



Medical Decision Making

Decisions, choice and shared decision making in antenatal clinics: An observational study

Francesca Garrard^{a,*}, Matthew Ridd^b, Harini Narayan^c, Alan A. Montgomery^d^a School of Acute Care Common Stem, Severn Deanery, Bristol, UK^b Centre for Academic Primary Care, School of Social and Community Medicine, University of Bristol, Bristol, UK^c The Great Western Hospital, Swindon, UK^d Nottingham Clinical Trials Unit, University of Nottingham, Nottingham, UK

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ABSTRACT

Objective: The UK Government has prioritised shared decision making (SDM) and choice in maternity services, but no studies have explored the breadth of antenatal decisions or the feasibility of this aspiration. This study aimed to describe the decisions made, investigate the factors associated with choice and explore SDM practice.

Methods: Cross-sectional audio-recording of consultations in a UK district general hospital. Multi-level regression models were used to investigate associations between choice and doctor, patient, consultation and decision variables.

Results: 585 decisions were documented with a mean of 3.0 (SD 1.5) per consultation. No choice was offered in 75% of decisions. Choice was associated with the decision topic, consultation length, Royal College membership status and presence on the specialist register.

Conclusions: Without a choice, it will be challenging for a patient and their healthcare profession to truly share decisions.

Practice Implications: If universal SDM is the aim, then further work is required to understand the factors impacting choice availability and SDM, while engaging and supporting healthcare professionals to offer options and share decisions with patients.

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1. Introduction

Shared decision making has been described as a middle ground between paternalism and informed choice. It involves the health care professional and patient exchanging information, discussing different options and making a decision together [1–3]. In 2010, the UK government prioritised shared decision making and choice, particularly in maternity services [4]. This reflected the belief that sharing decisions with patients was not only an ethical obligation, but would improve patient satisfaction, understanding and adherence. Within a culture of promoting patient engagement and self-care, it aimed to improve health outcomes and reduce health costs.

A key model of shared decision making proposed by Elwyn et al includes a list of competencies, which are shown in Box 1 [2]. Elwyn's model emphasises that shared decision making is

dependent on having a choice between equally valid options, known as equipoise [2]. In these decisions professionals are unable to have a clear preference based on research evidence. These decisions have been described as “common” but their frequency has never been formally described [5].

A number of studies suggest that shared decision making is associated with improved patient satisfaction, but there is limited evidence of an impact on treatment adherence or clinical outcomes [6]. There has also been little research documenting the range of decisions made within medical consultations and the factors affecting patient choice. Braddock et al. have demonstrated that American community consultations contain a mean of 3.2 decisions (range 1–8). Most decisions in this study were of basic or intermediate complexity (94%), and were initiated by doctors (86%) [7,8]. When O’Cathain et al surveyed women in Wales, 54% felt they had made informed antenatal and postnatal choices, but informed choice varied between decisions (foetal monitoring 31%, foetal screening 73%) and was associated with patient characteristics [9]. In order to establish if shared decision making is feasible, it is important to understand whether the decisions being made commonly involve multiple options.

* Corresponding author at: School of Acute Care Common Stem, Severn Deanery, Deanery House, Vantage Business Park, Old Gloucestershire Road, Hambrook, Bristol, BS16 1GW, UK.

E-mail address: FGarrard@doctors.org.uk (F. Garrard).

Box 1. Competencies for shared decision making

- Implicit or explicit involvement of patients in decision making process.
- Explore ideas, fears and expectations of the problem and possible treatments.
- Portrayal of equipoise and options.
- Identify preferred format and provide tailor-made information.
- Checking process: understanding of information and reactions (e.g. ideas, fears and expectations of possible options).
- Checking process: acceptance of process and decision making role preference, involving the patient to the extent they desire to be involved.
- Make, discuss or defer decisions.
- Arrange follow-up.

Based on competencies included in Elwyn G, Edwards A, Kinnersley P, Grol R. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. *Br J Gen Pract* 2000 Nov;50(460):892–9. [Research Support, Non-U.S. Gov't].

Therefore, we aimed to describe the decisions made in a secondary care obstetric clinic; including the options offered to women and the factors associated with more than one option (choice) being offered.

2. Methods

This was a cross-sectional study, which took place in the obstetric outpatient department of a southwest UK district general hospital. This service runs approximately 7500 antenatal appointments per year and is staffed by six consultants, five Obstetrics and Gynaecology trainees, six career grade doctors (non-consultant staff grade doctors) and two locums (temporary staff), each with a midwife.

All women attending clinics during the study period were recruited, if they were able to provide written consent; not previously taken part; and at least 18 years old. However, they were excluded if they did not receive the posted information leaflet; or if the midwives, doctors or any friends or family attending with them did not provide written consent. As this was an exploratory study a formal sample size was not determined, but we aimed to recruit as many women as possible over a two-week period. This was extended to enrol more women from clinics with low recruitment rates and data were collected between January and March 2011.

This descriptive study observed medical consultations via audio recording and coded the decisions made and options available, in each consultation. The participants were blinded to the exact outcomes of the study. They were informed that the study was investigating communication skills, in order to prevent any change in decision making behaviour.

Midwives and doctors were given information leaflets prior to the start of the study and consented before each clinic. Where staff members notified the research team that they didn't wish to take part, their patients were not approached. Prior to the start of each clinic, recording equipment was set up in the consulting room and the patient lists were labelled with study numbers. Patients were approached as they checked in for their appointment and patients who consented were given a card. If the patient had a card then the doctor would start recording, and read out the study number from their patient list before carrying on the consultation as normal. All recordings were checked prior to coding and a few were excluded

because they were incomplete. One researcher coded all the consultations (FG) and a second researcher (MR) rated a sample of thirteen recordings (one from each doctor), to assess inter-rater reliability of the classification system and choice variable.

Anonymous data on gestation, age and deprivation (index of multiple deprivation score) were collected for all patients who were booked to attend the clinics, to allow a comparison between participants and non-participants [10–13]. The IMD is a geographically based deprivation score produced by the UK Government that includes data on areas such as income, employment, education, housing and child poverty. Across the UK, the IMD ranges from 0.53 to 87.8, with higher scores indicating more deprivation. Across the hospitals local authority, the mean IMD is 17.2 (SD 13.6). For participants, consultation duration and type (first or follow up appointment) were also collected. Doctors were asked to provide basic demographic data; including grade, membership status and general medical council (GMC) number. The GMC number was used to obtain publically available data in place of graduation and presence on the specialist register [14]. In joint obstetrician–physician clinics, the obstetricians' demographic data were used for analysis.

Decisions were defined as “a verbalised choice or deferment of choice that could alter the patient's current or planned management.” This was based on Braddock's original definition, but adapted to include deferment as a valid outcome [2,7,8]. Care was taken to distinguish between decision-making and information giving. Information giving occurred when women asked a question and the doctor responded with advice, but there was no commitment to a particular course of action and hence a decision was not made. In the absence of any known system for classifying obstetric decisions by topic, the authors developed a categorisation system de novo. While listening to the consultations, decisions were identified and sorted into sub-categories, until no new decisions were found. Each time a decision was identified, it was either matched with an existing decision (and coded similarly) or it was added as a new decision under a sub-category. For the purposes of analysis, the subcategories were grouped into five decision categories (DCs): Delivery; Care Structure (appointments, referrals and admissions); Investigations; Medication and other therapy; and Other. Each consultation was reported as a binary variable (category discussed or not discussed) for each of these five categories.

The number of different options that were offered and available to be chosen were counted per decision. Where the option of doing nothing was offered, this was counted. However, options that were excluded by the healthcare professionals as impractical or unsafe did not count (see Fig. 1). Each decision was converted into a binary variable indicating that a choice between multiple options was or was not offered. The number of decisions with choice was divided by the total number of decisions in the consultation and reported as a percentage. This percentage was called the decisions with choice (DWC) variable and formed the study's primary outcome. The secondary outcome measures included the number of decisions per consultation, who initiated the decision discussion and the range of decisions made. They also included the proportion of decisions where the option to do nothing or defer the decision was offered, and the proportion of decisions that were deferred.

Basic descriptive statistics (percentages, means and standard deviation) were used to analyse and present the decisions made. Agreement between the two raters was assessed using a Bland–Altman plot. This scatter plot compares the pair mean with the pair difference for each observation [15]. In doing so, it uses the pair mean as an estimate for the unknown true value and the mean difference as an estimate of bias [16,17]. The Bland–Altman compares points in relation to a horizontal line at a mean difference of 0, which indicates perfect agreement. In normally distributed data, 95% of observations should lie within two

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