1.5 Shared decision making in perioperative care

Dr Ramai Santhirapala, Guy's and St Thomas' Foundation Trust, London
Professor Rupert Pearse, Queen Mary University of London

Why do this quality improvement project?

To use quality improvement strategies to improve the delivery of shared decision making (SDM) in perioperative care, through multidisciplinary working and patient involvement.

Background

Shared decision making is a process through which clinicians and patients work together to make evidence based decisions centred on patient preferences and values.[1] Patients involved in SDM have fewer regrets about treatments, better reported communication with clinicians, improved treatment adherence, and an overall better experience with improved satisfaction.[2]

One in three high-risk patients choosing surgery will experience serious medical complications leading to long-term decline in health and quality of life, but awareness of these risks is poor amongst both doctors and patients. Consequently, many high-risk patients do not receive the information they need to make an informed decision about surgery.

Whilst the evidence base for best practice SDM within perioperative care is not yet available, a recent systematic review suggested surgeons more often perceived a consultation as shared, than did patients.[3] Below are suggested drivers and barriers to be considered in quality improvement initiatives focused on bridging this gap and delivering truly informed consent.

Drivers

- Legal - Montgomery judgment cites the discussion of 'material risks' with patients. Implications for perioperative care mainly focus on ensuring robust informed consent.[4]
- Ethical - SDM supports beneficence and non-maleficence.
- Improved patient experience, satisfaction and outcomes seen in studies of SDM outside perioperative care.
- Policy - Department of Health White Paper 2012 'Liberating the NHS: No decision about me, without me'.[5] SDM has also been adopted in the national policy listed below.

Best Practice

Evidence based best practice is not yet available in perioperative care. Wider resources for guidance are given below:

- Legal: Montgomery Judgment recommendations.[4]
- RCoA Perioperative Medicine Programme 'Vision Document' 2015. https://www.rcoa.ac.uk/perioperativemedicine
- National Policy: NICE SDM Collaborative/NHS E SDM Initiative/AoMRC Choosing Wisely UK.[6]
- UK Research: Optimising decision making for high-risk surgical patients (OSIRIS)[7]/Choosing Wisely UK Pilot.[8]

Barriers[9,10]

- Professional culture - 'We do this already', due to lack of clear definition and understanding of SDM and a lack of understanding of clinical and legal obligations specific to perioperative practice
- Timing of consent/SDM - current pathways support the discussion of perioperative risk and involvement of anaesthetists after surgical informed consent has been sought. This can make shared decision making more difficult.
- Lack of standardised methods for risk assessment and risk communication.
- Instituting models which support true multidisciplinary working - SDM requires concurrent input from surgeons and anaesthetists (+/- geriatrician-led perioperative services where available) alongside patients/carers.
- A lack of robust data on postoperative outcomes with and without surgery (emerging in some surgeries; eg abdominal aortic aneurysm, prostate cancer).
- Patient Education/Information - need for evidenced based information in an understandable and accessible format ahead of clinical consultation.
- Strategies for patient activation - patients need to feel empowered to participate in SDM, and some may be reluctant to engage in this conversation.
- Measurement - need qualitative and quantitative methodology. Ceiling effect exists with some of the current tools, and there is no current consensus on how to measure the quality of perioperative shared decision making.

Facilitators

Both professional-facing and patient-facing approaches are needed to implement shared decision making. A national study into SDM concluded 'Skills trump tools, attitudes trump all' highlighting the need for cultural change for patients and professionals.[9]

- Professional education and training on communicating potential harms and benefits in the perioperative arena is available through e-learning - https://moodle.wintoncentre.uk. RCoA Shared Decision Making 'Train the Trainer' workshops are also available.
- Patient Facing Resources - Use of 'Benefits, Risks, Alternatives and doing Nothing' (BRAN, Choosing Wisely UK), 'Fitter, Better, Sooner'
- Decision aids/option grids - multiple options are available

Suggested quality improvement methodology and data collection

1. Baseline Practice - eg using the SDM 9-item questionnaire (SDMQ9 and SDMQDoc) for patients and professionals in surgical or anaesthetic clinics. Eliciting qualitative data through interviews or focus groups.

   Further reading: de Mik SML, Stubenrouch FE, Balm R, Ubbink DT. Systematic review of shared decision making in surgery. BJS 2018; 105: 1721-1730.

2. Implement an education and training shared decision making programme using MAGIC methodology.

   Further reading: Joseph-Williams N, Lloyd A, Edwards A et al. Implementing shared decision making in the NHS: lessons from the MAGIC programme.BMJ 2017;357:j1744.

3. Redesign a single preoperative surgical pathway, following process mapping of current pathway and data from qualitative interviews, to support SDM

4. Review current preoperative documentation for evidence of discussion regarding 'BRAN' ('benefits, risk, alternatives, doing nothing'). Then implement BRAN, or if already implemented, perform post implementation review.

   Further reading: Santhirapala R, Fleisher LA, Grocott MPW. Choosing Wisely: just because we can, does it mean we should? British Journal of Anaesthesia 2019;122(3):306-310.

   Resources: https://www.choosingwisely.co.uk/promotional-resources

5. UK Perioperative Quality Improvement Programme (PQIP) – use your local postoperative outcomes to inform risk assessment/communication.

   Further reading: Wagstaff D, Moonesinghe SR, Fulop NJ, et al. Qualitative process evaluation of the Perioperative Quality Improvement Programme (PQIP): study protocol BMJ Open 2019;9:e030214.

Mapping

CPD: IE01, IF06, 2A03, 2C06

Curriculum: Higher Curriculum GU_HS_02, RC_HS_04, POM_HK_03, POM_HS_05, MT_HS_06
Advanced Curriculum - Assisting colleagues in decisions about the suitability of surgery in difficult situations is a core clinical learning outcome. Additionally, shared decision making is specifically mentioned in AT_D1_01, DS_AS_01, OR_AS_01, TF_AS_18
Professionalism in Medical Practice - CC_D11_01

ACSA standards: 3.1.1.1, 3.1.1.2, 3.1.2.3

GPAS 2020: 2.9.1 to 2.9.15

References

1. Coulter A, Collins A. Making shared decision-making a reality: no decision about me, without me. London: The King's Fund; 2011
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5. Liberating the NHS: no decision about me, without me. London: Department of Health; 2010. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf) Accessed 9th September 2019
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7. National Institute of Health Research. OSIRIS: Optimising Shared decision-makIng for high-RIsk major Surgery. Available from (https://www.fundingawards.nihr.ac.uk/award/RP-PG-0218-20001) Accessed 4 September 2019
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10. Stugress J, Clapp JT, Fleisher LA. Shared decision-making in peri-operative medicine: a narrative review. Anaesthesia 2019 Jan;74 Suppl 1:13-19