Attitudes, And Practice Of Shared Decision Making Among Physicians From Guayaquil, Ecuador

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Abstract

Introduction: Shared Decision Making (SDM) is a world known strategy where collaboration between patient and physician engages patients in the decision making process. This study focuses in measuring the attitudes, and practice of SDM among physicians from Guayaquil, Ecuador as a developing country.

Methods: A cross-sectional survey was carried out from November 2014 to January 2015 on 152 physicians who were working in secondary and tertiary hospitals as well as in private practice in Guayaquil, Ecuador. The survey consisted of 13 questions, all with fixed responses. Six related to participants demographic characteristics, and seven related to perception and practice of SDM.

Results: Among all participants, the majority were men (59.2%), from 25-34 years old (58.6%), with 0-4 years of professional experience (46.7%), no specialty (44.7%), and that worked exclusively in hospitals (35.5%). From the total recruited physicians, 69.1% had heard about SDM before.

Conclusions: However, our findings demonstrate that SDM is a known term and it is considered a positive process. Therefore, SDM has a productive field where to be applied; and efforts should be directed to the creation of health policies that advocate SDM as a practice in medical consults.

INTRODUCTION

During the last decades, several health care policies have been created worldwide, to protect patients' rights and to dictate physicians' responsibilities. According to the American Medical Association Code of Medical Ethics, physicians have the obligations to explain the rights that a patient has; make decisions regarding the health care recommendations; and apply the right to courtesy, respect, dignity, responsiveness, confidentiality, and timely attention to fulfill the patients' needs. (AMA, 1992) One of the goals that physicians should also achieve in the medical consult is patients' comfort, which creates a strong physician-patient bounding that allows the achievement of the best possible outcome. This can change the typical medical consult from the physician-dominated relationship into a partnership, which is rarely accomplish due to the lack of patients' participation.

Shared decision making (SDM) is a strategy that is constantly growing all over the world. One of the first reported attempts to create it, was done in England by Dr. George Balint and his wife, who in the first half of the 20th century tried to increase their patients' awareness and understanding of their diseases through open dialogues and stories. (Balint, 1964)

SDM focuses in a discussion between the patient and the health care provider that engages the patient in the decision making process. (Burkhard, Doster, & McIntyre, 2011) In attempt to do it, several methods have been developed. One of the most accepted, are the patient decision aids (PDAs), which present the available treatment options and their advantages and disadvantages in a very didactic way. By doing this, patients' values and preferences are considered into their treatment election, which contributes to high quality care and medication adherence. (Heisler et al., 2003; Stacey et al., 2011)

Among the benefits associated with SDM, are to improve pathologies management outcomes, documentation of subsequent management goals, and levels of patients' knowledge and empowerment about their disease. Particularly, the socially disadvantaged patients are the ones that benefit more with the SDM intervention. The discussion about the management goal options with physicians allows them to choose the best accessible treatment according to their economic incomes. (Corser, Holmes-Rovner, Lein, & Gossain, 2007)

However, it is not easy to introduce SDM in every health system. The time established by governments during medical consultations fluctuates between 10 to 15 minutes. (Outomuro & Actis, 2013) As a consequence, patients do not receive enough information about their disease and its management options; and this has evidenced as a poor satisfaction from both parties (patients and physicians).

In the United States, Washington was the first state to officially endorse SDM as a practice in health care delivery. (Burkhard et al., 2011) Since then, several countries, especially those with high quality health systems, have adopted it. However, it is still not implemented among clinicians from many other countries, where the decision making process continues being unilateral and the SDM term unknown. The aim of this article is to determine the attitudes and practice of physicians from Guayaquil-Ecuador about SDM, a fact still unknown in our country. The information obtained will raise awareness about SDM in our society and will help other physicians to get familiarized with the topic and to adopt it in their regular practice.

METHODS

Setting

This study was conducted at secondary and tertiary hospitals, and in private practice in Guayaquil, Ecuador. The approval for conducting this study was obtained from the Research Center of Universidad Espíritu Santo. The duration of the study was 3 months, from November 2014 to January 2015.

Study design

This study was designed as a cross-sectional survey. Participants consisted of primary care physicians or specialists who were working at any health center of Guayaquil during the study period. Participants received no remuneration for their participation in this study.

The survey consisted of 13 questions, all with fixed-responses. Six related to participants demographic characteristics, and seven related to perception and practice of SDM.

Data collection

We recruited all 152 participants required by direct invitation. We decided this number after reading the paper by Godin et al., (Godin, Belanger-Gravel, Eccles, & Grimshaw, 2008) who states that studies based on social cognitive theories in healthcare professionals, need at least 150 participants to have a representative population.

RESULTS

Participants Characteristics

Among all participants in this study, 90 were men (59.2%) and 62 were women (40.8%). The main age interval was 25-34, representing 58.6% of the total participants, followed by 35-44 (19.7%), and 45-54 (15.1%). In terms of professional experience, 71 (46.7%) of the physicians included in this study had 0-4 years, 31 (20.4%) had 5-9 years, and 19 (12.5%) had more than twenty years. Regarding specialty, most of the physicians that were recruited had No Specialty 68 (44.7%), followed by Surgery 23 (15.1%), Internal Medicine 18 (11.8%), Critical Care 11 (7.2%), Gastroenterology 6 (3.9%), Anesthesiology 4 (2.6%), Gynecology 4 (2.6%), and Other 18 (11.8%). When physicians were asked how they would describe their medical practice, 54 (35.5%) answered that it was exclusively in hospitals, 51 (33.6%) mostly in hospitals, 40 (26.3%) equally in hospitals and private practice, while only 5 (3.3%) worked exclusively in private practice. Almost half of the physicians responded that their average time for medical consult was 11-19 minutes (48%), 41.4% more than 20 minutes, and 8.6% less than 10 minutes (See Table 1).

Familiarity, Use, and Importance of SDM

When asked about whether they have heard the term SDM before, 105 (69.1%) of physicians answered that they have heard it. Most of them did it during a medical conference 24 (22.9%), 22 (21%) read it in a medical journal, 16 (15.2%) in a book, and 14 (13.3) in a website. Only 12 (11.4%) learned it during medical school. From participants that had heard about SDM, 36 (34.3%) used it occasionally during their medical practice, 31 (29.5%) frequently, 18 (17.1%) always; while only 6 (5.7%) never used it.

Regarding to levels of importance of SDM, 69 (65.7%) of

respondents considered that SDM was a very positive process, 27 (25.7%) a somehow positive, and 9 (8.6%) a neutral process. No respondents considered SDM a negative process (See Table 2).

Attitudes about the SDM process

54 (35.5%) of the respondents said that the patient and physician should equally make decisions regarding health care; while 25 (16.4%) thought this actually happened. 77 participants (50.7%), thought that the actual decision was mostly made by the physician; followed by 39 (25.7%) who answered that it was totally made by the physician, and only 8 (5.3%) and 3 (2%) answered that it was made mostly and totally by the patient, respectively (See Table 3).

Barriers to Practicing SDM

Among the potential barriers found for the implementation of SDM, 48 (45.7%) said that the main limitation would be the patient's difficulty to understand about his/her disease, followed by the short time available for medical consult 34 (32.4%). Only 5 (4.8%) physicians consulted were afraid of medical lawsuits for malpractice (See Table 4).

DISCUSSION

The majority of participants were men. The sample was conformed primary by young physicians around 25-34 years old, who had less than 5 years of professional experience.

Most of them had no specialty. This can be explained because survey was performed mainly to residents in training from teaching hospitals, which was confirmed by the question how they would describe their medical practice, to which the majority responded that it was exclusively in hospitals.

The term SDM was known by the majority of physicians. It was mainly heard during medical conferences. Surprisingly, even though most of the respondents were young recently graduated physicians, only few of them learned it during medical school, showing a flaw in medical schools programs of our country regarding SDM teaching.

Although a very large number of physicians had heard about SDM before, only 17.1% used it always with their patients; showing a lack of skills that allow them to perform SDM in their regular medical practice. When physicians were asked "Nowadays, who do you think makes the decision about patient care?", the majority answered that it was mostly the physician. However, when asked about who they think should make the decision, they answered that it should be a process where both parties were involved. This shows that physicians want to apply SDM but somehow they believe they don't do it.

SDM was perceived by the majority of physicians as a very positive process, while none considered it as negative, revealing that the term had good acceptance among respondents. However, participants considered that the main limitation with the implementation of SDM was the patient difficulty to understand about his/her disease. This thought is supported by previous studies. Logtin et. Al. mentioned that patient-related factors such as poor medical knowledge lack of confidence, and various sociodemographic parameters affect patients' willingness to participate in the health care process. (Longtin et al., 2010) In addition, Makaryus and Friedman in 2005 surveyed 47 patients at discharge from a hospital. Less than half of them were able to list their diagnosis, the name(s), purpose, or the major side effect(s) of their medication(s). (Makaryus & Friedman, 2005) Both studies suggest that the patients' poor understanding can be caused by the lack of communication between patient-physician, which is the target of the whole SDM process.

CONCLUSION

SDM was known by most of the participants, and it was regularly used during their medical practice. SDM was seen as a very positive process, and physicians think it should be implemented. However, nowadays they consider it is still not used and mention as the main limitation, the patients' difficulty to understand their disease. However, this should be assessed in further studies involving patients' preferences and knowledge about SDM.

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