Finding stroke evidence: where and how far do clinicians have to look?

Tammy Hoffmann & Paul Glasziou

Shared Decision Making: More than decision aids

Tammy Hoffmann
Shared decision making ≥ Decision aids
Conditions with decision aids evaluated in RCTs...

Treatment 64%

Test or Screen 36%
Even when decision aids are available and appropriate, their use is not straightforward and training health professionals in their use may be needed.

Various types of decision support tools available
Finding them...
Appraising them...

“A good level of SDM occurs about 10% of the time”

SR of 33 studies
mean OPTION (Observing Patient Involvement in Decision Making, 0-100) score = 23


Barriers to SDM... & training

- Lack of time
- “We already do SDM”
- Not sure what it really is
- Not clear what it is meant to achieve
- “It doesn’t make any difference to outcomes”
- “Most of my patients don’t want to be *that* involved”

Patient-mediated interventions

  e.g. decision support tools or training in questions to ask

Health professional training in SDM


Shared decision making:
A skill that needs to be taught
The Shared Decision-Making Continuum

Alexander A. Kon, MD

During the 20th century, medical decision making shifted from a paternalistic approach to an autonomy-based standard in the United States. Now, in the 21st century, the pendulum is swinging back and the medical community and the public are increasingly embracing shared decision making. In many other parts of the world paternalism remained the primary approach, yet there is now a move toward shared decision making occurring internationally. This “meeting in the middle” has been spurred by the 2004 endorsement of shared decision making over either strict autonomy or physician-directed decision making by the leading cancer organizations in Europe (Figure). At one end is patient- or agent-driven decision making, at the opposite is physician-driven decision making, and in the middle are many possible approaches. Discussion of 5 points along the continuum illustrates some of the possible approaches.

In patient/agent-driven decision making (akin to strict autonomy), the physician presents all options and the patient makes his/her own choice. The physician provides expert knowledge only and makes no recommendations.

In physician recommendation decision making, the physician explains all options and also makes a recommendation. Because many decisions in health care are value laden, physicians must base their recommendations on an understanding of the patient's values, determines the best course of action and fully informs the patient. The patient may either remain silent, thereby allowing the physician’s decision to stand, or veto the decision. In this approach the patient must understand all pertinent information (as he/she would in any method of decision making). Furthermore, the patient must appreciate that silence will be construed as tacit agreement. Patients must understand that they are welcome to veto the decision and if so, their wishes will be honored and they will receive excellent care.

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Determining where on the shared decision-making continuum the patient feels most comfortable requires clear communication and dedicated time.
Patients should be educated about the essential role they play in decision making and be given effective tools.

Clinicians, in turn, need to relinquish their role as the single, paternalistic authority and train to become more effective coaches or partners — learning, in other words, how to ask, “What matters to you?” as well as “What is the matter?”
Shared decision making: really putting patients at the centre of their care

Postgraduate training and accreditation can also support implementation of shared decision making. Skills training can change the culture.

Because clinicians have to be able to discuss evidence based information and elicit patient preferences, linking courses on shared decision making with those on evidence based medicine could also be beneficial. Risk communication and eliciting patient preferences remain a neglected part of evidence based medicine. Integrating shared decision making into the evidence based medicine framework will cut both ways, helping clinicians to communicate evidence and ask patients for their preference as well as promoting shared decisions.
Authors’ conclusions
The results of this Cochrane review do not allow us to draw firm conclusions about the most effective types of intervention for increasing healthcare professionals’ adoption of SDM. Healthcare professional training may be important, as may the implementation of patient mediated interventions such as decision aids.
A N INCREASING NUMBER OF MEDICAL SCHOOLS AND residency programs are instituting curricula for teaching the principles and practice of evidence-based medicine (EBM). For example, 95% of US internal medicine residency programs and 32% of family medicine residencies have incorporated EBM courses into their curricula. However, the quality of this evidence is often weak, as many EBM courses are taught by faculty who have not themselves been trained in EBM. This is likely to result in an educational program that is not effective in teaching EBM skills.

Almost all the research on EBM education has focused exclusively on the third item: teaching critical appraisal skills.
Why teach SDM to undergraduates?

- Time when health professionals acquire their professional identity
- Time when interview and consultation ‘scripts’ and habits are developed
- ‘Hidden’ curriculum – trained to believe it is important to have “the answer”
- Lack of role models who practice SDM
Why offer SDM training as CPD?

- Most likely **not** taught when undergraduate
- Lack of training is a major barrier to SDM occurring

Who should be taught?

- Skills that are needed by **ALL** clinicians

- Systematic review of facilitators and barriers to the implementation of shared decision making (Légaré et al 2008):
  
  ~ 90% of all study participants were physicians
What are some of the skills needed?

- Developing a **partnership** with the patient
- Determining patient’s preferences for information (amount & format)
- Determining patient’s preferences for his/her role in decision making
- Eliciting and responding to patient’s ideas, concerns, expectations
- Discussing options, along with the benefit/s and harm/s of each
- Presenting likelihood of benefits and harm/s, individualising where possible
- Helping patient reflect on options and impact of each, values and lifestyle
- Checking understanding; making or negotiating a decision or agreeing to defer
- Agreeing upon an action plan & arranging follow-up as needed
Core skills?

- Current debate about ‘core’ skills
- Agreement about 2 broad areas of competencies:
  - Relational skills
  - Risk communication skills

Are SDM skills routinely taught to health professionals?
What do we know about how to teach SDM?
Studies to date of teaching students...


Already full curricula (in EBP course & elsewhere)

But important topic!

Brief intervention needed

Have always taught this topic/skills this way, but was it effective?

Background to Hoffmann et al RCT
(Wait-list) RCT of a brief intervention

- Medical, physiotherapy, and occupational therapy students (n=107) from 2 universities

- Intervention group:
  - 1 hour interactive tutorial on SDM and evidence communication skills, including facilitated critique of videoed role-play

- Control group:
  - Content in chapter of course EBP book
**Procedure**

**Baseline**
- Provided with 2 scenarios and ‘key’ evidence (single RCT)
- Pairs – one scenario for each member of pair
- Two weeks to prepare approx 5 min role-play (videorecorded)

**Intervention**
- Intervention group: 1 hour intervention
- Both groups: 2 new scenarios (and 2 weeks to prepare)

**Post-intervention**
- Performance of role-plays (videorecorded)
  [+ feedback from academic staff member; not part of RCT]
Outcome measures

Primary measures:

- shared decision-making and evidence communication skill
- Observing Patient Involvement (OPTION) scale (Elwyn 2003)
- selected Assessing Communication about Evidence and Patient Preferences (ACEPP) Coding Scheme items (Shepherd 2011)

→ Performance evaluated by blinded assessor from videorecorded roleplays

OPTION scale item

1. The clinician identifies a problem(s) needing a decision making process
2. The clinician states that there is more than one way to deal with an identified problem (“equipoise”)
3. The clinician lists “options” including the choice of “no action” if feasible
4. The clinician explains the pros and cons of options to the patient (taking “no action” is an option)
5. The clinician checks the patient’s preferred information format (words/numbers/visual display)
6. The clinician explores the patient’s expectations (or ideas) about how the problem(s) are to be managed
7. The clinician explores the patient’s concerns (fears) about how problem(s) are to be managed
8. The clinician checks that the patient has understood the information
9. The clinician provides opportunities for the patient to ask questions
10. The clinician asks for the patient’s preferred level of involvement in decision making
11. An opportunity for deferring a decision is provided
12. Arrangements are made to review the decision (or the deferment)
ACEPP items

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<tr>
<td>1.</td>
<td>The clinician describes the <strong>benefits</strong> of the treatment in terms of patient outcomes</td>
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<td>2.</td>
<td>The clinician describes the <strong>harms</strong> of the treatment in terms of patient outcomes</td>
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<td>3.</td>
<td>Has the <strong>probability or likelihood</strong> of benefit or harm been discussed either in words or numbers?</td>
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<td>4.</td>
<td>Has <strong>individualised</strong> information, tailored to the patient been provided?</td>
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<td>5.</td>
<td>Has the <strong>source</strong> of research evidence been mentioned?</td>
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<td>Behaviour not observed (0)</td>
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<tr>
<td>1</td>
<td><strong>The clinician draws attention to a problem needing a decision-making process.</strong></td>
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<td>2</td>
<td><strong>The clinician states that there is more than 1 way to deal with an identified problem.</strong></td>
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<td>3</td>
<td><strong>The clinician lists options, including the choice of “no action” if feasible</strong></td>
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Outcome measures

Secondary measures:

- **Confidence** in these skills (11-items, 10-point Likert scale)

- **Attitude** towards shared decision making (Patient Practitioner Orientation Scale) (Krupat et al 2000)
Results
Limitations

• Length of effect?
• Competence vs performance discrepancy?
• Different behaviour with actual patients?

• Focus of the intervention - situations where a decision about an intervention needs to be made
Han et al study

• Observational study with 2nd year medical students (32 exposed compared to convenience sample of 23 unexposed students)

• Experience-based curriculum ("Risk Talk") – guided by Choice talk, Option talk, & Decision talk model

• 3 hour workshop:
  – 45 minute didactic lecture
  – 2hr experiential learning session
    • Groups of 3 students practiced communicating risk information with training standardised patients, facilitated by a faculty preceptor
    • Students took turns leading, observing and providing feedback
Han et al study - Outcomes

- Evaluated with an OSCE 3 weeks after the workshop
- Used trained SPs and case similar to that in the workshop

- Primary outcome: objective risk communication competence
  - Mean scores higher for exposed students (although absolute level of competence still quite low)

- Secondary outcome: subjective risk communication competence
  - Mean scores higher for exposed students
Han et al study - Conclusions

• Risk communication is a teachable advanced communication skill

• This intervention was very resource-intensive and authors suggested less resource-intensive approaches may be needed, e.g.:
  – role play without SPs
  – Integration of risk communication training with existing training - e.g. EBP, patient simulations, communication skills
Current situation in Australia – Teaching to undergraduates

• IF taught, typically integrated with other teaching e.g. case studies, problem-based learning
  • Extent to which core skills covered not clear

• 10% - taught it as part of stand-alone course (e.g. EBP, communication skills, etc)

• Student skill/competency typically not not assessed

• ~50% reported involvement of consumers with teaching of communication skills
  • very few involved consumers with assessment of skills
Barriers to teaching SDM to undergraduates

- “Lack of knowledge of importance of this issue to clinical practice”
- “Very full curriculum already”
- “potential resistance of students who come in with perceptions about what treatment is...”
- “Lack of practical experience so students don’t grasp the important aspects”
- “No follow through/modeling on professional placements”
Current situation in Australia

- **SDM training offered as CPD**
  - Very few options

- One course run by a private provider
  - E.g. 3 hour workshop – with a focus on risk management and “reducing litigation”