Development of an online tutorial to train doctors in shared decision making with patients considering colon cancer screening

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BACKGROUND AND AIM

The concept of shared decision making (SDM) has recently been incorporated into the German law regulating cancer screening (2013). In 2016, invitation to colon cancer screening will be implemented in regular health services in Germany. Up to now, German doctors are exposed to predominantly biased information on pro colon cancer screening.

The Bavarian Ministry of Health, health fund Techniker Krankenkasse (TK) and the Association of Statutory Health Insurance Physicians of Bavaria (KVB) commissioned the development of a 45 minutes evidence based online tutorial. The tutorial aims at enabling doctors to counsel their patients in colon cancer screening according to the requirements of the law.

METHODS

The design of the tutorial was realized by a multidisciplinary developer group in close discourse with a steering committee. Criteria of evidence based patient information [1,2] were considered in both selection and presentation of information. Based on previous studies [3,4], a new interactive format was developed to visualize risk, benefit, harms and test accuracy in relation to the screening population. A key feature is a video feedback for 7 typical barriers towards patient involvement. The draft was piloted by a theoretic sample of 9 physicians (gynecology, urology, internal medicine, gastroenterology, primary care) followed by in depth interviews to study feasibility, comprehensibility and acceptance. Implemented in the web-based further training platform, CuraCampus, the newly revised version was reviewed by an external EBM expert.

CONSULTATION STRUCTURE

According to SDM, the communication is structured into six stages of a decision making roadmap:
1. Problem definition
2. SDM key-message
3. Explaining options
4. Deliberating
5. Making a decision
6. Follow up arrangements

FORMAT TO PRESENT FREQUENCIES

An identical given total amount (so 000 persons, visualized by a big station) is used to show the following frequencies:
- risk (tailored according to age, sex, fam.history)
- test accuracy
- benefit/ non-benefit
- harms / non-harms

EXAMPLE: colon cancer risk / w, 60-69 / in 10 years

Darmkrebs: Risiko in zehn Jahren

<table>
<thead>
<tr>
<th>Age</th>
<th>Risk</th>
<th>Persons</th>
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<tbody>
<tr>
<td>60-69</td>
<td>1:1000</td>
<td>10 000</td>
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<tr>
<td>70-79</td>
<td>1:500</td>
<td>5 000</td>
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INTERACTIVE VIDEO-BASED SDM TUTORIAL

The training consists of 7 parcours comprising 5 steps demonstrating barriers towards SDM and how to overcome them.

1. Omitting decision
2. Eager recommendation
3. Disturbing presentation of risks
4. Omitting the key message
5. Omitted option: doing nothing
6. Use of relative percentages
7. Avoidance of uncertainty

EXAMPLE: Barrier 7: Step 1: Suboptimal sequence

The doctor provides biased information on possible benefit of coloscopy screening.

Steps 2 & 3: Exercise question / Discovering solution

Which of the following statements apply to the situation of this consultation sequence?
1. The information on benefit enables the patient to make an informed decision.
2. The doctor should report on medical evidence rather than expressing his own opinion.
3. The information about possible benefit is not evidence based, it even impedes the patient from making an informed decision.

Step 4: Coaching / feedback

The coach guides a way to express medical uncertainty as given in the evidence and expert advice.

Step 5: Optimized version

The doctor clearly expresses scientifi- c uncertainty about benefit of coloscopy screening, then indicates his expert view.

RESULTS FROM EVALUATION

Although mostly in favour of screening, most doctors agreed with contents and presentation formats of the tutorial. Some doctors expressed concerns regarding the information on lacking efficacy proof of coloscopy. This information was expected to be easily misconstrued as disussion. With regard to design and didactic, the tutorial was perceived motivating and supportive to acquire SDM skills. Due to non-interactive communication and clear learning goals, the 7 training tracks and the included short coaching sequences were highly appreciated by all participants. In the revision, the sensitive information on the lacking efficacy proof was not removed or diminished. However, to prevent the doctors’ resistance due to cognitive dissonance, more guidance was included how to communicate uncertainty. In particular, the differentiation between reporting scientific evidence and providing advice to the patient was given more emphasis in the tutorial. The external review was positive throughout.

CONCLUSIONS

The newly developed tutorial is a promising intervention into the physicians’ decision making communication. The entire tutorial is now implemented in CuraCampus (training platform). More evaluation is needed to determine the tutorial’s actual impact on the communication and to further investigate the single components. The tutorial can serve as a model to develop tutorials addressing other prototypic medical decisions.

REFERENCES