss evidence for statin treatment in older persons in detail</td>
</tr>
<tr>
<td>Adverse effects of statins</td>
<td>You briefly discuss the adverse effects of statins</td>
<td>You don’t discuss the adverse effects of statins</td>
</tr>
<tr>
<td>Uncertainty around what will happen to Margrethe as an individual</td>
<td>You don’t discuss about uncertainty for Margrethe</td>
<td>You briefly discuss uncertainty for Margrethe</td>
</tr>
</tbody>
</table>

Which of the above discussions would you prefer?

- √ Discussion A
- √ Discussion B
- √ If A and B are the only options, I would prefer not to discuss statin treatment with Margrethe at all
Table 2. Characteristics of respondents.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=90</td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>48 (8)</td>
</tr>
<tr>
<td>Sex, n(%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>54 (60)</td>
</tr>
<tr>
<td>Male</td>
<td>36 (40)</td>
</tr>
<tr>
<td>Practice type, n(%)</td>
<td></td>
</tr>
<tr>
<td>Partnership</td>
<td>77 (86)</td>
</tr>
<tr>
<td>Solo</td>
<td>13 (14)</td>
</tr>
<tr>
<td>Years in practice, mean (SD)</td>
<td>11 (9)</td>
</tr>
<tr>
<td>Collaborative practice, n(%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>84 (93)</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Involved in teaching, n(%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>10 (11)</td>
</tr>
<tr>
<td>Yes</td>
<td>80 (89)</td>
</tr>
</tbody>
</table>

SD = standard deviation
Table 3. Results from analysis examining relative importance of different depths of discussion topics.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Depth of discussion</th>
<th>Coefficient (95% CI)</th>
<th>Standard deviation (95% CI)</th>
<th>Relative Importance (Rank)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>Brief</td>
<td>2.19 (1.38 to 2.99)</td>
<td>1.29 (0.52 to 2.07)</td>
<td>0.35 (1)</td>
</tr>
<tr>
<td></td>
<td>Detailed</td>
<td>1.67 (0.80 to 2.54)</td>
<td>1.38 (0.47 to 2.28)</td>
<td></td>
</tr>
<tr>
<td>Evidence</td>
<td>Brief</td>
<td>1.76 (1.03 to 2.49)</td>
<td>1.35 (0.62 to 2.09)</td>
<td>0.24 (2)</td>
</tr>
<tr>
<td></td>
<td>Detailed</td>
<td>0.58 (-0.17 to 1.32)</td>
<td>1.96 (1.13 to 2.80)</td>
<td></td>
</tr>
<tr>
<td>Adverse effects</td>
<td>Brief</td>
<td>1.62 (1.00 to 2.23)</td>
<td>1.60 (0.95 to 2.24)</td>
<td>0.19 (4)</td>
</tr>
<tr>
<td></td>
<td>Detailed</td>
<td>0.58 (-0.17 to 1.32)</td>
<td>1.96 (1.13 to 2.80)</td>
<td></td>
</tr>
<tr>
<td>Uncertainty</td>
<td>Brief</td>
<td>1.38 (0.69 to 2.07)</td>
<td>0.18 (-1.50 to 1.14)</td>
<td>0.22 (3)</td>
</tr>
<tr>
<td></td>
<td>Detailed</td>
<td>1.02 (0.28 to 1.77)</td>
<td>1.51 (0.82 to 2.22)</td>
<td></td>
</tr>
<tr>
<td>Opt-out(^b)</td>
<td>-</td>
<td>2.30 (1.21 to 3.40)</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

CI = confidence interval

Goals = discuss goals of statin therapy; Evidence = discuss limited evidence for statin use in older persons; Adverse effects = discuss possible adverse effects of statins; Uncertainty = discuss uncertainty around what will happen to individual patient regardless of decision; all topic depths compared to the reference category of “no discussion”

Model fit: Number of observations = 1,620; LR chi2(7) = 56.36; Prob > chi2 = 0.00; LL model = -463.03979; LL null = -491.2181; Pseudo R2 = 0.06

\(^a\)The 95% CIs around the standard deviation represent the degree of heterogeneity in preferences regarding an attribute level.

\(^b\)Opt-out option was chosen in 79/540 choice sets (15%)
Table 4. Preferred depth of discussion for GPs when asked to choose their ideal level of discussion for each topic.

<table>
<thead>
<tr>
<th>Topic</th>
<th>None, n(%)</th>
<th>Brief, n(%)</th>
<th>Detailed, n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>3 (3)</td>
<td>69 (77)</td>
<td>18 (20)</td>
</tr>
<tr>
<td>Evidence</td>
<td>10 (11)</td>
<td>63 (70)</td>
<td>17 (19)</td>
</tr>
<tr>
<td>Adverse effects</td>
<td>8 (9)</td>
<td>64 (73)</td>
<td>18 (20)</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>12 (14)</td>
<td>56 (62)</td>
<td>22 (24)</td>
</tr>
</tbody>
</table>