



Medical Education

Training physicians in shared decision-making—Who can be reached and what is achieved?

Christiane Bieber^{a,*}, Jennifer Nicolai^a, Mechthild Hartmann^a, Klaus Blumenstiel^a, Nadja Ringel^a, Antonius Schneider^b, Martin Härter^c, Wolfgang Eich^a, Andreas Loh^d

^aUniversity of Heidelberg, Department of Psychosomatic and General Internal Medicine, Heidelberg, Germany

^bUniversity of Heidelberg, Department of General Practice and Health Services Research, Heidelberg, Germany

^cUniversity of Freiburg, Department of Psychiatry and Psychotherapy, Freiburg, Germany

^dUniversity of Freiburg, Department of Primary Care, Freiburg, Germany

ARTICLE INFO

Article history:

Received 15 July 2008

Received in revised form 3 March 2009

Accepted 6 March 2009

Keywords:

Shared decision-making

Physician–patient relationship

Physician training program

Physician personality

ABSTRACT

Objective: To report on experiences with a general shared decision-making (SDM) physician training program offered to physicians throughout Germany.

Methods: This study enrolled 150 physicians in an 8-h SDM training program. Physicians were assessed with standardized instruments before and after training. Main variables of interest were physician professional attributes, personality characteristics, attitudes, measures of training success (quality rating, knowledge, competency ratings), and variables associated with training success.

Results: The SDM training obtained positive quality ratings, led to an amelioration in an objective SDM knowledge test ($p < .001$), and highly improved physicians' confidence in their SDM competencies ($p < 0.001$). It attracted experienced, middle-aged (45 years), male and female (46%) physicians, mostly office-based (2/3) general practitioners and internists (2/3). Most physicians (94%) reported positive attitudes towards SDM. They were securely attached (63%) with predominant social career choice motives (46%). Physicians with personality characteristics clashing with the SDM concept benefited mostly from the training.

Conclusion: A voluntary SDM training program is attractive to practicing physicians and effective in increasing SDM-related confidence and knowledge.

Practice implications: Even physicians who are highly motivated to use SDM can improve their skills and benefit from SDM training. The dissemination of SDM training programs should be encouraged.

© 2009 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Shared decision-making (SDM) is increasingly advocated as the ideal model of physician–patient interaction when it comes to making healthcare decisions [1–5]. In addition to ethical considerations, which prompt the use of SDM, there is also growing evidence from surveys that this is the approach that most patients desire [6–8].

Strategies for the advancement of SDM in medical encounters have either focused on the patients, the physicians, or both, as SDM requires a commitment from both parties [2,9]. For patients, the

use of patient decision aids (PtDAs) is a well-acknowledged and an increasingly employed means to prepare for SDM [10–13]. For physicians, SDM training programs seek to convey SDM skills to physicians and medical students [14–23].

Whereas the interest in PtDAs seems to be flourishing, and many beneficial effects have been shown in a multitude of trials [10–13], much less is currently known about the feasibility, acceptance, and effects of SDM physician training programs [22,23]. Until now, rather few SDM physician training programs have been evaluated in RCTs. However, the few existing studies show that training programs are – along with PtDAs – another effective way to facilitate an SDM approach in medical consultations [14–17,20,22,23]. Most of those SDM training efforts have been undertaken within clinical trials [14–17,20,22,23]. Consequently, samples are rather homogeneous and the generalizability to a broad range of work settings remains unclear.

Currently, there are no reports on general SDM training. So far, SDM training has mostly been tailored to promote SDM in disease-specific situations, as in atrial fibrillation, prostatism, menopausal

Abbreviations: SDM, shared decision-making; GI, general interaction; PtDA, patient decision aid; CME, continuing medical education; RCT, randomized controlled trial.

* Corresponding author at: Centre for Psychosocial Medicine, Department of Psychosomatic and General Internal Medicine, University of Heidelberg, Thibautstraße 2, D-69115 Heidelberg, Germany. Tel.: +49 6221 56 38657; fax: +49 6221 56 8450.

E-mail address: Christiane.Bieber@med.uni-heidelberg.de (C. Bieber).

symptoms [22,23], acute respiratory infections [14], chronic pain [15,16,20], or depression [17]. The trainings available have only been roughly outlined [14,18,22].

Most SDM trainings refer to the set of SDM core competencies suggested as a framework for SDM [24,25]. These competencies exceed the basic communication skills usually taught; additional, advanced skills are required for partnership-building, risk presentation, discussion of evidence-based information, and explicit dialogue [24].

Nowadays, most physicians adopt a positive attitude towards SDM [9,21,22,26,27]. In representative samples, a majority of 75–89% of physicians even name it as their favourite interaction model [9,27]. However, surveys demonstrate that the actual use of SDM lags far behind the ideal level of SDM implementation [21,27–30], and, by far, patients do not feel involved to the extent they desire [8]. Even though physicians are motivated and like the idea of SDM, they are not sufficiently prepared for it. Full engagement requires certain advanced SDM communication skills [2,24]. This leads to the conclusion that efforts to disseminate SDM training approaches in practice are needed [2,31].

To date, little is known on how practicing physicians will respond to a voluntary SDM training offer [18]. To our knowledge, no efforts have been made to systematically offer general SDM training opportunities as part of continuing medical education programs for physicians. “Low-threshold” training opportunities might increase the motivation for physicians to participate.

The ability to establish a good relationship with the patient is one of the key goals of health care, and it is of special importance in SDM. It is known from related research in psychotherapy that certain personality characteristics, such as physicians’ attachment style [32] and interpersonal interaction style [33], have an important influence on the ability to form a positive physician–patient relationship. Against this background, it seems likely that physicians’ attachment style and interpersonal interaction style will have an impact on the receptiveness for SDM. However, studies to date have not assessed the relationship between these personality characteristics and the success of SDM training.

During 2006–2007, an SDM transfer project jointly conducted by the university clinics of Heidelberg and Freiburg tackled the challenge of implementing SDM into the German healthcare system using a variety of strategies and measures. The transfer project was part of a national German research consortium called “Patients as Partners in the Medical Decision Making Process,” [34] which was supported by grants from the German Federal Ministry of Health. In this paper, we focus on recent experiences with one of these transfer measures: a general SDM training program [35] offered free of charge to volunteer physicians throughout Germany.

The aim of this practical clinical trial [36] was to explore the possibility of implementing SDM training for physicians in practice. Positive immediate and long-term effects of this SDM training program for physicians and their patients have been demonstrated in an RCT before [16]; therefore, outcome-based long-term effects were not reassessed again. The rationale was, rather, to reach the highest number of participating physicians by keeping their additional workload as low as possible. The objective of this paper is to describe our experiences with the training. Special attention is paid to participant characteristics and measures of training success.

Central questions that will be addressed in the present paper are:

- Will a voluntary SDM training program attract practicing physicians?
- What are the characteristics of physicians who participated in the training and what are their attitudes towards SDM?

- Was their training successful?
- Are there any specific participant characteristics that are associated with training success?

2. Methods

2.1. Participants

Physicians willing to participate in an SDM training program were recruited from January 2006 until January 2007. Standardized general SDM physician trainings were conducted by the Heidelberg and Freiburg study teams and offered throughout Germany. The training was advertised by flyers distributed at national medical conferences and by articles in relevant German medical journals describing the training curriculum and announcing the possibility of enrolling, free of charge. Physicians could easily register for the training via e-mail or telephone. As an incentive, continuing medical education (CME)-credit points were allocated to all physicians for training participation by Federal State Medical Associations. In Germany, it is obligatory for physicians to collect CME-credit points to keep their health insurance license. The trainings took place in any German city where a minimum of at least 8 physicians could meet.

Physicians were eligible for study participation if they had direct patient contact, either worked in a hospital or practice, attended the complete training program, agreed to fill in the study documentation, and provided informed consent to anonymous data analysis.

The Ethics Committees of the Universities of Heidelberg and Freiburg approved the study.

2.2. Training procedures

The training program comprised two modules, each 4 h in duration, and was administered over the span of two afternoons within four weeks. The size of the training groups varied between 8 and 12 physicians. The curriculum, training procedures, and all teaching materials are available in a training package [35] comprising of a written training manual, and a DVD featuring power-point slides and SDM model films. The package may be obtained from the authors or at www.patient-als-partner.de. The program aims to improve SDM-related physician knowledge, attitudes, and skills. The didactic methods used include short power-point-supported interactive presentations, model films on SDM consultations, instructional videos with standardized patients, group discussions, practical exercises, and role-playing of simulated consultations. The use of risk charts and decision boards for several exemplary conditions (e.g., diabetes, hypertension, back pain, depression, and breast cancer) is integrated into the training sessions. The agenda of the first training session covers patient preferences [6], the theoretical framework [24], key competencies, effects, indications [37], limitations, and the pros and cons of the SDM concept. The second training session is aimed at consolidation by embedding the SDM skills into the broader concept of patient-centeredness. Its agenda covers aspects such as partnership-building with patients, techniques of good communication, special challenges with regard to difficult patients, and consideration of the psychodynamics of the physician–patient interaction from the perspective of the physician.

2.3. Data collection and measures

Physicians filled in a set of questionnaires at two points in time: at a baseline two weeks before the training (T0) and immediately after the last training session (T1).

Download English Version:

<https://daneshyari.com/en/article/3816292>

Download Persian Version:

<https://daneshyari.com/article/3816292>

[Daneshyari.com](https://daneshyari.com)