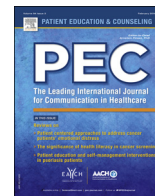




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## Communication study

## Using Option Grids: steps toward shared decision-making for neonatal circumcision

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## ABSTRACT

**Objectives:** To assess the impact, acceptability and feasibility of a short encounter tool designed to enhance the process of shared decision-making and parental engagement.

**Methods:** We analyzed video-recordings of clinical encounters, half undertaken before and half after a brief intervention that trained four clinicians how to use Option Grids, using an observer-based measure of shared decision-making. We also analyzed semi-structured interviews conducted with the clinicians four weeks after their exposure to the intervention.

**Results:** Observer OPTION<sup>S</sup> scores were higher at post-intervention, with a mean of 33.9 (SD=23.5) compared to a mean of 16.1 (SD = 7.1) for pre-intervention, a significant difference of 17.8 (95% CI: 2.4, 33.2). Prior to using the intervention, clinicians used a consent document to frame circumcision as a default practice. Encounters with the Option Grid conferred agency to both parents and clinicians, and facilitated shared decision-making. Clinician reported recognizing the tool's positive effect on their communication process.

**Conclusions:** Tools such as Option Grids have the potential to make it easier for clinicians to achieve shared decision-making.

**Practice Implications:** Encounter tools have the potential to change practice. More research is needed to test their feasibility in routine practice.

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## 1. Introduction

It is widely recognized that parental preferences are vital to decision making about newborn male circumcision. Clinicians, therefore, must be able to convey information about the health benefits and risks in an unbiased and accurate manner [1]. However, evidence indicates that there is a need to improve how clinicians engage parents in conversations about newborn male circumcision [2,3]. For example, a study of 136 Australian parents found that 41% wanted more information prior to or at the time of childbirth to help them make a “better” decision about circumcision [4]. Similarly, 55 of 149 parents in the USA making a decision about circumcision did not receive adequate information [5].

Parents are also confronted by conflicting recommendations. For example, the American Academy of Pediatrics (AAP) says that the “preventative health benefits of elective circumcision of male newborns outweigh the risks” [1], while other guidance states the claimed benefits are “questionable, weak, and likely to have little public health relevance in a Western context” [6]. Given this context, there is a need for more research in how to facilitate a discussion with parents using the principles of shared decision-making (SDM).

SDM is a collaborative process where patients and their clinicians make decisions together using the best scientific evidence and integration of patient preferences [7,8]. Efforts to implement SDM, such as by introducing patient decision aids, have met resistance, especially in routine clinical workflows [9]. However, some evidence suggests that tools designed to be used within clinical encounters may be more successful [10,11]. One example of these encounter tools are Option Grids, one-page documents that describe the attributes of alternative treatment options by using a set questions frequently asked by patients [12]. These tools were developed to support the implementation of SDM in clinical settings in the United Kingdom [13], and are undergoing

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evaluation in different contexts (TOGA trial protocol) [14]. Previous research in newborn male circumcision has focused on how information provision influences circumcision rates [3,15–17], instead of on the decision-making processes. The primary aim of this study was to introduce clinicians to an Option Grid for newborn male circumcision and assess the impact of their use of the tool on the SDM process. Our secondary aim was to assess parent involvement in the decision-making process and whether clinicians perceived the tool to be acceptable and feasible.

## 2. Methods

To achieve triangulation, we assessed clinician-patient interactions applying a mixed-methods design and analysis. The Dartmouth College Committee for the Protection of Human Subjects provided ethical approval for the study.

### 2.1. Development of the Option Grid

The Circumcision Option Grid (see Supplementary Table) was developed by an editorial group composed of researchers, clinicians, and parents, following a published procedure [18]. The editorial group compiled a list of the most common parental questions and concerns about circumcision and reviewed the current literature to provide answers.

### 2.2. Clinician training in the use of the Option Grid

Clinicians who agreed to participate in the study were introduced to the Option Grid by one of the investigators (MF). After viewing a short online video that demonstrated the use of the tool, each clinician participated in a simulation exercise using role play to consolidate their skills. The training emphasized that clinicians should “explain it, give it, use it”—introduce and describe the tool, give it to the parents, and use it to facilitate a discussion and elicit parental pReferences

### 2.3. The setting and participants

The study was implemented in the newborn care unit at Dartmouth Hitchcock Medical Center, New Hampshire, USA. Parents of male newborns who were over 18 years of age and spoke English and clinicians who discussed circumcision with parents were eligible to participate. Parents who were caring for babies with serious complications were ineligible. We obtained permission from consenting parents and clinicians to video-record, transcribe, and analyze their clinical encounter. We planned to examine four clinical encounters per clinician in both pre- and post-intervention phases, rendering a proposed sample of 32 sets of parents considering circumcision.

### 2.4. Data collection

#### 2.4.1. Video-recordings and transcripts

Two authors (MF and SG), and a research assistant each transcribed one third of video-recorded encounters. MF and SG examined clinician communication strategies, the duration of

encounters, clinician adherence to suggested use of the intervention, and the number of questions asked by parents.

#### 2.4.2. Post-intervention semi-structured interviews

To explore clinicians' reactions to the use of these tools, each clinician was interviewed four weeks after their final post-intervention encounter, and asked three questions: “What are your thoughts on the Option Grid itself? Did you find the Grid helped or hindered your process, and in what way? What other additional thoughts do you have on using the Grid?” Detailed notes of the interviews were kept.

### 2.5. Analysis

#### 2.5.1. Quantitative analysis

We used Observer OPTION<sup>5</sup> to assess SDM in the pre- and post-intervention encounters [8,19]. This five-item measure is based on the collaborative deliberation model of constructive engagement, comparative learning, preference construction and integration [13]. Assessments provide scores that are rescaled from 0 to 100 (maximum), where higher scores indicate increasing levels of SDM. Each video-recording was assessed independently by two raters (MF & SG), who subsequently compared agreement levels. Following this calibration step, the recordings were re-assessed independently before scores were collected for final analysis.

To assess changes in communication we recorded the difference in encounter duration and the number of questions asked by patients. We examined the overall mean difference in OPTION<sup>5</sup> scores in pre- and post-intervention encounters at both group and clinician levels. We evaluated whether the effect of the intervention was consistent across clinicians. We assessed the effect on the group mean of removing high or low individual scores. To account for the possible correlation of OPTION<sup>5</sup> scores at the clinician level, we used a generalized estimating equation approach with an exchangeable working correlation structure and robust standard errors [20].

#### 2.5.2. Qualitative analysis

2.5.2.1. *Video-recordings.* We analyzed the transcripts using iterative interpretative cycles from thematic analysis [21,22]. An initial set of codes was developed, then after independent analysis by MF and SG, the codes were reviewed and modified. A third researcher (GE) coded a sample of transcripts, as a verification check for “other competing interpretations” [23]. A final reflexive analysis involved comparison and final interpretation (MF, SG, GE).

2.5.2.2. *Post-intervention semi-structured interviews.* Data from the post-intervention interviews with clinicians were also analyzed using a thematic analysis process.

## 3. Results

Three attending and two resident clinicians agreed to participate. One clinician left the study after conducting one pre-intervention encounter (we excluded this from the dataset). Prior to training in how to use Option Grids, the four participating

**Table 1**  
Comparison of pre- and post-intervention encounters ( $n = 32$ ).

	Pre-intervention (SD)	Post-intervention (SD)
Mean encounter duration (min:s)	8:58 (3.8)	8:27 (4.9)
Range of encounter duration (min:s)	4:23–16:11	2:16–17:10
Mean number of parent questions	3.2 (SD 2.6)	5.3 (SD 5.0)

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