



Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou



Surgeons' perspective on shared decision making in trauma surgery. A national survey

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ARTICLE INFO

Article history:

Received 29 December 2017

Received in revised form 14 May 2018

Accepted 5 June 2018

Keywords:

Shared decision making

Orthopaedic surgery

Trauma surgery

Treatment decisions

ABSTRACT

Objective: This study aimed to answer the following research question: What is the knowledge, opinion, and experience of trauma surgeons with respect to shared decision making (SDM)?

Methods: An online survey was sent out in September 2016 to all 257 surgeons registered as a trauma surgeon with the Dutch Association of Trauma Surgery, to gather demographic, knowledge, and practice based information regarding their use of SDM. Results were presented according to the Checklist for Reporting Results of Internet E-Surveys (CHERRIES).

Results: The questionnaire was filled out by 112 (44%) trauma surgeons. Opinions about what SDM entails differed, but 27% described a process that was clearly discordant with current consensus. Eighty-six percent of trauma surgeons regarded SDM as (very) relevant for providing good care. Sixty-two percent reported to encounter problems in achieving SDM.

Conclusion and implications: The general opinion of Dutch trauma surgeons towards SDM is very positive, but many lack the understanding of what SDM really implies and surgeons report SDM to be difficult to accomplish. To improve the occurrence of SDM in trauma surgery, there is an obvious need for education and training in SDM skills for surgeons.

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1. Introduction

Originated in non-surgical disciplines, shared decision making (SDM) has become an accepted way of decision making in many medical fields and is particularly appropriate for decisions with more than one reasonable treatment option (i.e., preference-sensitive decisions). SDM is thought to improve patients' commitment to and satisfaction with their treatment, and to reduce their decisional conflict and anxiety [1–3]. In light of the increasing importance of patient autonomy in contemporary health care and the role that physicians have in supporting that autonomy, it is ethically imperative to make decisions that incorporate the patient's values and priorities. Apart from some decisional challenges with a highly acute nature, many decisions in trauma surgery are preference-sensitive because there is not one clearly superior treatment for all patients with that specific condition. Examples are whether or not to operate a displaced, midshaft clavicular fracture [4] or a displaced proximal humerus fracture [5]. Decisions of this kind are thus suitable for SDM.

However, the concept has proven to be complex to apply and measure in practice [6,7].

In SDM, a medical decision is based not only on scientific evidence, objective patient characteristics, and on the knowledge and experience of the treating physician, but also on the individual preferences and values of the patient [8]. Opposed to other models of medical decision making, the communication in SDM is aimed in *two directions*, so that the patient expresses his or her personal priorities and goals [9]. If these are taken into account when designing a treatment plan together with the patient, it is irrelevant whether the patient or the physician makes the actual decision [10].

The little research that has been done on SDM in orthopaedic trauma surgery focuses mainly on measuring the occurrence and implementation of SDM, and its influence on patient-related outcomes [11,12]. It is however also important to study the concept from the surgeon's perspective, and evaluate what surgeons believe true SDM comprises and what their opinion and experiences are regarding SDM. SDM is not a routine part of surgical training in most countries, and the approach is relatively new in orthopaedic trauma surgery compared with for instance primary care [6]. Also, although literature suggests that most surgeons support SDM and decision aids [13,14], opinions towards this new concept are likely to vary, which could influence the effect

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of interventions aimed to improve SDM or attempts to implement decision aids.

This study aimed to answer the following research question: What is the knowledge, opinion, and experience of trauma surgeons with respect to SDM?

2. Methods

2.1. Design and setting

This exploratory study of Dutch trauma surgeons used a population-based online survey to gather demographic, knowledge and practice-based information regarding their use of SDM. An invitation for the survey was sent out by e-mail in September 2016 to all 257 surgeons who were registered as a trauma surgeon with the Dutch Association of Trauma Surgery. In the Netherlands, trauma surgeons are specialists who treat both visceral and orthopaedic trauma, with a clear emphasis on orthopaedic trauma for most. The investigators developed the survey using a Dutch website designed for this purpose. The technical functionality of the electronic questionnaire was tested before the invitations were sent out by e-mail. In the invitation e-mail, participants were informed about the topic of the survey, its duration (10 min), the fact that all answers were anonymous, and who the investigators were. Up to three reminders were sent out, as appropriate. Results were anonymously downloaded into an excel file, which was automatically converted into an SPSS file. No IRB approval was sought.

2.2. Survey

The terminology for shared decision making used to introduce the survey was: ‘Shared decision making (SDM, gedeelde besluitvorming or samen beslissen)’, in which SDM is the acronym that is often used in the Netherlands. ‘Gedeelde besluitvorming’ is the literal Dutch translation of SDM, and ‘samen beslissen’ is a less formal but commonly used Dutch expression for SDM. These terms were used interchangeably throughout the rest of the questionnaire.

The survey consisted of twelve questions in total. First, the surgeon’s gender and years of experience were assessed, and the type of trauma center that he or she worked in (academic / non-academic). The first open question was: “What is your understanding of SDM?” The literal Dutch translation ‘gedeelde besluitvorming’ was used in this phrase. The extent to which the answers were in line with prevailing views in the literature on what SDM processes entail [9,10] was rated as “concordant”, “inconclusive” or “discordant”. Before data collection started, it

was decided that to be rated as concordant, answers had to contain some aspects indicative of an understanding of key elements of SDM. Regarded as key elements, were the physician-related behaviors that are indicated as essential for SDM, which are marked by an asterisk in Table 1. An answer was rated as inconclusive if it was too general (e.g., talk with the patient about the decision) or too short to reliably determine whether the surgeon understands the concept. Finally, answers were rated as discordant if they disagreed with key elements of SDM (e.g., the patient has to make the decision alone), or did not contain any aspect unique to SDM (e.g., describing SDM only as informing the patient about the pros and cons of the treatment and alternatives). The primary investigator (SW) rated the answers. In any case of doubt, the categorization was discussed with the research team to reach consensus.

Then, the surgeons were asked if they qualified thirteen different physician-related behaviors to be essential for SDM or not. The thirteen behaviors were selected with the help of an expert on decision making (AP), and seven of them are regarded as essential according to current consensus in the literature as indicated with an asterisk in Table 1 [9,10]. The other six were a selection of common behaviors in a decisional conversation, but not essential or even inadequate in an SDM process (e.g., letting the patient decide after giving thorough information).

Next, the survey enquired if surgeons regarded SDM as relevant to provide good care on a five-point scale (1 = ‘not relevant at all’ to 5 = ‘very relevant’), after which they were asked to explain their answer in free-text. The surgeons were asked in what percentage of SDM-suitable decisions they engage in SDM in daily practice (‘0%’ to ‘100%’ on a 5-point scale), and to tick up to three out of six provided reasons for not attempting SDM. Finally, the surgeons were asked to indicate in free-text what decisions they find particularly suitable for SDM and what difficulties they encounter when engaging in SDM, if any. The online questionnaire showed one question per page and did not allow going back to previous answers.

Results of the survey were reported according to the Checklist for Reporting Results of Internet E-Surveys (CHERRIES)-guideline [15].

2.3. Statistical analysis

Quantitative data were analysed using summary statistics; qualitative (free-text) data were categorized, and frequencies of categories were reported. IBM SPSS Statistics for Windows, version 20.0 (IBM Corp., Armonk, N.Y., USA) was used for descriptive statistics to report the outcomes.

Table 1

Physician-related behaviors considered essential for SDM according to 112 trauma surgeons.

Physician-related behaviors during a consultation	Number of participants considering the behavior as essential, (%)
Informing the patient about the possible pros and cons of the treatment*	111 (99)
Explaining to the patient that there is more than one treatment option*	111 (99)
Informing the patient how big the chance of these pros and cons is*	104 (93)
Explaining to the patient why a certain treatment is chosen	99 (88)
Making the decision together with the patient*	98 (88)
Explaining to the patient that his/her opinion is important in making the decision*	96 (86)
Asking the patient about his/her personal values and preferences*	89 (80)
Informing the patient that a decision has to be made	82 (73)
Giving information in more ways than only verbally (e.g., leaflet, website)	68 (61)
Letting the patient decide after giving thorough information	65 (58)
Letting the patient repeat the given information	60 (54)
Asking the patient to bring someone to the consultation	47 (42)
Allowing the patient time by making the decision in a second consultation	42 (38)

* Physician-related behaviors usually described as being essential in SDM models [7,8].

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