

Communicating with patients and families about medically unnecessary tests and treatments

Preceptor Guide

Part of the CanMEDS Resource Stewardship Curriculum Toolkit Series


Editors

Geetha Mukerji, MD, MSc, FRCPC
Division of Endocrinology & Metabolism
Women's College Hospital
Institute of Health Policy, Management and Evaluation
University of Toronto
Toronto, Ontario

Adina Weinerman, MD, FRCPC
Department of General Internal Medicine
Sunnybrook Health Sciences Centre
Toronto, Ontario

Series Editor

Chris Hillis, MD, MSc (QI/PS), FRCPC
Department of Oncology,
McMaster University
Hamilton, ON



The Royal College of Physicians and Surgeons of Canada
774 Echo Drive
Ottawa, Ontario K1S 5N8 Canada
Telephone: 613-730-8177
Toll-Free: 1-800-668-3740
Fax: 613-730-3707
Website: royalcollege.ca/canmeds
E-mail: canmeds@royalcollege.ca

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PREAMBLE

The focus of this power point presentation is on **teaching residents communication skills associated with resource stewardship**. More specifically, it will provide a framework for how to communicate with patients and families that are requesting a medically unnecessary test/treatment.

We have incorporated a few introductory slides on resource stewardship from the Foundations Toolkit in order to set the stage for the toolkit's **focus on effective communication**. For a more comprehensive review of resource stewardship principles, please see the [Foundations Toolkit](#).

Depending on the time available for this presentation a sample agenda is provided below. Regardless of how much total time is available, the bulk of the presentation should focus on Part 2, learning the communication framework and then Part 3, practicing the learned framework.

Sample Agenda (for a two hour session):


1. **Part 1** – 20 minutes – Depending on the basic resource stewardship knowledge of the group, the first several slides should be a quick review. The bulk of the discussion in this section should focus around how communication can play a role in one of the reasons for overuse; which is patients/family requesting a medically unnecessary test/treatment. Spending approximately 10 minutes on the think-pair-share exercise would be ideal.
2. **Part 2** – 40 minutes – Take time to go through the framework and allow for questions from learners so that they feel comfortable applying the framework in Part 3.
3. **Part 3** – 60 minutes – It will take a while to properly practice and debrief a new communication framework. The more time allotted to this section, the better.

Slide 1:


Communicating with patients and families about medically unnecessary tests and treatments

Part of the CanMEDS Resource Stewardship Curriculum Toolkit Series

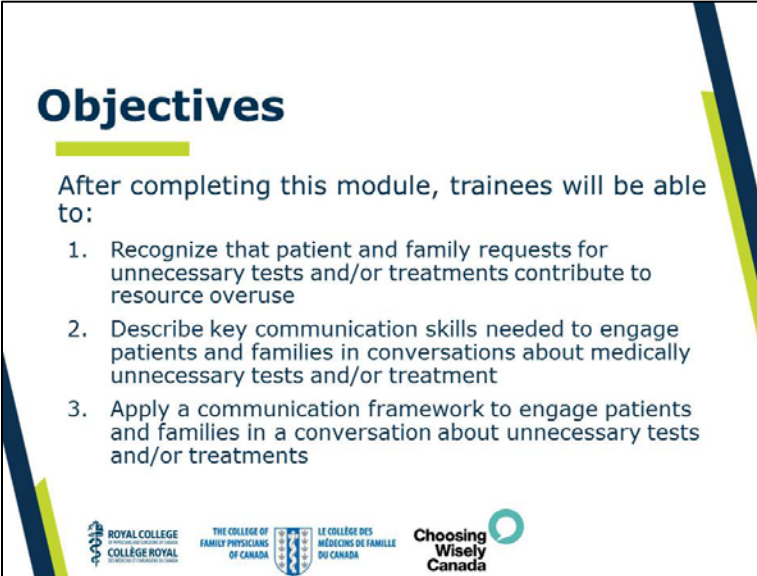
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Slide 2:



Objectives

After completing this module, trainees will be able to:

1. Recognize that patient and family requests for unnecessary tests and/or treatments contribute to resource overuse
2. Describe key communication skills needed to engage patients and families in conversations about medically unnecessary tests and/or treatment
3. Apply a communication framework to engage patients and families in a conversation about unnecessary tests and/or treatments

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The objectives for the trainees are as stated.

The first part of the presentation is a brief summary of key concepts relating to resource stewardship in healthcare (for a more comprehensive review of resource stewardship principles, please see the **Foundations Toolkit** at royalcollege.ca/resourcestewardship). It is meant to provide learners with some background leading up to the first objective: to recognize that patients and families requesting medically unnecessary tests/treatments is one reason for overuse.

Because overuse can be potentially modified by learning new communication skills, the remainder of the presentation focuses on the communication framework. This framework should be applied when engaging in a conversation with patients and families who are requesting a medically unnecessary test/treatment.

The final part of the talk introduces a role-play scenario so trainees can practice applying the framework.

Based on the above, after reviewing the power point presentation and this corresponding faculty development handout, the objective for educators and teachers is:

1. Recognize that patient and family requests for unnecessary tests and/or treatments can contribute to resource overuse
2. Describe key communication skills needed to engage patients and families in conversations about medically unnecessary tests and/or treatment
3. Apply a communication framework to engage patients and families in a conversation about unnecessary tests and/or treatments

Slide 3:

*Communicating with patients
and families about medically
unnecessary tests and
treatments*

Part 1

Brief review of resource
stewardship and reasons
for overuse

In a two hour session, approximately 20 minutes should be allotted to **Part 1**. The first few slides in this section are meant as a quick review of resource stewardship. The bulk of the discussion in this section should focus around how communication with patients/family requesting a medically unnecessary test/treatment can play a role in overuse.

Slide 4:

Recognize that patient and family requests for unnecessary tests and treatments can contribute to resource overuse

Slide 5:

Resource Stewardship

Resource stewardship = parsimonious medicine

Care that uses the most efficient means to effectively diagnose a condition and treat patients. It respects the need to use resources wisely, and ensures that resources are equitably available and used judiciously.

Resource stewardship is the appropriate and responsible use of resources to achieve high value, effective care.

The ACP Ethics Manual (Sixth Edition) states that “Physicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly. Parsimonious care that uses the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely...”¹

Berwick² has noted three types of quality and safety problems **related to stewardship**:

1) Underuse – omission of appropriate care (e.g., failure to order a screening colonoscopy for a 50-year-old patient with a family history of colon cancer).

2) Misuse – failure to properly execute clinical care plans and procedures² (e.g., ordering a screening colonoscopy in an 80-year old patient with average risk of colon cancer. Guidelines suggest stopping screening in adults aged 75 and older).

3) Overuse – unnecessary use of health resources and procedures that are not supported by evidence, or that may be duplicative of other tests previously done² (e.g., ordering multiple colon cancer screening modalities for the same average-risk patient, such as fecal immunohistochemical testing (FIT) followed by colonoscopy and/or CT colonography).

Data suggests that we have traditionally focused QI efforts on underuse problems.³ While underuse problems are important, we also recognize that there are overuse problems: that is the impetus for resource stewardship. Resource stewardship can address overuse.

You may have encountered other terms and concepts that are synonymous with overuse. Some of these terms include overdiagnosis; overtesting; overtreatment; too much medicine; inappropriateness; overutilization; waste; low-value care.

Resource stewardship is so important that it is included as a key competency under the 'Leader' role in the [CanMEDS Framework](#).

¹Snyder L and the American College of Physicians Ethics, Professionalism, and Human Rights Committee. 2012. American College of Physicians Ethics Manual: sixth edition". *Annals of Internal Medicine*. **156**(1 Pt 2):73-104.

²Berwick, DM. 2002. A User's Manual for the IOM's 'Quality Chasm' Report. *Health Affairs*. **21**(3): 80-90.

³Kale MS, TF Bishop, AD Federman and S Keyhani . 2013. Trends in the Overuse of Ambulatory Health Care Services in the United States. *JAMA Internal Medicine*. **173**(2):142-148.

Slide 6:



How is high-value care defined?

Providing high-value care means providing the highest quality care at the lowest cost. As demonstrated by the value equation - **value can be improved by either increasing quality or decreasing cost.**

Quality is defined by the Institute of Medicine¹ as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

The Institute of Medicine has six Quality domains¹:

- **Safe:** Avoiding injuries to patients from the care that is intended to help them
- **Patient-Centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring patient values guide all clinical decisions
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy
- **Effective:** Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those unlikely to benefit
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care

The burden of care for patients can be significant; this is an often under-recognized harm, or “cost” in health care. When discussing cost, monetary considerations often come to mind, but “cost” should be viewed more broadly as expenses, both financial and non-financial, to the patient, to the system, and to society.

Providing high-value care does not equate to healthcare practitioners selecting the lowest-cost care option in every case. Some low-cost interventions may decrease value if they provide minimal benefit, or if they unjustifiably increase downstream costs. Conversely, some high-quality treatments (i.e. chemotherapy; coronary artery bypass grafting surgery (CABG)) may be expensive, yet they offer good value because they help to achieve the best possible patient outcome².

In their 2014 Policy document, the CMA indicated that they believe “fiscal benefits and cost savings of exercises in accountability and appropriateness in clinical care are a by-product rather than the primary focus of these exercises.”³

Value is an important concept to understand when making clinical decisions, helping us to remember that for each additional procedure and associated cost, the relative clinical benefits and patient experience should be factored into the ultimate treatment decision².

¹Institute of Medicine (IOM). 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C: National Academy Press.

²Institute for Healthcare Improvement. *Open School Course TA 103: Quality, Cost, and Value in Health Care*. Last retrieved November 21, 2016 from <http://ihi.org> on

³Canadian Medical Association. *CMA Policy Document PD15-05. Appropriateness in Health Care*. Last retrieved July 27, 2017 from <http://policybase.cma.ca/dbtw-wpd/Policypdf/PD15-05.pdf>

Slide 7:



The definition of quality, the value equation and the notion that cost goes far beyond dollars and cents.

***Note to presenter: Interactive Moment** – the presenter can ask the audience what non-monetary “costs” that patients, the system, and society may face when unnecessary care is delivered.

Direct costs to patients: out-of-pocket expenses (i.e. parking, transportation); time; anxiety; iatrogenic harm.

Direct costs to the system: time; personnel resources; equipment, supplies and procedural expenses; increased wait-times across the system.

Downstream costs and harm to patients: further follow-up appointments and procedures; long-term side effects (i.e. cellular damage and malignancy risk related to CT imaging); hospital-acquired infections; exposure to multi-drug resistant microorganisms.

Opportunity costs: time the patient spends away from work and responsibilities; time and resources directed away from other patients who may be in greater need; system delays resulting from unnecessary resource use.

The impact of inappropriate use of treatments and procedures can also be viewed from a micro-meso-macro systems perspective.

Micro:

Individual harm to patients and their family, including direct harm (examples: time, anxiety, related out-of-pocket expenses, clinical harm, false-positives); direct downstream impact (examples: follow-ups and further procedures, long-term side effects, cumulative radiation exposure from imaging, infections acquired from exposure to healthcare facilities); and opportunity costs (example: time spent away from work, family and responsibilities)

Meso:

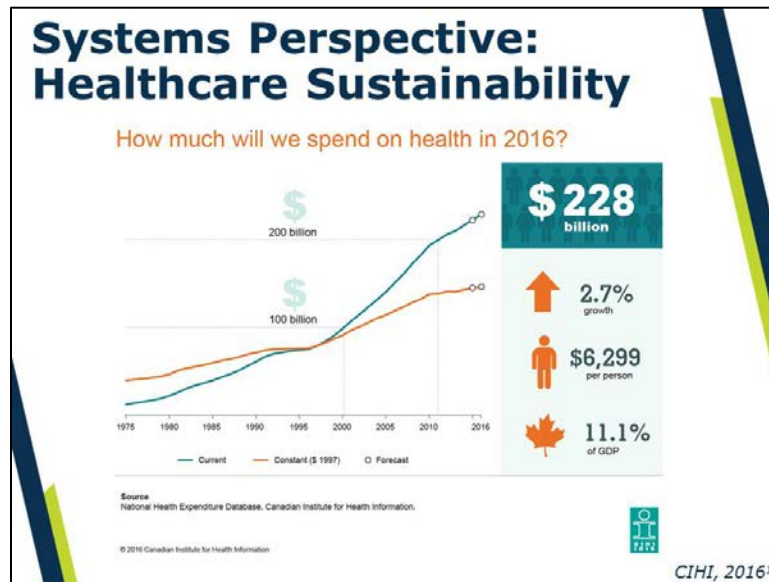
Harms to the health system and its organizations, including time, financial cost, personnel resources, overburdened emergency departments

Macro:

Deplete finite resources that could be redistributed to address other societal needs, which ultimately impacts population health outcomes. Examples of societal needs include:

- Health Promotion (examples: disease prevention, promotion of health equity, addressing the social determinants of health)
- Other publicly-funded sectors (examples: education, housing, environment, public transportation, infrastructure)

Slide 8:



Before delving into the specifics of resource stewardship, it is important to take a broader systems perspective. The concepts of sustainability and waste are rooted in growing concern about healthcare spending. In 2016, healthcare spending in Canada was estimated at \$228 billion¹, which has increased by \$68 billion since 2007. Healthcare costs grow by 2.7 percent per year.

¹Canadian Institute for Health Information. *National Health Expenditures: How much does Canada spend on health care?* Last retrieved July 31, 2017 from <https://www.cihi.ca/en/nhex2016-topic1>

Slide 9:



A recent Choosing Wisely Canada – CIHI¹ report highlighted that up to 30 per cent of healthcare spending can be unnecessary, demonstrating how overuse and unnecessary care have been driving increases in healthcare spending.

¹Canadian Institute for Health Information. *Unnecessary Healthcare in Canada*. Last retrieved July 31, 2017 from <https://www.cihi.ca/en/unnecessary-care-in-canada-infographic>

Slide 10:



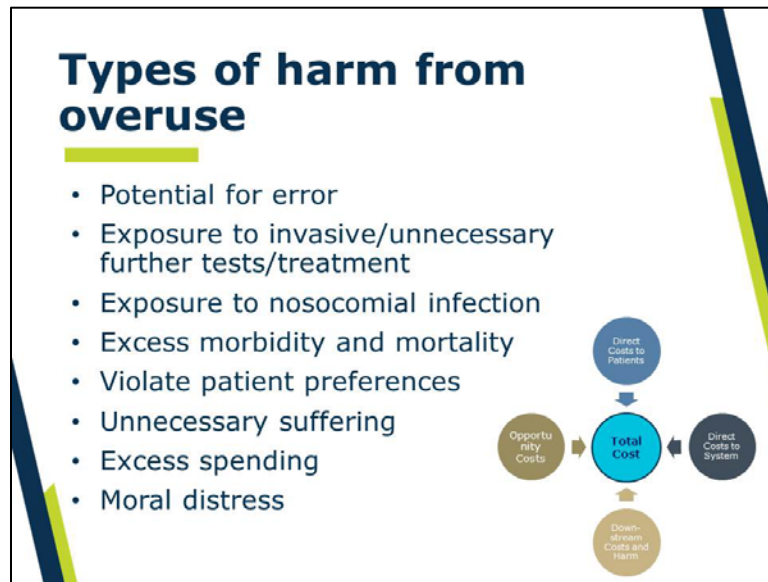
This is adapted from an interesting paper by Don Berwick that discusses the “wedges of waste” in the US healthcare system. The paper discusses the increasing waste in healthcare. The percentage of a nation’s GDP spent on healthcare, in a sustainable system, should be constant. Berwick identifies wedges (or increases) in this percentage, projected to be directly attributable to each type (wedge) of waste. Two wastes, failures of care delivery and care coordination, reflect issues with underuse and misuse, while another wedge represents overuse (overtreatment). There is an estimate that nearly 30 per cent of care delivered is duplicative, or unnecessary, and may not improve patients’ health¹.

Physicians are key to resolving the expenditure problems faced by all health systems worldwide. Physician decision-making drives 80 per cent of all healthcare costs². For instance, consider that physicians determine which patients are seen and how frequently; which patients are hospitalized; which tests, procedures, and surgical operations are administered; which technologies are used; and which medications are prescribed.

¹Berwick D and AD Hackbarth. 2012. Eliminating Waste in US Health Care. *JAMA*. **307**(14):1513-1516

²Emmanuel R and A Steinmetz. 2013. Will Physicians Lead on Controlling Healthcare Costs? *JAMA*. **310**(4):374-375

Slide 11:




***Note to presenter:** The focus of this slide is examples of types of harm that can be caused by overuse. This slide directly relates back to [Slide 7](#) [p.12] on the discussion of “costs” in the value equation. The graphic in the bottom right hand corner is meant to remind trainees of this.

There are several costs/harms associated with medically unnecessary tests/treatments (such as the examples outlined on this slide) and the focus certainly should not solely be on the financial cost to the system.

Slide 12:

Quick Poll on Overuse

What are the reasons that MDs order unnecessary tests or treatments?



***Note to presenter: Interactive moment** - Before presenting the following slides focusing on the barriers and reasons for overuse, this is an excellent opportunity to open the floor for trainees to volunteer their own perceived barriers to resource stewardship. Additionally, they can be prompted to volunteer their own anecdotal experiences to illustrate one of these points. Once all responses have been exhausted, the slide can be presented with the list of barriers (hopefully most of which have already been discussed).

Slide 13:

Why does overuse happen?

1. Failure to recognize harms
2. Culture of "more is better"
3. Volume driven system and financial gain
4. It's the way we have always done things
5. Unease with uncertainty
6. Poor knowledge of evidence (or poor adherence to guidelines)
7. Time constraints
8. Satisfying referring colleague's requests
9. Pre-emptive ordering for efficiency
10. Marketing by hospitals, pharmaceutical companies, device makers
11. Defensive medicine
- 12. Patient and family request and expectations**

1. Failure to recognize harms:

Until recently, the harms and costs associated with overuse were seldom discussed. Therefore, many physicians practice without recognition of the potential harms that can be associated with overuse of unnecessary tests/treatments. The immediate benefits are often more apparent than the downstream harms, making them more difficult to recognize.

2. Culture of "more is better":

The prevailing and dominant culture in medicine has often been one of "more is better." Although this is changing, culture change takes time and there are still many who would not fully support the opposite view that 'less is more'.

3. Volume driven system and financial gain:

The current healthcare funding structure uses a volume-based fee-for-service reimbursement model, in which physicians are paid based on high patient volumes. This acts as a disincentive to take the extra time that may be needed to discuss whether tests and/or treatments are beneficial.

Due to the publicly-funded nature of the Canadian healthcare system, there are few restrictions on test ordering in Canada; oftentimes all that is needed is a requisition or referral and the test is carried out.

Providers are better reimbursed for tests and procedures, than for counselling patients on what might be a more appropriate, but non-interventional, approach.

In some cases, physicians stand to benefit financially by performing more tests and/or procedures, creating may be a financial incentive for overuse.

4. It's the way we have always done things:

Providers may have been trained to pursue certain interventions lacking therapeutic value for a specific clinical scenario. Due to established habits, they may experience challenges in deviating from their usual behaviour.

5. Unease with uncertainty

Physicians may feel compelled to order tests to chase down a definitive diagnosis or to completely rule out a diagnosis, even if this information is unlikely to change clinical management. In these instances, there is a tendency to overvalue the benefits of a normal result, and under appreciate the harms of over testing.

6. Poor knowledge of evidence (or poor adherence to guidelines)

A lack of appreciation for, or misunderstanding of, the limitations and evidence for certain investigations or treatments often results in their inappropriate use.

7. Time Constraints

Busy physicians may feel that they do not have time for a thorough discussion with patients regarding inappropriate or unnecessary tests and/or treatments. Instead, physicians will simply order the test because this is the most time-efficient course of action. Obviously, this rationale for ordering a test is suboptimal and shortsighted. Patients often value the time spent having a conversation with their physician more than having a test ordered. Also, if a test is not going to be ordered, there is additional work created to follow up on it – work that could be avoided if the test is unnecessary.

8. Satisfying referring colleague's requests

Specialist physicians may accept inappropriate referrals or order tests and/or procedures that are not clinically indicated to satisfy the referring physician's request.

9. Pre-emptive ordering for efficiency

Physicians – especially working in hospital settings - may pre-emptively order tests as a means of “expediting” a work-up or to improve efficiency or facilitate discharge, even when some of these tests might not have been necessary after results from initial tests become available.

10. Marketing by hospitals, pharma, device makers

Providers and patients may believe that the newest, most expensive technologies are superior, when, in fact, these technologies may not have proven to actually lead to improved care.

Marketing strategies, such as funded events or honoraria, by hospitals, pharma, and device makers, may bias physicians towards selecting newer interventions that may not be superior to tried and tested options (for instance, newer agent from the same class of drug with marginally improved benefit; use of newer surgical supplies and equipment when existing technologies would work equally well).

Patients may be influenced by direct-to-consumer marketing strategies that encourage them to ask their physicians about new tests and treatments (e.g., pharmaceutical ads on US channels or in US magazines that Canadian patients can access).

11. Defensive medicine

Physicians may order more tests to be more definitive in ruling out a diagnosis in an attempt to avoid litigation.

12. Patient and family requests and expectations

Patients may request or expect tests or procedures that they have heard about, or may expect providers to take action as opposed to inaction. Providers may feel pressured to satisfy their patients' requests.

***Note to presenter:** The final bullet point is the focus of this toolkit. Although it is only one of a number of reasons why overuse happen, it is the reason that can be mitigated and influenced based on improved communication between patients and physicians

Slide 14:

**Why does overuse happen?
Possible Additional Factors
among residents**

13. Lack of confidence in clinical assessment
14. Desire to impress supervisor
15. Need to rule out “zebra”
16. Better to do something than do “nothing”
17. Curiosity and/or desire to gain experience
18. Lack of reinforcement for exercising restraint



13. Lack of confidence in clinical assessment

Residents often lack sufficient experience and may not have confidence in their own clinical assessment; therefore may consequently over-order investigations for reassurance.

14. Desire to impress supervisor

Residents may over-order investigations to demonstrate a breadth of knowledge, even when many of these investigations are unnecessary.

15. Need to rule out “zebra”

The educational focus on “weird and wonderful” conditions frequently presents an accessibility bias to residents. This can lead them to order investigations to rule out diagnoses that are often of sufficiently low likelihood based on history and physical examination alone.

16. Better to do “something” than do “nothing”

Residents may be uncomfortable with inaction and may feel compelled to take any action, as opposed to no action, in alleviating patient’s concerns.

17. Curiosity and/or Desire to Gain Experience

Residents may be curious to know what the investigation results may show; to confirm their own clinical suspicions; or out of a desire to gain clinical experience, even when a test or intervention is unlikely to change overall patient outcome.

18. Lack of Reinforcement for Exercising Restraint

A discussion reflecting the interventions that were *appropriately avoided* is often lacking, and residents are rarely praised for demonstrating such restraint.


Neither residents nor seasoned physicians generally receive feedback on their practice patterns, and thus, may be uninformed of whether an action is low-value or harmful to patients.

It is important to recognize that while providers cite patient-related factors as a common driver of resource overuse, this belief is unsupported by the literature evidence. Patients may request to have tests, interventions, or prescriptions for a variety of reasons, such as anxiety, misinterpretation of online information, or social or work-related stressors. Patients may falsely believe that interventions equate to a high quality of care. However, if physicians are able to counsel their patients, then these better-informed patients are less likely to continue to request unnecessary interventions.

Slide 15:

Think, Pair, Share

Reflect on a situation where a patient was requesting an unnecessary test/treatment



***Note to presenter:** This “Think, Pair, Share” slide is meant to have trainees get together in pairs to reflect on a situation where they felt over-testing caused harm. If trainees are comfortable, some of these examples can be shared to the wider group for reflection and debrief. Spending approximately 10 minutes on this exercise would be ideal.

Step One: Think (*give the students two to three minutes to do this on their own*)

Have students reflect on the question.

Step Two: Pair (*give the students three to five minutes to do this in pairs*)

Have students pair up with one other student and share their responses.

Step Three: Share (*allocate three to five minutes for the large group discussion*)

When the larger group reconvenes, ask pairs to report back on their conversations or ask students to share what their partner said.

Group discussion can focus on what the test or treatment being requested was. Potential discussion topics include:

- What did the resident/attending do? (e.g., did they order the test/treatment or not?)
- What were the challenges in this scenario?
- How did the interaction between patient and physician go?
- How did the interaction make the resident feel?
- Which factors influenced the unnecessary test or treatment ordered in this situation?
- What happened? (i.e., did the patient experience harm? Did the test reveal anything?)
- What would they consider doing the same or differently next time?

Slide 16:

*Communicating with patients
and families about medically
unnecessary tests and
treatments*

Part 2

Learning a communication
framework for patients/family
who are requesting an
unnecessary test

The second part of the presentation will focus on a communication framework. This framework will focus on communicating with patients and families about unnecessary tests and treatments.

In a two hour session, approximately 40 minutes should be allotted to **Part 2**.

Take time to go through the framework and allow for questions from learners so that they feel comfortable applying the framework in **Part 3**.

While you prepare for this talk, please take the time to think about examples that reflect the discipline of the trainees that you will be teaching.

Slide 17



As you prepare for this talk, please take the time to think about examples that reflect the discipline of the trainees that you will be teaching.

Slide 18:

Five steps to have a conversation with patients and their families

1. Elicit patient and/or their families' concerns
2. Demonstrate empathy and acknowledge patient / family concerns
3. Engage in shared decision making process
 - a. Discuss risks and benefits
 - b. Provide reassurance using health information/decision aids
 - c. Reinforce key points with written information
4. Provide clear recommendation(s)
5. Agree on a plan of action and document

This slide anchors the remainder of the talk. The communication framework presented teaches trainees how to engage in conversations with patients and families who are requesting an unnecessary test/treatment. This framework is an adaptation of a tool originally created by ABIM Foundation and Drexel University (<http://www.choosingwisely.org/resources/modules/>). We have adapted it to acknowledge some of the evolution in this field that has occurred over the last few years.

- 1) **Elicit concerns:** The physician should elicit the concerns of the patient and/or their families. This should include an explicit expression or statement: "What are you most worried about?" or "What are you concerned about?"
- 2) **Demonstrate empathy and acknowledge concerns:** The physician should ensure that they demonstrate empathy and explicitly acknowledge the patient's concerns (Slide 20 provides some concrete ways to demonstrate empathy)
- 3) **Shared decision-making:** This step is to engage in a process of shared decision making – while there are many frameworks that exist, we have tried to simplify these to three concrete steps.
 - a) Discuss risks and benefits: it is critical to ensure that both risks and benefits of tests or treatments are fully discussed. In particular, it is often better to present benefits and risks in absolute terms rather than relative terms.
 - b) Provide reassurance using health information/decision aids: patients in particular want their physicians to reassure them that if the test is not

performed, or the treatment is not prescribed, that their wellbeing is not being threatened. One way to provide reassurance is to make an explicit statement that your recommendation is based on published evidence / guidelines, or that the recommendation is backed by research that suggests that the test and/or treatment in question is not needed.

In addition, there are a number of websites now that feature patient decision aids, which provide a visual depiction of risk and benefit to aid patients in making informed choices regarding their care.

- c) Reinforce key points with written information – one option is to provide written patient education information to the patient (such as a pamphlet). For example, Choosing Wisely Canada, has a collection of patient education materials that you can refer patients to:
<http://www.choosingwiselycanada.org/materials/>.
- 4) Provide clear recommendation(s):** It is important for the physician to synthesize their understanding of the information, and incorporate the patient's preferences/beliefs/values/concerns and to communicate a clear recommendation to the patient or family.
- 5) Agree on a plan:** The final step is to confirm a plan of action and document the conversation.

***Note to presenter:** The slides that follow will break down the evidence and rationale for several of the steps. After the framework has been discussed in more detail, there will be a video demonstrating this framework in action and then an opportunity for the trainees to practice using this framework in role play.

Slide 19:

1. Elicit Patient Concerns

- Incorporate the patient's values
"What is most important when it comes to your health?"
- Include patient in decision-making process
"Which option seems like the best fit for you?"
- Elicit patient's concerns
"What are you most concerned about today?"

The ultimate question that should be asked in every patient encounter is whether the patient has been considered. This should include reflection on whether you have incorporated the patient's values, whether they have been a participant in the decision-making process, and whether their concerns have been properly elicited.

***Note to presenter - Interactive moment:** trainees can be prompted to provide examples of the questions that they can ask during a patient encounter, to elicit the above information. Here, we present examples of how to ask these questions.

One approach that trainees may consider using to elicit patient values and concerns is the FIFE model.¹ This model reminds the physician to explore the patient's feelings about their illness, the ideas and meanings they attach to their illness, the impact of the illness on their daily function, and their expectations for their physician.

For more information on how to elicit patient concerns and have a patient centred approach to the conversation, we recommend readers review the Patient-Centred Clinical Method (PCCM). This is a broader framework for patient-centred communication that can be used in many health care scenarios.²

In addition to the patient's values and concerns, it is also important to elicit the patient's preferences. The assumption in this framework is that the patient's preference is to receive the test/treatment they are requesting. However, as we discuss the remainder of the framework, the patient's preference may change over time once they are provided with the necessary information in an appropriate way, which is a part of including them in a shared decision-making process.


¹ Weston WW, JB Brown and MA Stewart. 1989. Patient-centred interviewing part I: understanding patients' experiences. *Canadian Family Physician*. **35**:147–151.

²Brown J. 2004. *Patient-Centred Clinical Method*. Last retrieved August 31, 2017 from Memorial University's website: <https://www.med.mun.ca/StudentHandbook/pdf/Patient-Centred-Clinical-Method.aspx>

Slide 20:

2. Demonstrate Empathy

| Empathic Skill | Example |
|--------------------------|---|
| Non-verbal skills | Eye contact, head nodding |
| Reflection | "I can see you are upset by this." |
| Legitimation | "It is normal for people in your situation to feel this way." |
| Attentive Silence | |
| Statement of partnership | "We will work together on helping you to feel better." |


An initiative of the ABIM Foundation
Choosing Wisely 2017 ¹

This slide elaborates on the second step in the framework: Demonstrate empathy and acknowledge patient / family concerns.

Patients, particularly those with health concerns, are looking to their physicians to be optimistic, empathic and supportive. They want to know that their physicians care about them. However, *feeling* empathetic and caring is not the same as *communicating* that you care by using the skills outlined on this slide.

Empathy is defined as understanding what a patient might be experiencing, then expressing that understanding back to the patient.

¹Choosing Wisely. *Communication Skills to Providing Empathy during a Patient Encounter*. Last retrieved August 31, 2017, from Choosing Wisely's website:
http://modules.choosingwisely.org/modules/m_00/content/1_30_Empathy.htm

Slide 21:

3. Engage in shared decision making

a. Discuss Risks and Benefits

- Discuss risks and benefits of tests/treatments in absolute terms when possible
- Example:
 - Warfarin reduces the risk of ischemic stroke in patients with Atrial Fibrillation but increases the risk of bleeding
 - Calculate a patient's CHAD-VASC score for risk of ischemic stroke and HAS-BLED score for bleeding
 - Discuss the **absolute risk** of stroke reduction rather than in relative terms
 - e.g. if we treat you with warfarin, we will reduce your risk of having a stroke from 10% to 3% (absolute risk) as opposed to relative terms - if we treat you with warfarin, we will reduce your risk of having a stroke by 65%

This slide elaborates on the third step in the framework: promoting shared-decision making, with particular emphasis on communicating risk and benefits. You may choose to discuss challenges patients may have in interpreting both relative risks and absolute risks.

Slide 22:

3. Engage in shared decision making

b. Provide Health Information/ Patient Decision Aids

- Tools to support patients to actively participate in shared decision making
- Helps patient clarify and articulate their values, preference and concerns
- Provides patients with easy to consume health information (and specifically interpret risks and benefits to make an informed choice)

This slide continues elaborating on the third step in the framework: promoting shared-decision making, this time emphasizing on providing health information and/or decision aids.

Decision aids are increasingly being used. They can be a very tangible way to help patients clarify and articulate their own values, preferences and concerns (which we hoped to illicit in the first step of the framework). They are also a valuable way of providing reassurance to patients by using health information that is easier for them to consume and understand.

It is important to emphasize here that patients need to be included in the decision-making process. However, the patient should not be the one to put together the list of available options. From the available and evidence-based options, the physician needs to help the patient determine which option suits them best and addresses their concerns.

As a useful reference, the University of Ottawa has compiled a repository of decision aids on the following website: <https://decisionaid.ohri.ca/>

Slide 23:

Evidence for Decision Aids

- Cochrane review showed that the use of decision aids led to:
 - Patients who are clearer about their values
 - Increased patient knowledge
 - Increased participation in decision-making
 - More accurate risk perceptions
 - Increased comfort with decisions

Stacy D et al. 2017. *Cochrane Database Syst Rev.*¹

This slide highlights some of the cumulative evidence on decision aids, as presented in a recent Cochrane review.

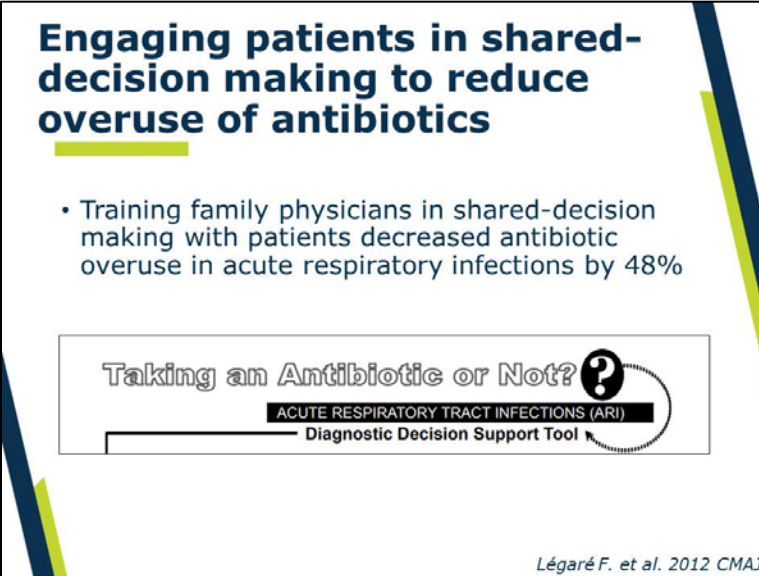
The authors' conclusions are, that compared to usual care, patients exposed to decision aids "feel more knowledgeable, better informed, and clearer about their values, and they probably have a more active role in decision making and more accurate risk perceptions."

Some specific examples from the Cochrane review on the effectiveness of decisions aids are listed below:

- Decision aids reduced the number of people choosing major elective invasive surgery in favour of more conservative options (RR 0.86; 95 per cent CI 0.75 to 1.00; 18 studies; N = 3844)
- Decision aids reduced the number of people choosing prostate-specific antigen (PSA) screening (RR 0.88; 95 per cent CI 0.80 to 0.98; 10 studies; N = 3996)
- Decisions aids increased those choosing to start new medications for diabetes (RR 1.65; 95 per cent CI 1.06 to 2.56; 4 studies; N = 447)
- Importantly to note: The median effect of decision aids on length of consultation was *only* 2.6 minutes longer (24 versus 21; 7.5 per cent increase).


¹Stacey D, F Légaré, K Lewis, MJ Barry, CL Bennett, KB Eden, M Holmes-Rovner, H Llewellyn-Thomas, A Lyddiatt, R Thomson and L Trevena. 2017. Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews*. **4**:CD001431


Slide 24:



Engaging patients in shared-decision making to reduce overuse of antibiotics

- Training family physicians in shared-decision making with patients decreased antibiotic overuse in acute respiratory infections by 48%

Taking an Antibiotic or Not? 

ACUTE RESPIRATORY TRACT INFECTIONS (ARI)
Diagnostic Decision Support Tool 

Légaré F. et al. 2012 CMAJ

Here is an example of the impact of decision aids to support patient-centered care plans. A CMAJ article published in 2012 demonstrated the effectiveness of training physicians on how to participate in shared-decision making with their patients. The result of training physicians in shared-decision making was a reduction of the overuse of antibiotics for acute respiratory infections by 48 per cent.

A few helpful links:

Decision aid tool used in the CMAJ study:

<http://www.cmaj.ca/content/suppl/2012/08/03/cmaj.120568v1.DC1/train-legare-1-at.pdf>

Additional decision aids (also called option grids): <http://optiongrid.org/option-grids/current-grids>

A video on how to decision aids:

<http://videos.webpatientencounter.com/annotatevideoV2.aspx?a=620>

¹Légaré F, M Labrecque, M Cauchon, J Castel, S Turcotte and J Grimshaw. 2012. Training family physicians in shared decision-making to reduce the overuse of antibiotics in acute respiratory infections: a cluster randomized trial. *Canadian Medical Association Journal*. **184**(13): :E726-34.

Slide 25:

3. Engage in shared decision making

c. Reinforce with Written Information

Unnecessary care in Canada

1 in 10 seniors in Canada uses a benzodiazepine (sedative-hypnotic) on a regular basis, even though this is not recommended by experts.

CIHI, 2017¹

Caring for a person with severe Alzheimer's disease

Feeding tubes can have risks.

- Tube feeding has many risks.
- It can cause bleeding, infection, skin irritation, or leaking around the tube.
- It can cause nausea, vomiting, and diarrhea.
- The tube can get blocked or fall out, and must be replaced in a hospital.
- Many people with Alzheimer's disease are bothered by the tube and try to pull it out. To prevent that, they are often tied down or given drugs.
- Tube-fed patients are more likely to get pressure sores.
- Tube-fed patients are more likely to spit up food, which may lead to pneumonia (a term called "aspiration pneumonia").
- At the end of life, fluids can fill the patient's lungs, and cause breathing problems.

So when are feeding tubes a good idea?

Feeding tubes can be helpful when the main cause of the eating problem is likely to get better. For example, they can help people who are recovering from a stroke, brain injury, or surgery.

The tubes also make sense for people who have problems swallowing and are not in the last stage of an illness that can't be cured. For example, they can help people with Parkinson's disease or amyotrophic lateral sclerosis (Lou Gehrig's disease).

Treat conditions that cause appetite loss.

When caring for a person with severe Alzheimer's disease, these steps can help with eating problems and other end-of-life concerns.

Feed by hand. Ask the doctor about the best kind of foods to offer and the best ways to feed by hand.

Stop unneeded medicines. Some drugs can make eating problems worse, including:

- antipsychotics such as quetiapine (Seroquel) and generic
- sleeping pills or anti-anxiety drugs such as zolpidem or Zolpidem
- muscle-control drugs such as orphenadrine (Disipal) and generic

Some drugs for osteoporosis such as alendronate (Fosamax) and generic

Drugs for Alzheimer's disease such as donepezil (Aricept) and generic

Schedule dental care. Badly fitting dentures, loose joints, and toothaches can make eating hard or painful.

Consider hospice care. Many people with advanced Alzheimer's disease qualify for hospice care if they have difficulty drinking and eating enough to keep their weight up. Hospice teams suffering and pain in the last six months of life. Hospice can be given in the patient's home.

Plan ahead. Family and friends should have an advance

Choosing Wisely Canada, 2017²

Also incorporated in the third step of engaging in a shared decision making process is reinforcing the key points of the verbal communication with written information.

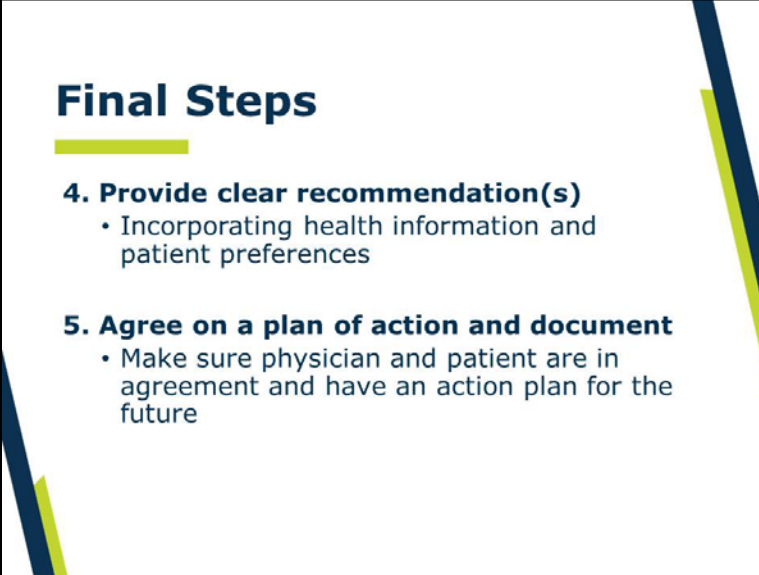
Historically this information was thought of as being more passively received by the patient. However, in the right patient population, decision aids with visual information that require more active participation are considered more often part of shared decision making.

Visually representing statistical information to help patients understand benefit and risk (as shown on the left of the slides)¹ may help patients make better informed decisions about their healthcare. An example of these is the Choosing Wisely Patient pamphlets² (as shown on the left hand of the slide). These pamphlets are geared towards explaining medical issues to patients in a format that is easier to understand.

¹Canadian Institute for Health Information. *In health care, more is not always better*. Last retrieved September 28, 2017, from CIHI's website: <https://www.cihi.ca/en/land/data-in-action/in-health-care-more-is-not-always-better>

²Choosing Wisely Canada. *Patient Pamphlets*. Last retrieved August 31, 2017, from Choosing Wisely Canada's website: <http://www.choosingwiselycanada.org/materials/>

Slide 26:



Final Steps

- 4. Provide clear recommendation(s)**
 - Incorporating health information and patient preferences
- 5. Agree on a plan of action and document**
 - Make sure physician and patient are in agreement and have an action plan for the future

The final two steps of the communication framework are 'Provide Clear Recommendation(s)' and 'Agree on a plan of Action and Document.'

Once the physician has elicited the patient's concerns in an empathic fashion and engaged in a shared decision making process as described in steps one to three; they should synthesize this information for the patient and provide their clear recommendation to avoid ambiguity.

Ideally, the physician and patient can reach an agreement on a plan of action that they and the patient feel comfortable with. The plan of action should also include an explicit description of the 'red flags' that they should watch out for to seek medical attention more urgently or when to come back for a follow up appointment if their situation has not changed. It is critical to make sure, irrespective of what happens, that reliable follow up is arranged.

Slide 27:



The third and final part of the talk will allow the residents to practice applying the communication framework to counsel patients about unnecessary tests and/or treatments that was presented in [Part 2](#).

In a two hour session, approximately one hour should focus on **Part 3** in order to allow ample time for the residents to practice the newly learned skill and receive feedback.


Slide 28:



Here we enter the final part of the talk where ideally the session should focus on having the residents or learners practice applying the communication framework to counsel patients about unnecessary tests and/or treatments. This is the section of the toolkit that should be the **focus** of your session.

Slide 29:

How to have a discussion regarding appropriate resource utilization?



Patient with Back Pain who requests an MRI

Choosing Wisely
An initiative of the ABIM Foundation

<https://www.youtube.com/watch?v=cJLuxDbBs1w>

Credit: Choosing Wisely® campaign¹

Now that we have reviewed the framework for communicating with patients and families who are requesting an unnecessary test/treatment and reviewed the importance of shared decision making, the video linked above will demonstrate how the framework can be used in a real scenario with a patient. This scenario is of a patient requesting an MRI for back pain in his family physician's office. While no video is perfect, this one is meant to highlight some of the elements discussed in the framework.

After showing the video, discuss some of the below questions below with the group:

- 1) What did the physician do well in the interaction with the patient?
- 2) What could have been improved upon?
- 3) How would you handle the interaction if the patient continued to be more insistent that the test/treatment was required?

***Note to the presenter:** One point that may be raised by the trainees is that they've experienced situations where the patient or their families will continue to persist in their request for medically unnecessary tests. It is important to acknowledge this point of view and remind them that, although these experiences are often salient in our minds, they generally do not represent the majority of these conversations. The communication framework provided should be effective in the majority of situations to reduce medically unnecessary testing/treatment and can be seen as a conflict prevention strategy. You can also speak to the literature that discusses the evidence for decision aids [[slide 23](#) on p. 34]. It demonstrates that more patients choose less invasive approaches when communicated with effectively - providing evidence that communication strategies can and do work.

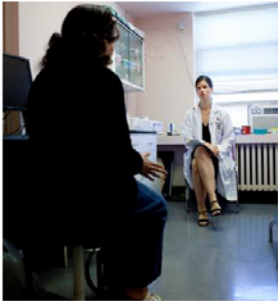
¹Choosing Wisely. *Patient with Back Pain who requests an MRI*. Last retrieved August 31, 2017 from the ABIM Foundation's YouTube page: <https://www.youtube.com/watch?v=cJLuxDbBs1w>
The Royal College of Physicians appreciates the ABIM Foundation for granting permission to use this Choosing Wisely module as part of its work to educate clinicians across Canada.

Slide 30:

Breakout Case

Sarah Davis is a 25 year-old patient that you are seeing in the emergency department. She is presenting with a cough, runny nose and a subjective fever for the past 2 days.

Sarah is waiting to see you to discuss the management plan for her symptoms. You are aware that antibiotics are not indicated.



This is an opportunity for the trainees to practice the communication framework. This toolkit contains two sample OSCE scenarios that can be used to role play these skills.

One of the cases intends to be as generic as possible (requesting unnecessary antibiotics for a viral illness), while the other is a general case about radiologic imaging (unnecessary MRI for lower back pain). Should you wish to create your own scenario, you can do so by pulling a recommendation from the subspecialty of your choice from lists of recommendations by specialty on the Choosing Wisely Canada website¹ and embedding it into the template case.

The Alliance for Academic Internal Medicine also provides examples of several other scenarios that may work in your clinical context on their webpage.²

Ideally, the trainees will be broken up into groups of three. One trainee will be role-playing as the physician; another as the patient; and a third as the observer. Role-plays can be modified based on your setting, number and type of participants.

Other examples of how role-plays are facilitated are as follows:

- In smaller groups, choose two volunteers and have them role-play in front of the entire group who can act as observers (e.g., a “fish-bowl” exercise)
- Alternatively, if you are fortunate enough to have real patients or standardized patients, they can play the patient role and your learners can focus on the physician role exclusively

Within each scenario are handouts for each role. The resident role-playing as the physician will have the traditional ‘case stem’. The resident role-playing as the patient will have the information that is traditionally given to the standardized patient. The observer will have an

example of our rating scale that we have suggested for use in resource stewardship communication stations. The rating scale is based on the communication framework presented in this slide set.

Time should be allotted for appropriate debriefing of the role-play.

When debriefing a role-play, make sure that you debrief from the most “high-stakes” participant to the “lowest-stakes” participant. For example: in the above scenario, the participant playing the role of the physician should be debriefed first, followed by the patient, followed by the observer (if there was one), ending with a general debrief.

If you are completely unfamiliar with role plays or require more information, please see useful resource from AAMC’s website: *From Role Play to Real Play: Teaching Effective Role-Playing Facilitation Skills*.³

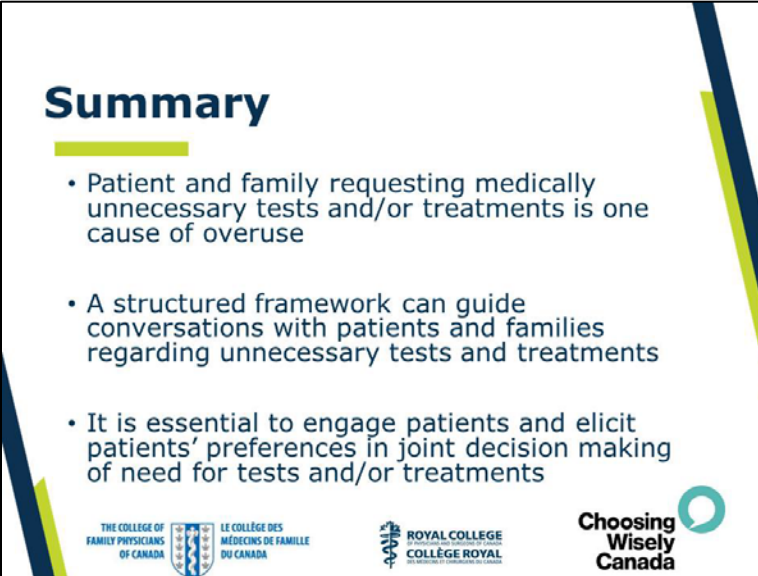
Alternatively, you can use the section of this toolkit called Developing Cases for Role Play found at: royalcollege.ca/resourcestewardship

¹Choosing Wisely Canada. *Recommendations and Resources, by Specialty*. Last retrieved July 31, 2017, from Choosing Wisely Canada’s website: <https://choosingwiselycanada.org/recommendations/>

²Alliance for Academic Internal Medicine. *High Value Care Learner Assessment Tools - Standardized Patients and Cases*. Last retrieved August 31, 2017, from AAIM’s website: <http://www.im.org/p/cm/ld/fid=1536>

³ AAMC MedEd PORTAL. *From Role Play to Real Play: Teaching Effective Role-Playing Facilitation Skills*. Last retrieved August 31, 2017, from AAMC’s website: <https://www.mededportal.org/publication/8603>.

Slide 31:



Summary

- Patient and family requesting medically unnecessary tests and/or treatments is one cause of overuse
- A structured framework can guide conversations with patients and families regarding unnecessary tests and treatments
- It is essential to engage patients and elicit patients' preferences in joint decision making of need for tests and/or treatments

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA | ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA | COLLÈGE ROYAL DES MÉDECINS ET CHIRURGIENS DU CANADA

Choosing Wisely Canada

This final slide of this presentation summarizes a few key points.

The first part of the slide deck provided a background on resource stewardship. It is important to remind trainees that providing unnecessary care to patients exposes the patient and the system to harm (not just financial harm). And, although patients/family requesting an unnecessary test/treatment is only one of many reasons for overuse, it is the reason that can potentially be overcome by communication.

The focus then shifted to a communication framework that can be applied when a patient/family is requesting an unnecessary test/treatment. The framework emphasized that when discussing resource stewardship with patients, it is crucial to participate in shared decision making.

Finally, given that this is such a complex task, the last part of the talk provided a video as an example of how the framework can be applied and allowed trainees to participate in a role-play exercise for practice.

CONTRIBUTORS AND REVIEWERS

Contributors

Samantha Buttemer, MD, CCFP
Public Health and Preventive Medicine
Queen's University
Kingston, Ontario

Ming-Ka Chan, MD, MHPE, FRCPC
Department of Pediatrics and Child Health
University of Manitoba
Winnipeg, Manitoba

Constance Leblanc, CCFP(EM), MAEd, CCPE
Department of Emergency Medicine
Dalhousie University
Halifax, Nova Scotia

Jennifer Russell, MD, FRCPC
Division of Cardiology within the Department of Paediatrics
Hospital for Sick Children
University of Toronto
Toronto, Ontario

Reviewers

Nancy Fowler, MD, CCFP, FCFP
Academic Family Medicine
The College of Family Physicians of Canada
Ottawa, Ontario

Brian M. Wong, MD, FRCPC
Department of Medicine
Sunnybrook Health Sciences Centre
University of Toronto
Toronto, Ontario