Shared decision making between registrars and patients

Web based decision aids

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BACKGROUND
Current evidence suggests that doctors do not always involve patients in decisions; this may be due to lack of training. This study explores the feasibility of using web based decision aids (DAs) to improve the skills of general practice registrars in sharing decisions with patients.

METHOD
Interviews were conducted with registrars to explore their attitudes to shared decision making. Following an educational intervention, registrars were asked to adopt shared decision making within their consultations using DAs as appropriate. The registrars were interviewed again to explore their experiences and any barriers to the process.

RESULTS
Registrars had positive views about the shared decision making process but required more training. They had mixed opinions about the use of DAs and identified several barriers to their use. They felt that they had learned from the project and process without necessarily wanting to pursue the use of DAs as interactive tools, preferring to use them as educational resources.

Shared decision making (SDM) is a process linked to the patient centred clinical method[1] and involves doctors and patients sharing information to negotiate a management plan based on a set of appropriate options.[2] Decision aids (DAs) help patients make deliberative choices from health care options by providing information relevant to a person's health status.[3]

Current evidence suggests that doctors do not always involve patients in decision making.[4] One possible reason is lack of training of doctors. This study aimed to explore the feasibility of using web based DAs to improve the skills of general practice registrars in practising SDM with patients.

Method

We sought volunteers for the project from a group of 40 general practice registrars enrolled with our regional training provider; 11 accepted.

We conducted interviews to explore the registrars' attitudes to SDM and the use of DAs. The registrars were spread over a large geographical area, making it difficult to get them together for workshops. Based on the interview data we conducted a 1 hour workshop for three registrars, and short teaching sessions with handouts for the remainder. After 6 months we interviewed individual registrars to explore their experience of using the DAs and their further training needs.

Both sets of interviews were semistructured and audiotaped. Data was coded by the four co-investigators and emerging themes identified and compared for reliability and validity.[5]

Results

At the start of the project we recruited 11 registrars and conducted eight one-on-one interviews (interviewee quotes below denoted as 1–7, 11) and one focus group of three registrars. We were only able to follow up with five registrars as the others had left the area by the time of follow up, a disappointing result that represents a limitation of our study.

Attitudes to shared decision making

Overwhelmingly the registrars had a positive attitude to SDM, identifying the sharing of decisions with patients as being very important. They reported that they already used the SDM model to varying degrees in their practice.

The internet was seen as a good method of giving patients extra details about management and allowing patients time to think about their choices.

'I give the patient all the options and then I usually send them away for a couple of days to come back. I often will ask them if they have a computer and ask them to look something up on the net about it' (1).

A strong theme was that sharing decisions leads to greater patient satisfaction with the treatment decision and therefore better adherence with subsequent management.

'I think that the advantages, the degree of patient responsibility for their health and their decision that they are more likely to accept the outcome if they have had an active role in that' (6).

Problems with shared decision making

Problems relating to SDM include the time factor and the possibility that patients might not choose the correct option (in the doctor's opinion). There was some unease about moving from a degree of paternalism to giving patients a real choice.

'I guess there is more potential for the patient to choose an option that you really don't feel is in their best interest and then you are sort of a wee bit stuck' (3).

Differences between general practice and hospital

Registrars believed that doctor-patient interactions in general practice are more suitable for adopting a SDM model as patients tend to be more active partners in the consultation.

'Definitely – more highly involved in GP practice – management of patients in a hospital is definitely a lot more paternalistic...' (11).

Learning about SDM

Role models

The registrars felt they had learnt about management models through observation of other doctors rather than from formal teaching sessions.

'Since then, in the last 3–4 years, really just watching other people, doing observations – and kind of it (sic) is also discussing so we're having teaching sessions with the bosses here and with the supervisors and part of it is also talking to them about how they do it and what they think the process should be' (4).

Attitudes to DAs

Knowledge

None of the registrars had used a web based decision aid before. Some knew what they were or could define them but had no practical experience of them.

Advantages

The registrars could see several reasons to use DAs, including giving patients more information, helping patients to take responsibility for their own health and aiding patient adherence to treatment.

'It will give them a chance to come back with more intelligent questions about what is actually really bothering them' (2).

Consultations in which DAs could be useful

Registrars suggested different scenarios in which DAs could be useful. Some involved screening decisions, others related to longer term management of conditions and the use of DAs as patient education tools.

'The two I used it for were mainly antibiotics with otitis media and also for the PSA screening decisions. Because both of those I normally give them the option to talk about it anyway...' (4).

Attributes of patients with whom to use DAs

Registrars considered that DAs would be more useful for younger people as this group would more likely have online skills and access to the internet.

'I think probably younger people was easier. I think from about 50 there's difficulty in explaining a decision aid and a lot of them don't have computer skills anyway' (4).

This opinion seemed to be based on supposition rather than by directly asking elderly patients; their responses when asked about their willingness to use the internet sometimes came as a surprise.

'I've had a couple of oldies that have had computers and have been on the net and will go, "yeah, that's a good idea"' (1).

Further considerations included the socioeconomic status of the patient as it related to internet access and also patients' English proficiency and their ability to understand information provided in English language DAs.

Resistance/barriers to patient use of DAs

Wanting to make decision within same consultation

Registrars believed that many patients wanted to have their management decided on the day of the consultation rather than access the DA at home and return at a later date. This may be because of the additional cost for the patient in making further appointments or the desire to make instant decisions. In these cases the DA could be used as a patient education resource, similar to a printed leaflet.

'We find though that most people aren't wanting to delay a decision very often – much more confident people want to make a decision on the spot. Once the decision has been made it is more a matter of giving them information sheets about that decision' (2).

However one registrar saw no problem in asking patients to return at a later date.

'I think it's very much the way you approach the consultation' (1).

Attempting to use a DA was also viewed as being a possible inconvenience to the patient if the patient perceived they were being given 'homework' outside the consultation. Some registrars expressed concern that even if the patient accesses a decision aid outside the consultation, they may not return for follow up, meaning there will be no opportunity to review the patient's understanding of the condition and/or treatment options. To avoid this, registrars felt it best to go through the decision aid or treatment options within the consultation.

'...and even when I am just explaining that there are pros and cons they seem to feel that they could absorb that information best or ask questions just within the consultation' (6).

Barriers to doctor use of DAs

Concerns about the process

There were a number of reasons why registrars were less than keen to use DAs. Some felt the use of DAs might reduce the authority of the doctor's opinion or at least lead to patient expectations of GPs being unfulfilled.

Concerns about accessibility and reliability of information

Some registrars noted problems with some DAs themselves. Registrars were concerned about the navigability of DAs and the need to register – and in some cases pay – to use them. They felt this might might deter patients from using some DAs properly, or even from accessing them at all.

Time

The concern about time was twofold. First, the registrar had to have the time to review DA sites and be satisfied with the accuracy and reliability of the content. Second, the registrar had to have sufficient time within the consultation to engage the patient in the process of using the DA.

'The biggest barrier is the fact (of) being a new registrar struggling to get everything I needed to get done in that consultation anyway... so I guess the time factor, being a short consultation. The other thing was even just with my own time to actually find DAs that I felt comfortable using' (3).

Ways of using DAs

Decision aids may be used interactively in the consultation in partnership with the patient, enhancing the SDM aspect of the process. This would effectively eliminate concerns about getting the patient to return for follow up.

Effect of the project on behaviour

Registrars learnt from the project and the process without necessarily wanting to pursue the use of DAs.

'It made me think a little more about the decision aid... but ultimately didn't have a great impact on my practice. I think when more user friendly and more comprehensive decision aids are available I probably would take them up' (2).

'I think it has made me a lot more aware of it (sharing decisions with patients) (3).

Training needs

Registrars were keen to have more training in these skills, in particular in the facilitation of patients making health care decisions.

Discussion

Most registrars had positive views and some

pre-existing knowledge about SDM and tended to use the model to a certain extent already.

The main perceived barriers to SDM and the use of DAs were time, the possibility that the patient might not choose the 'correct' option, and the possibility that the doctor might be more aware of the patient's best interests than the patient themself.

This showed that while registrars leaned theoretically toward being patient centred, they were often fairly paternalistic in practice, probably due to their training. Changing to a patient centred approach is hard to sustain and intensive support is required[9] in the early years, especially when moving from predominantly hospital based training to the community.

An assessment of interns' skills in 2000[10] found that while the interns felt competent in history taking and clinical examination, they felt they were less skilled in management and giving information sensitively. British general practice registrars report that they are not receiving the necessary training in the skills needed for successful involvement of patients in decision making;[11] there seems to be a similar picture in Australia.

The registrars' perceptions that patients want a decision to be made immediately may be a function of the types of consultation that registrars have: they are often seeing patients they have not consulted with before and who have more 'acute' problems such as infections. Registrars start seeing patients with chronic conditions or conditions that allow time for choice later in their attachments, when they are busier and time may be short for following up those patients. However one registrar pointed out that it is the way in which the consultation is conducted that gives patients a chance to become involved in the decision making process.

Registrars felt that many patients preferred decisions to be made for them. Junior doctors acknowledge that they also make value judgments about patients by intuition,[12] but the authors would argue that such intuition should be confirmed by exploring the patient's desire for involvement in the decision making process.

The registrars' feelings that they wanted to use DAs as educational resources rather than as interactive tools may be a reflection that the

DAs currently available are not sufficiently user friendly to be used in an interactive manner, and are more easily implemented as sources of patient information.

There seems to be little formal training on SDM or DAs in undergraduate medical courses or the postgraduate general practice curriculum. Registrars were keen to undertake more training in SDM skills, and most felt they had learnt from this short intervention. The authors therefore recommend that training regarding SDM and DAs be incorporated into the postgraduate curriculum and that such training be evaluated.

Conflict of interest: none declared.

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