Do GPs think patient decision aids are a useful tool?

Michael Wilcock MRPharmS, Paul Hughes MRPharmS and Nick Gibson MRCGP, FPCert

A small survey among a group of GPs has identified certain barriers to the use of patient decision aids. But without such aids can we really claim to practice shared decision making?

The concept of “shared decision making” with patients started to appear in the late 1990s along with the recommendation to make prescribing decisions in partnership with patients through “concordance in medicine taking.” Since then there has been increasing emphasis on shared and informed decision making, in contrast to the doctor-led paternalistic approaches that have previously dominated.

Shared decision making relies on two sources of expertise: the health professionals’ knowledge on the effectiveness, probable benefits, and potential harms of treatment options, while the patient is there as an expert on themselves, their social circumstances, attitudes to illness and risk, and values and preferences. Hence shared decision making is a process where patients are active partners with the clinician in clarifying acceptable medical options and choosing a preferred course of care and treatment.

It is appropriate in the common situation where there is more than one reasonable course of action and evidence does not point to a clear best choice. When patients are supported to be active participants in their care, it has important implications for patient satisfaction, the extent to which people concord with treatment, relationships between patients and professionals and long-term health outcomes.

There is increasing evidence that patients want to take part in decision making. A recent systematic review of peer reviewed journal articles found that in 63 per cent of those articles most patients expressed a wish to actively participate in decisions around their treatment.

Patient decision aids (PDAs) are tools that present evidence-based estimates of the benefits and risks of the available treatment options in sufficient detail such that people are better able to judge their value. Such tools are useful when there are various treatment options, and different people might choose different courses of action. By describing the available options and their salient attributes, these tools are intended to supplement or support the interaction between the person and their healthcare professional.

Their use in clinical consultations has led to improvements in measures of the
Table 1. Number of instances a pre-determined barrier to using PDAs was identified

| Insufficient time in the typical consultation to use a PDA | 16 |
| I’m aware of PDAs but cannot easily locate them | 11 |
| PDAs are typically based on population averages and may not apply to the patient in front of me | 10 |
| I feel less than confident in being able to use them effectively with my patients | 4 |
| I don’t think my typical patients want me to use a PDA | 4 |
| I don’t have confidence in how the numbers are calculated to produce the PDA | 3 |
| I’m not aware of any that would be useful to me | 3 |
| Other | 4 |

quality of treatment decisions for pharmacological preventive interventions.

Graham et al noted that despite strong support for the format, content, and quality of patient decision aids, and physicians’ stated intentions to adopt them into clinical practice, most did not use them within three months of completing the survey. Other studies show that doctors, nurses and other clinicians often think they are sharing decisions more than their patients do. Such reluctance to refer patients to decision support is largely based on the scepticism of professionals that these tools add value, coupled with the difficulties of incorporating the tools into existing workflows and competing organisational pressures. In addition many clinicians were explicit that they would not direct patients to tools that do not support their own views about effective treatments. We set out to gain an understanding of what GPs in one CCG know of PDAs.

Method
Across Cornwall, locality-based prescribing meetings are held five times a year. These meetings, organised by NHS Kernow CCG prescribing team, are intended to have a focus on clinical prescribing and medicines optimisation issues. A GP prescribing lead from each surgery is invited to attend these meetings and disseminate the learning within their own practice.

At each of the three locality meetings late in 2014 the GPs were asked to complete a questionnaire during the tea break having been advised that it was anonymous and would take only a few minutes to complete. The questionnaire contained five questions seeking their views on, and their experience of, PDAs. This small survey consisted of a mixture of closed questions and questions that allowed respondents to make free-text comments.

It should be noted that the prescribing team included an illustrative scenario depicting the use of the NICE atrial fibrillation (AF) PDA (see Figure 1) during these meetings, prior to the request to complete the questionnaire.

Results
The three meetings were attended by a total of 57 GPs, with completed questionnaires returned from 47 (82 per cent). No GP characteristics were recorded, although it is known that approximately 70 per cent were male and approximately half of the GPs belonged to dispensing practices.

When asked how often they had used PDAs in the past 12 months, responses were evenly split between the three pre-determined answers of more than a handful (16, 34 per cent), less than a handful (16, 34 per cent), and not at all (15, 32 per cent).

Thirty-five GPs were aware of easily accessible PDAs, and 12 were not. A range of examples were given by 34 of those GPs who acknowledged their awareness of PDAs. Seventeen GPs named one example of a PDA, 10 named two, five named three or four, with two GPs unable to specify an example. The three most frequently listed PDAs were the NICE AF (17 responses), a lipid management PDA (10 responses) and QRISK (7 responses).

The elements of a PDA that the GPs like were the smiley faces pictogram (Cates Plot), how risk/benefit can be quantified and illustrated, and as a tool to allow the patient to reflect during consultation, and to reinforce the information given. Barriers to using PDAs are shown in Table 1.

Discussion
Although we know that patients desire and value information about treatment choices, there are well recognised challenges in embedding the attitudes, skills, and interventions into routine NHS practice. Barriers that have been identified include concerns about insufficient time, lack of fit into organisational routines and the fact that professionals may perceive there is no need for this approach because shared decision making is already happening. Indeed research suggests that many health professionals may support shared decision making, but need help to implement it in practice. Therefore there is a need to ensure that decision support materials are easily and routinely accessible to both patients and clinicians and that they fit into clinical workflows.

Time was the most frequently acknowledged barrier in our small survey, followed by being unable to easily access PDAs in a busy consultation. Concern by the GP that their patient does not wish to have a consultation that involves a PDA was expressed by only four respondents. Others have suggested that one of the primary barriers to shared decision making may be clinicians’ belief that some patients are either not capable of, or do not want to feel burdened, with making complex medical decisions. Solomon et al found that 90 per cent of patients trusted their doctor to make the best decision for them which these authors argue is at odds with the presumed expectation that patients want shared decision making and choice. They see this as indicating that many patients value having a GP they can trust and do not necessarily wish to be involved in the actual decision making. For the clinician there is also a fear of truly sharing decisions and moving forward with something that a patient wants which may not be consistent with the clinician’s ideal approach.

We had only a few responses indicating lack of confidence in being able to use PDAs. Practitioner acknowledgement that they have limited experience of PDAs either in hypothetical situations or in practice has been identified as a barrier by others.

Limitations of the study include the reliance of the survey on self-reporting and the relatively small number of GPs surveyed. A common problem in questionnaire surveys is the tendency of people to give perceived desirable answers.
Attempts to minimise this tendency were made by emphasising that the responses would be processed anonymously. We also recognise those limitations associated with delivering a questionnaire that was brief and hence could be completed quickly (with the aim of achieving a high response rate), as well gauging the views of GPs who attended meetings held specifically for other purposes and who, in their role of practice prescribing lead, could be described as a self-selected group.

Conclusion
If PDAs are to become part of routine clinical practice they need to be embraced by the clinical community as well as by patients. They need to be established as part of the clinical workflow and included in education, training and development programmes for healthcare professionals. They also need to be easily accessible and available in a useful format. It is clinicians who need to deliver the vision of shared decision making as only they can choose whether or not to share decisions with patients.

References
17. NICE. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NG5. March 2015.

Declaration of interests
None to declare.

Michael Wilcock is head of prescribing support unit, pharmacy department, Royal Cornwall Hospitals NHS Trust, Paul Hughes is senior pharmaceutical adviser, prescribing team, NHS Kernow and Dr Gibson is GP prescribing lead, NHS Kernow