Shared decision making – Supervisors take the lead!

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What is Medical Shared Decision Making?
“A process in which patients are involved as active partners with the clinician in clarifying acceptable medical options and in choosing a preferred course of clinical care”

(Sheridan et al, 2004)
3 possible models for making decisions about patient management

Paternalistic  ∋  Shared decision making  ∋  Informed choice
Key characteristics of shared decision making

- That at least two participants (the doctor and the patient) be involved
- That both parties share information
- That both parties take steps to build a consensus about the preferred treatment
- That an agreement is reached on the treatment to implement

Charles et al (1997)
The consultation

Increasingly being framed as a meeting between two experts

Tuckett et al (1985)
We have FOUR
treatment options...
let's call them
EENY, MEENY, MINY and MOE!
Why?
Why not?
Evidence in favour of shared decision making

- Better informed patients and improved satisfaction
- Fewer unnecessary investigations and referrals
- Increased adherence to treatment regimens
- Improved outcomes in hypertension and diabetes
- Patients are more likely than their doctors to defer or decline surgery – with no adverse effect on health outcomes or satisfaction and with potential to reduce costs
- Fewer medico–legal problems
When?
“Professional equipoise”
Is it happening?

- Patient surveys (Picker Institute, 2007) 68% in general practice and 52% in hospitals
- MRCGP video exam (Campion et al, 2002)
- nMRCGP CSA exam (RCGP report, 2008)
- Focus groups with GP registrars
Doctor, I want to choose how I’m treated

Hmm. You’re not just ill — you’re deluded
Research question

What are GP supervisors’ perceptions of how this skill might be acquired?
Two focus groups
Focus group questions

- What do you think shared decision making is?
- Do you share decision making with patients yourselves?
- How much of a priority do you feel it is?
- Do other doctors in your practice have similar views to your own on this issue?
- How and when did you learn this skill yourselves?
Focus group questions (cont)

- How important is it for GP registrars to learn this skill?

- How do you think they acquire it?

- If you do teach it, what teaching methods have you used?

- What methods have been most effective?

- What do you see as the blocks to registrars learning this skill?
Empirical form of discourse analysis

Themes

- Cognitive aspects of the task
- Contextual issues
- Individual characteristics of the learner
- Pedagogy and teacher
Results
Cognitive aspects of the task

- Defining the task
  - Difficult to pin down
  - Shared decision making is not a fixed entity
Cognitive aspects of the task

- Highlighting the task
  - “Very very important” and “a big priority” but not actually named and explained as a specific entity by the trainers
Cognitive aspects of the task

Deconstructing the task

- Supervisors were not dividing the skill into its component parts

- Ascertaining degree of desired patient involvement was done intuitively

- “Well, you are the doctor, you tell me!”
Cognitive aspects of the task

Benefits for the doctor

◦ Increased understanding of patient’s experience
◦ Improved relationship with patients
◦ More meaningful and enjoyable consulting style
◦ ?
Cognitive aspects of the task

- Costs to the doctor
  - Much harder work – “A cost to this, a cost”
  - More time consuming
  - Conveying risk sometimes challenging (e.g. breast cancer patient)
Cognitive aspects of the task

 Complexity

- “Multifaceted and so subtle”
- Avoid it becoming “a cosmetic exercise” with false options
- Knowing when not to share decision making – “There is a line isn’t there, where you say; I am not sharing, not being party to this”
Contextual issues

- Current community of practice
  - Time pressure
  - Apprenticeship
    “They just watch it and they learn”
    “Absorb it, don’t they?”
  - Practice ethos could be influenced by other doctors with different views
Contextual issues

Previous communities of practice
  ◦ Unlearning to learn
    “They have come from a didactic environment in hospital where, you know, decisions aren’t shared; decisions are imposed”

“The environment of the hospital where they are taught, you know, not to share decisions. It is not probably their own fault, it is probably through culture of the environment”
Contextual issues

Trajectories

- Later rather than early on in training
- Higher level skill acquired over prolonged period of time
  
  "Sort of evolution"

  "A continual process"
Contextual issues

- Performance targets and money
  - Professional equipose disrupted
  - Shared decision making compromised
Individual characteristics of the learner

- Professional identity
  
  “Why are they coming to see me if they are not prepared to listen to what I think they should be doing?”
Individual characteristics of the learner

- Doctors’ individual personalities
  “I think it is really difficult to change your personality, to change the way you consult in that sense”
Individual characteristics of the learner

- Uncertainty
  - “Owning up to not knowing” the best treatment option for a particular patient is possibly misconstrued as incompetence or weakness
  - Coping with uncertainty and using time as a therapeutic option
Individual characteristics of the learner

- **Power**
  - Neutral stance on power
  - Giving away power during shared decision making is modelled by sharing of power in the trainer–registrar relationship
Individual characteristics of the learner

Socio–cultural factors

- Cultural background of both patient and doctor

“Back home, in my country, I am never allowed to ask the doctor a question and I think it is quite incredible that I can ask you what is wrong with me or why I should take this treatment”
Pedagogy and teacher

Teaching methods

- Case discussions during tutorials
- Video analysis of consultations
- Shared sessions with registrar and trainer

“Teaching it, reflecting on it and encouraging registrars to do the same has definitely helped me”
Pedagogy and teacher

- Mirroring shared decision making in teaching
  - Collaborative approach to registrar in the teaching sessions with modelling of necessary skills
    - “It becomes actually a way of approaching people”
  - Modelled in shared sessions too
Summary

Integration of cognitive and situated learning theories

- Complex and contested skill that needs highlighting
- Cognitive dimensions need to be identified
- Unlearning to learn
- Context of the practice is important
Summary (continued)

Apprenticeship

- Seeing how an expert leads shared decision making
Summary (continued)

- Mirroring in the teacher/learner relationship

- Very gradual process

- Teaching shared decision making enhances the ability to do it
Discussion
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Eight defining competences

1. Develop partnership with patient
2. Establish patient’s preference for information
3. Establish patient’s preference for role in decision making
4. Ascertain and respond to patient’s ideas, concerns and expectations
5. Identify choices and evaluate evidence in relation to individual patient
6. Present evidence and help patient assess impact of alternative decisions
7. Negotiate a decision and resolve conflict
8. Agree action plan and arrange follow up

Towle and Godolphin (1999)
The Salzburg Statement on Shared Decision Making (2011) calls on doctors to:

- Recognise that they have an ethical imperative to share important decisions with patients
- Stimulate a two-way flow of information and encourage patients to ask questions, explain their circumstances, and express their personal preferences
- Provide accurate information about options and the uncertainties, benefits and harms of treatment in line with best practice for risk communication
- Tailor information to individual patient needs and allow them sufficient time to consider their options
- Acknowledge that most decisions do not have to be taken immediately, and give patients and their families the resources and help to reach decisions
Decision aid for choosing statin in a diabetic with 20% risk over 10 years of heart attack

Downsides
- Take every day for long time
- Cost of drug
- Side effects: 5 in 100 patients have muscle aching/stiffness
- Liver blood test goes up: 2 in 100 (no pain or permanent damage)
- Muscle and kidney damage: 1 in 20,000 patients, need to stop statin
Questions to support deliberation

- What do you expect from treatment for your condition?
- Do you have all the information you think you need to weigh up these two options?
- Thinking about this decision, what is the most important aspect for you to consider?
- What aspects of surgery are you most concerned about?
- How do the benefits of both options compare? And how do the harms compare?
- Are there important other people that you want to talk to in making this decision?