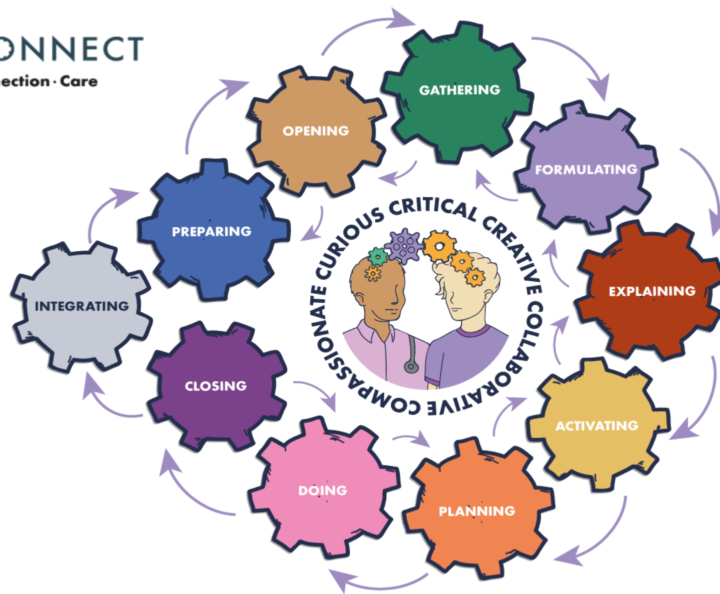
Clinical Communication: taken from student resources

HHW 6- GP session - Planning, Doing, Closing and Integrating. Shared decision making



PREPARING *Am I prepared?*	OPENING *Are we off to a good start?*
- Preparing oneself - Preparing the space - Checking the medical record	- Establishing the agenda - Establishing relationships - Initial observations
GATHERING *Have we covered all the relevant areas?*	**FORMULATING** *What is going and what is next?*
- Sources of understanding - History - Clinical examination	- Bias checking - Considering the options - Red flag signs and symptoms
EXPLAINING *Have we reached a shared understanding?*	**ACTIVATING** *Is the patient better placed to engage in self-care?*
- Chunking - Checking - Visual Aids	- Identifying problems and opportunities - Rolling with resistance - Building self-efficacy
PLANNING *Have we created a good plan forward?*	**CLOSING** *Have I brought things to a satisfactory end?*
- Encourages contribution - Proposing options - Attends to ICE (IE)	- Summary - Patient questions - Follow Up
DOING *Have I provided a safe and effective intervention?*	**INTEGRATING** *Have I integrated the consultation effectively?*
- Formal and informal consent - Due regard for safety - Skilfully conducted procedure	- Clinical record - Informational needs - Affective progressing

Gathering clinical (hi)stories

A comprehensive history is essential to help activating patients with self-care and lifestyle change. Students are encouraged to obtain a well-rounded impression and to consider the information they gather in the 3 domains:

- Nature of the medical problem
- Patient perspective on the problem
- Relevant background and lifeworld

Shared decision making in clinical practice

In their previous Effective Consulting session last week, the students learnt about shared decision making. The following information is from this EC lab session.
In the recent Department of Health White Paper 'Equity and Excellence: Liberating the NHS', Shared Decision Making was highlighted as an essential feature of the NHS moving forwards. Following its publication, the slogan 'No decision about me, without me' hit the headlines.

Shared decision making relies on two sources of expertise:

- The health professional is an expert on the effectiveness, probable benefits, and potential harms of treatment options

- The patient is an expert on herself, her social circumstances, attitudes to illness and risk, values, and preferences

Shared Decision Making is a process in which clinicians and patients make an informed decision together using the best available evidence and based upon both clinical need and patient preferences and consideration of patient values and lifestyle.

Shared Decision Making has also been described as: an interactive process during which patients and practitioners collaborate in choosing healthcare.

Why is this important?

Decisions that are made on behalf of patients, without their input, do not promote an effective partnership between the clinician and the patient. Whilst not all patients want the same level of involvement in decisions about their treatment and care, it is important that clinicians explicitly discuss this with them.

Shared Decision Making encourages the patient to think about what is important to them. It identifies decisions, encourages an information exchange, encourages discussion about personal preferences and develops a shared responsibility for those decisions.

The current evidence base for shared decision making

- Approximately 50% of patients want to be more involved in their healthcare decisions
- On average, 50% of patients don't take medication prescribed (or take it incorrectly), and 70% don't adhere to dietary recommendations made by healthcare professionals.

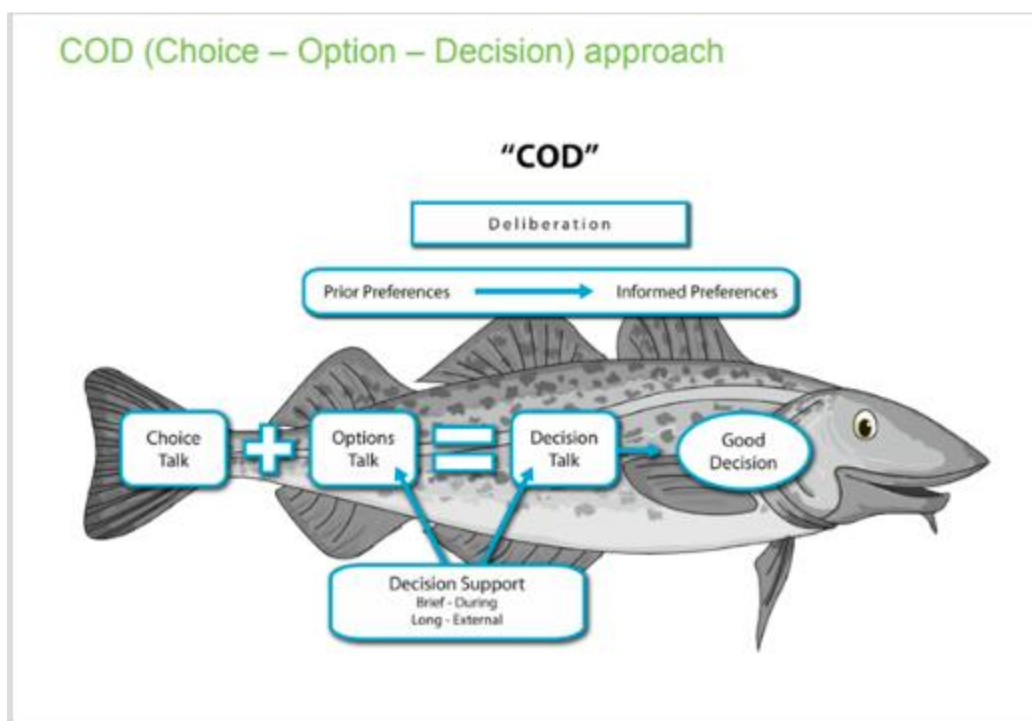
- Better communication and collaboration are correlated with better patient adherence. Training doctors to communicate better enhances patient adherence.
- Patients who are active participants in managing their health and healthcare have better outcomes than patients who are passive recipients of care.
- Shared Decision Making may lead to a reduction in complaints and litigation

Some healthcare decisions are appropriate for shared decision making, and some are not, but the principles of sharing information and collaborative planning between patient and doctors are universal. Understanding the patient's ideas, worries, values and preferences can help negotiate the planning and decision-making aspects of any consultation.

If there is an opportunity for Shared Decision Making, there are a number of issues that need to be considered:

- Firstly, is there a decision to be made? If there is, is it preference-sensitive?
- Is there sufficient time for consideration/information gathering?
- Is the patient actively seeking a balanced relationship within the consultation?
- What are the different treatment options?
- Does the patient wish to be involved in choosing the treatment?

One way to implement Shared Decision Making is using the COD model:



Elwyn, G et al, *A Three Talk Model for shared decision making: multistage consultation process*, BMJ 2017;359:j4891

Patient perspective:

The "Ask 3 Questions" Campaign.

Ask 3 Questions

Sometimes there will be choices to make about your healthcare. If you are asked to make a choice, make sure you get the answers to these 3 questions:

what are my **options**?

What are the possible **benefits** and **risks** of those options?

What help do I need to make my decision?

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MAGIC

NHS Bristol Clinical Commissioning Group

The above information is extracted and adapted from a variety of sources. We recommend using the open access e-learning resource Introduction to Shared Decision Making from which much of this material is derived. It is a well-designed e-learning module. You do not need to register. However, please note that all medical students and other healthcare professionals are able to register for further online training modules at e-learning for health which is an invaluable resource.

Planning

So, when doctors make a plan with their patients it should not be the doctor telling the patient what to do or what will happen next. Instead, the doctor should discuss the available options with the patient and provide enough information to collaborate with the patient to make the best decision for them. As part of this the doctor needs to work out how much information the patient needs and the patient's perspective—their ideas, concerns, and expectations. The doctor should try and enable the patient to be as involved as they can be and enable self-efficacy in their care.

Safety net

Part of making a plan is knowing when things are not going as expected and what to do about it. This is called "safety netting." Missed diagnoses are common, especially when doctors see patients at an early stage in their illness, so discussing uncertain diagnosis with patients is important. Also, certain conditions or medication carry a risk of complications or side effects so knowing what to do if they occur is important. Roger Neighbour[1] considered safety netting a core component of the consultation and said there were 3 questions to ask oneself:

1. If I'm right, what do I expect to happen?
2. How will I know if I'm wrong?
3. What would I do then?

[1]Neighbour R. *The inner consultation*. 2nd edn. Oxford: Radcliffe Publishing; 2004.

Doing

Not all consultations have a 'doing' aspect, but many do. At one extreme this might include simply handing over a prescription, at the other perhaps a joint injection, a coil fitting, or implant insertion. We need to consider whether our intervention is appropriate, safe, and effective, and make sure the patient has consented in an informed way. Spend some time talking to students about the things you 'do' in consultations, and how you go about seeking consent.

Closing

Students often find bringing the consultation to a satisfactory end is tricky. They may have discovered on their home visits that the conversation with a patient came to uncomfortable end as they "just couldn't think of anything else to say." But even experienced clinicians get the patient who brings up their most important problem just as they are leaving the room. Talk to your students about how you end consultations. You will have your own ways of doing this but use the following points to start you off:

- Identifying next steps; for you and the patient
- Summarising key points of your discussion. Consider a written summary or patient information leaflet

Does the patient agree you've come to the end? Have they got anything they haven't asked, or you haven't covered, or they are still not sure about? (It can be good not to invite general questions right at the end—keep them specific to the consultation you've just had).

Integrating

Sits somewhat outside the consultation and covers the things that happen in the space within and between clinical interactions.

There are various aspects of Integrating, some of which are very practical, for example

- Updating the clinical record
- Presenting clinical information
- Handing over to a colleague
- Asking for help
- Arranging a referral

Some aspects are more reflective and will include:

Identifying learning needs

Was there something they didn't know during the consultation that they need to look up? A medication they weren't sure about? A condition they hadn't heard of?

Did they identify a bias in themselves during formulating? Does this need challenging? Identifying ones own bias (and bias in colleagues) are essential skills for effective consulting: patient safety is at risk if bias remains unchecked.

Dealing with the emotional and psychological impact of consulting

Discussing these with students, how this can be managed and where help can be sought will be one of the most important things we can share with students. Here is a paragraph from the students EC learning on this subject.

Consulting is tiring! As a medical student you are taking on new information almost every time you meet someone. As a clinician each person's story is unique, even if you have heard similar before. You need to maintain your curiosity and interest at all times, and also identify when this is becoming challenging. The big consultations are easy to identify - if you have just broken bad news to a patient or relative, you might want to take some time, even just a few minutes to debrief with a colleague. Even just an acknowledgement that 'that was hard' .... the smaller, incremental drains on our emotional reserves can be harder to notice. But each patient deserves your full attention, so you need to find a way to reset between each patient and after a long day. It might be something as simple as taking a few deep breaths, or it might be getting up from your desk, but you need to find your own way to manage this aspect of medicine. Two excellent accounts for tips on looking after yourself are

https://www.instagram.com/themindmedic/

If you are struggling, please seek support there are lots of resources available

BMA - Your wellbeing