Integrating the teaching of shared decision making into the teaching of evidence-based practice

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Workshop objectives

1. To raise awareness of the link between shared decision making and EBP and why shared decision making skills should be explicitly taught, and how they can be logically incorporated into EBP teaching

2. To overview strategies and tools for teaching and assessing shared decision making core skills

Theme group tomorrow

→ Integrating the teaching of shared decision making into the teaching of EBP: why, how and what else do we need to know?
Main topics

- What does SDM have to do with EBP?
- What are some of the skills needed for SDM?
- Strategies and tools for facilitating SDM
- Some ideas for how to teach and assess these skills

- Others?
What does SDM have to do with EBP?
One way of conceptualising the link...

Figure 1.1 Evidence-based practice involves using clinical reasoning to integrate information from four sources: research evidence, clinical expertise, the patient's values and circumstances, and the practice context.

from Hoffmann, T., Bennett, S., & Del Mar, C. (2013). Evidence-based Practice across the Health Professions (2nd ed)
A benefit of shared decision making...
Shared decision making ≥ Decision aids
Conditions with decision aids evaluated in RCTs...

“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”

Solutions:

**Patient-mediated interventions**

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

**Health professional training in SDM**


Is it typically taught to student clinicians and clinicians?
The teaching of SDM skills...

- Patient communication skills
- SDM skills
- Evidence-based practice skills
Shared decision making:
A skill that needs to be taught
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 have incorporated EBM into their curricula. However, a recent survey of US gynecology residency programs found that only 60% of programs had incorporated EBM into their curricula. While the quality of evidence for teaching EBM is somewhat weak, many of these programs are limited in educational research in general. First, quantitative research methods may be inadequate to capture the complexity of an educational system. Second, students and residents change frequently, making it difficult to retain a consistent sample. Third, the time allotted for a given intervention may be brief in the context of the overall medical curriculum. Fourth, educational institutions may be hesitant to pay students as research participants or to allocate them to unproved educational interventions. Fifth, because most educational interventions are unique to specific institutions, assessment of their effectiveness is usually limited by small sample sizes. Furthermore, even if such interventions could be instituted across multiple institutions, the problems of standardization and comparison would be particularly challenging. Sixth, perhaps because they are simpler to measure, the most frequently reported outcomes are subjective variables such as satisfaction or self-reported changes in attitudes or knowledge, rather than more important assessments of objective measures of clinical skills or improved patient outcomes. Finally, granting agencies do not give priority to educational investigations, making it difficult to undertake definitive multicenter studies.

Educators who have struggled to evaluate educational interventions will find these issues all too familiar. With the increasing prevalence of EBM teaching, however, high-quality evidence is more important than ever. In addition, high-quality evidence can help to guide the development of future EBM curricula.

There are several reasons why the quality of the evidence for teaching EBM is so weak. Many of these problems are related to the limitations in educational research in general. First, quantitative research methods may be inadequate to capture the complexity of an educational system. Second, students and residents change frequently, making it difficult to retain a consistent sample. Third, the time allotted for a given intervention may be brief in the context of the overall medical curriculum. Fourth, educational institutions may be hesitant to pay students as research participants or to allocate them to unproved educational interventions. Fifth, because most educational interventions are unique to specific institutions, assessment of their effectiveness is usually limited by small sample sizes. Furthermore, even if such interventions could be instituted across multiple institutions, the problems of standardization and comparison would be particularly challenging. Sixth, perhaps because they are simpler to measure, the most frequently reported outcomes are subjective variables such as satisfaction or self-reported changes in attitudes or knowledge, rather than more important assessments of objective measures of clinical skills or improved patient outcomes. Finally, granting agencies do not give priority to educational investigations, making it difficult to undertake definitive multicenter studies.

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Since critical appraisal skills involve the ability to differentiate strong from weak research methods, one might expect that this research would be of relatively high quality. In fact, most of these studies are methodologically weak. Using broad criteria to identify any reports of a graduate (residency) EBM curricula, Green1 identified 18 reports published between 1980 and 1997. Of these, 72% used a traditional journal club format to teach critical appraisal skills. Only 7 of the 18 studies evaluated the effectiveness of their intervention. Five of these 7 studies compared intervention with control (only 1 with randomized design); only 2 of 7 studies used any blinding. Of these 5 controlled studies, 2 used a validated outcome measure to evaluate critical appraisal skills. Measurement of behavioral change relied on self-report in all 5 studies, and none examined patient outcomes. Most reports did not evaluate their intervention.
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 medical organizations in Europe and the United States.

Although shared decision making is becoming the new standard, it remains unclear exactly what “shared decision making” means. The model for shared decision making described herein is consistent with ethical principles and patient preferences and can be referred to as the “shared decision-making continuum” because shared decision making will necessarily take different forms in different situations.

Shared decision making does not mean the same thing in all cases and therefore can best be understood as a continuum (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 individual patients’ values.

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?”
Postgraduate training and accreditation can also support implementation of shared decision making. Skills training can change 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.
Interventions for improving the adoption of shared decision making by healthcare professionals (Review)

Légaré F, Ratté S, Stacey D, Kryworuchko J, Gravel K, Graham ID, Turcotte S

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.
When should SDM be taught?
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 should be taught?
What are some of the steps & 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 & impact of alternative decisions, considering values and lifestyle
- Checking understanding; supporting negotiating a decision or agreeing to defer
- Agreeing upon an action plan & arranging follow-up/review as needed
Core skills?

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

One model: Choice, option, decision talk

Box 1. Choice talk

Choice talk is about making patients that reasonable options exist. This step does not necessarily have to be done face-to-face — an email, letter or a telephone call can also be effective; e.g. asking a patient whose tests come back showing a herniated intervertebral disc to use a decision support website.

‘Choice talk’ is a planning step (45). Components of the choice talk include:

a) **Step back.** Summarise and say: “Now that we have identified the problem, it’s time to think what to do next”

b) **Offer choice.** Beware that patients often misconstrue the presentation of choice and think that the clinician is either incompetent or uninformed, or both. Reduce this risk by saying: “There is good information about how these treatments differ that I’d like to discuss with you.”

c) **Justify choice.** Emphasise: 1) the importance of respecting individual preferences and, 2) the role of uncertainty.

   *Personalizing preferences:* Explaining that different issues matter more to some people than to others should be easily grasped. Say: “Treatments have different consequences … some will matter more to you than to other people…”

   *Uncertainty:* Patients are often unaware about the extent of uncertainty in medicine: that evidence may be lacking and that, individual outcomes are unpredictable at the individual level. Say: “Treatments are not always effective and the chances of experiencing side effects vary…”

d) **Check reaction.** Choice of options may be disconcerting: some patients may express concern. Suggested phrases: “Shall we go on” or ‘Shall I tell you about the options?’

e) **Defer closure.** Some patients react by asking clinicians to “tell me what to do …” We suggest that *deferring closure* if this occurs, reassuring that you are willing to support the process. Say: “I’m happy to share my views and help you get to a good decision. But before I do so, may I describe the options in more detail so that you understand what is at stake?”
Box 2. Option talk

a) **Check knowledge.** Even well-informed patients may only be partially aware of options and the associated harms and benefits, or misinformed. Check by asking: “What have you heard or read about the treatment of prostate cancer?”

b) **List options.** Make a clear list of the options as it provides good structure. Jot them down and say: “Let me list the options before we get into more detail”. If appropriate, include the option of ‘watchful waiting’, or use positive terms such as ‘active surveillance’.

c) **Describe options.** Generate dialog and explore preferences. Describe the options in practical terms. If there are two medical treatments, say: “Both options are similar and involve taking medication on a regular basis” Point out when there are clear differences (surgery or medication), where postponement is possible or where decisions are reversible. Say: “These options will have different implications for you compared to other people, so I want to describe …”

**Harms and benefits.** Being clear about the pros and cons of different options is at the heart of shared decision making. Learn the about effective risk communication (46)(47), about framing effects and the importance of providing risk data in absolute as well as relative terms. Try giving information in ‘chunks’ (chunking and checking) (48).

d) **Provide patient decision support.** These tools make options visible and may save time. Some are sufficiently concise to use in clinical encounters (38). Examples of these short tools are Issues Cards (49), Decision Boards (50), and Option Grids (http://www.optiongrid.co.uk/) (42). SDM may need more than one encounter. More extensive patient decision support tools may play a crucial role (51). Say: “These tools have been designed to help you understand options in more detail. Use them and come back so that I can answer your questions”.

e) **Summarize.** List the options again and assess understanding by asking for re-formulations. This is called a ‘teach-back’ method and is a good check for misconceptions.
Box 3. Decision talk

a) **Focus on preferences.** Guide the patient to form preferences. Suggested phrases: “What, from your point of view, matters most to you?”

b) **Elicit a preference.** Be ready with a back-up plan by offering more time or being willing to guide the patient, if they indicate that this is their wish.

c) **Moving to a decision.** Try checking for the need to either *defer* a decision or *make* a decision. Suggested phrases: “Are you ready to decide?” or “Do you want more time? Do you have more questions?” “Are there more things we should discuss?”

d) **Offer review.** Reminding the patient, where feasible, that decisions may be reviewed is a good way to arrive at closure.
5 Questions

• What will happen if I wait and watch?
• What are my test or treatment options?
• What are the benefits and harms of these options?
• How do the benefits and harms weigh up for me?
• Do I have enough information to make a choice?
Key steps to communicating evidence

General strategies and skills for effectively communicating with patients

1. Understand the patient’s experiences and expectations
2. Build partnerships
3. Discuss the evidence, including a balanced discussion about uncertainties
4. Present recommendations
5. Check for understanding and agreement

Teaching ‘communicating numbers’ skill

• Tips and tricks
• What to teach, resources to use, etc

Decision support tools

- 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...

Registry of decision aids

- http://decisionaid.ohri.ca/resources.html
What do we know about how to teach SDM to students?
Studies to date of teaching students...

- Hoffmann, Del Mar, et al. (under review) Brief training of student clinicians in shared decision making: a randomised controlled trial.


Background to Hoffmann et al RCT

• Already full curricula (in EBP course & elsewhere)
• But important topic!

• Brief intervention needed
• Have always taught this topic/skills, but was it effective?
For Discussion ...