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Core Competencies for Shared Decision Making Training Programs: Insights From an International, Interdisciplinary Working Group

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Abstract

Shared decision making is now making inroads in health care professionals' continuing education curriculum, but there is no consensus on what core competencies are required by clinicians for effectively involving patients in health-related decisions. Ready-made programs for training clinicians in shared decision making are in high demand, but existing programs vary widely in their theoretical foundations, length, and content. An international, interdisciplinary group of 25 individuals met in 2012 to discuss theoretical approaches to making health-related decisions, compare notes on existing programs, take stock of stakeholders concerns, and deliberate on core competencies. This article summarizes the results of those discussions. Some participants believed that existing models already provide a sufficient conceptual basis for developing and implementing shared decision making competency-based training programs on a wide scale. Others argued that this would be premature as there is still no consensus on the definition of shared decision making or sufficient evidence to recommend specific competencies for implementing shared decision making. However, all participants agreed that there were 2 broad types of competencies that clinicians need for implementing shared decision making: relational competencies and risk communication competencies. Further multidisciplinary research could broaden and deepen our understanding of core competencies for shared decision making training.

Keywords

shared decision making; education; patient-centered care; implementation science; theory; risk communication

Introduction

In response to rapid changes in society, shared decision making is now making inroads in health care professionals' continuing education curriculums.¹ In the United States, initiatives such as the patient-centered medical home reinforce the importance of shared decision making with an emphasis on placing the patient at the center of the care process.² As defined by the authors of the most cited model, shared decision making between a patient and one or more health care professionals is an exchange in which information giving and deliberation is interactional, the parties work together towards reaching an agreement on the treatment, and all parties have an investment in the decision made.^{3,4} However, research shows that shared decision making is not routinely used in clinical practice.⁵

Continuing education is one intervention that may result in a greater uptake of shared decision making,⁶ but a 2011 environmental scan which identified and analyzed shared

decision making training programs for health care professionals worldwide found that while the number of such programs is steadily increasing, they vary greatly in what training they deliver and how.⁷ Most of these programs have been introduced since 2007, suggesting that interest in shared decision making among health care professional educators is growing.⁷ Despite increasing interest in the best strategies for training clinical teams in shared decision making and providing support,⁸ there is little evidence about which training programs are effective.^{9,10} Moreover, there is no consensus on what core competencies clinicians require if they are to effectively involve patients in health-related decisions.

In this context, in 2012, an interdisciplinary, international group of 25 participants from Canada, France, the United States, United Kingdom, and Germany participated in a 2-day workshop to reflect on (1) concepts and theories defining core dimensions of and approaches to shared decision making; (2) experiences of existing shared decision making training programs, the competencies they teach and how they teach them; and (3) policy issues related to shared decision making training programs for health professionals. Participants included educators, policy makers, clinicians, patient representatives, graduate students and researchers in shared decision making. This article summarizes how the workshop unfolded, the key issues addressed and recommendations agreed to by the group.

How did the workshop unfold?

On the first day of the workshop, a conceptual framework for shared decision making developed by researchers at McMaster University (and still the most often cited model in this field) was presented to participants and introduced them to different approaches to treatment decision making in the medical encounter. This framework describes 3 “pure” approaches to making treatment decisions (paternalistic, shared decision making, and informed) as well as many in-between approaches, which the authors point out are the kind more likely to be found in actual practice.^{3,4} Then educators shared information about (1) the rationale for competency-based programs in general, (2) training programs in shared decision making they had designed and implemented (at the local, national, and/or international levels), (3) competencies taught in these programs, (4) findings from evaluations of these programs concerning notably their length, components and activities (or methods for teaching, i.e. small-group discussion, role-play, simulation, case study), and (5) lessons learned. Following a question period with plenary presenters, participants broke into working groups to further discuss shared decision making definitions and shared decision making training programs.

On the second day, stakeholders (1 patient representative, 1 patient educator and several policy makers) made presentations on how they perceive shared decision making, and competencies they see as essential to enabling health care providers to implement shared decision making. Workshop participants were then asked to try to reach consensus on core competencies to include in shared decision making training programs using a comprehensive list of competencies identified by the presenters and enlarged by new ideas generated from the working group discussions. Despite extensive discussion, consensus was not reached. Instead, by the end of the meeting, participants discussed conceptual definitions of shared decision making proposed by Charles and colleagues^{3,4} as well as those proposed by other

authors^{1,11,12} ; became more aware of existing training programs and their strengths and limitations; and identified broad categories of essential shared decision making competencies. The next section of this paper summarizes factors that were identified as relevant to these issues and recommendations by the group.

What were the key issues addressed?

A debate took place about the clarity of the concept of shared decision making in the scientific literature and the degree to which current conceptual frameworks are sufficiently developed to derive core competencies for use in shared decision making training programs. No consensus was reached on the definition of shared decision making to be used to determine core competencies for health care professional education and 2 different points of view clearly emerged.

Confidence in existing models of shared decision making

Some participants believed that existing shared decision making frameworks currently provide a sufficient conceptual basis for developing and implementing training programs for shared decision making on a broad scale. These participants also argued that core competencies should be identified for incorporation in shared decision making training programs, but that the focus of training programs should not be expanded to include the many approaches to making health decisions. Finally, they remarked that deferring the establishment of core competencies until consensus is reached on the definition of shared decision making (and other decision-making approaches) and research evidence emerges about what competencies to recommend, is problematic. This will further delay the development of core competencies at a time when many clinical educators, faculties and institutions are pressing for shared decision making training programs.

Reflections on the complexity of best decisions

Other participants felt that further reflection was needed to build consensus both on the meaning of shared decision making and on the desirability of focusing solely on one approach (shared decision making) in developing core competencies for treatment decision making.¹³ These participants pointed to research evidence suggesting that not all patients want to be engaged in sharing decisions with their providers.^{14,15} They viewed the patient role in decision making as a dynamic process that may shift among the different approaches even during a single consultation. Therefore, shared decisions may not always be the best decisions. They argued that health care professionals should remain flexible in order to respond to possibly changing patient preferences in this regard, rather than imposing one approach on all patients, and they made the case for identifying competencies that would allow for a flexible approach that covers the spectrum of decision making approaches described in the framework shown in Table 1.^{3,4}

Requirements for informed consent

Several participants suggested that given the legal requirements for informed consent (e.g. consent legislation in Washington State), patients need to be sufficiently involved in the treatment decision to understand their options and potential benefits and harms.¹⁶

Furthermore, there is some evidence to show that when patients are given support to be involved in shared decision making with the use of patient decision aids, they become more active participants in the decision-making process.¹⁷ Finally, some participants highlighted the need for physicians to tailor their approach to the treatment decision-making process to match each patient's preferences for participation, while others argued that all patients should be exposed to the same shared decision-making approach.

Lessons learned from existing training programs in shared decision making

Participants from different countries were asked to share their experiences and lessons learned in developing and operationalizing shared decision making training programs for health care professionals, their use of various teaching methods, the competencies they taught in their educational programs, and the results of evaluations they had conducted to date. Descriptions of 3 programs from 3 countries, including their underlying conceptual models, were discussed: (1) the MAGIC (Making Good Decisions in Collaboration) program, (United Kingdom);¹⁸ (2) The Patient as Partner program (Germany)^{6,19–21} and (3) The Ottawa Shared Decision Making Training Program (Canada).^{22–25} These training programs showed remarkable variability in how and what they deliver. Two of the programs presented had been evaluated in randomized controlled trials, and the third was being evaluated at the time of the workshop using a developmental approach. Evaluation results from the German and Canadian studies indicated an increase in patient participation in making decisions and in health professionals' shared decision making skills after health professionals were exposed to training.^{6,20,21,25} Shared decision making training programs discussed in the workshop were not based on any educational model or theory but were based on shared decision making theories or models, such as the Ottawa Decision Support Framework²⁶ (Canada), the Charles and al. model^{3,4} (Germany) and a conceptual model developed by the originators of the MAGIC program (United Kingdom), which included choice, option and "decision talk."²⁷

Components of training programs proposed by educators

Participants further discussed the knowledge base of effective strategies for training health professionals to change behaviours in general and practise shared decision making. They suggested that essential elements to consider in building effective training programs in shared decision making are program structure, length, and teaching methods; these were thought to be the fundamental elements for targeting clinician behaviour change in shared decision making. More specifically, the medical education expert attending the workshop highlighted that effective programs in shared decision making should include (1) interactive sessions; (2) multiple learning strategies; (3) material useful to participants (e.g. online resources, DVDs, manuals, decision aids, video, checklists); and (4) reminders and reinforcers. Given the large gap between what the evidence suggests about necessary clinical competencies for shared decision making and how clinicians actually behave in practice, this expert felt that further research should focus on finding the best approach to changing health care professionals' behaviour towards implementing shared decision making in their clinical practice.²⁸ The medical education expert also argued that a wide range of factors can influence the clinical practice of health care professionals,²⁹ including individual motivational predispositions to change as well as economic, political, and

organizational contexts. However, she stated that our understanding of these factors and optimal approaches to changing health care professional behaviour is incomplete. These observations led to suggestions by some participants that the design of interventions to change health care professionals' behaviour could be informed by socio-cognitive theories that link determinants of intention to behaviour.³⁰ These could be helpful in defining shared decision making competencies and then translating them into training programs that can be evaluated.^{31,32}

Needs of policy makers regarding shared decision making core competencies

If it is to be widely implemented, as indicated in health policy documents produced by the United States, United Kingdom, and Canada, shared decision making needs to be supported by the whole range of stakeholders involved in the delivery of health care, including health policy decision makers, professional standards regulators, employers, educational institutions, clinicians, and patients/health care users. Programs should define clear learning objectives and outcomes for specific skills, for example being aware of patients' information needs and knowing how to communicate relevant information, nondirective interviewing, risk communication and eliciting patients' preferences, personalized care planning, and self-management support. Most of the participants, including health ministry and/or health care organization representatives, underlined the growing government demand for better quality of care in health care systems and stated that one way to address this issue is for patients to participate in clinical decision making and in their own care overall. Providing patients with more evidence about their condition and treatment options is a first step.

What recommendations did the group agree on?

Lack of consensus on a set of shared decision making core competencies

Despite the large group collective deliberations and extensive small group work focused on discussing and identifying relevant core competencies, the group agreed to disagree: no consensus could be reached on a set of shared decision making core competencies. Some participants argued that developing a more specific list of core competencies for a shared decision making approach alone neglects the many in-between approaches to decision making, and that it is premature to develop such a list before the evidence in support of such recommendations is clear. However, the participants did reach consensus on 2 broad types of competency categories, and proposed to name these "relational competencies" and "risk communication competencies." The group felt it was important that clinicians acquire these 2 types of competencies to help their patients to be involved in decision making to the extent that they prefer. It also moved towards detailed definitions of these 2 broad types of competencies.

Relational competencies

Relational competencies include those necessary for creating a favorable environment for communication and appropriate interaction during the clinical encounter,³³ listening to the patient, and facilitating patient involvement as much as the patient wants. Health professionals may need to recognize that a decision needs to be made and explain what type of decision it is (e.g. behaviour change versus treatment; acute versus chronic). As stressed

by patient representatives in the group, patients need respect foremost. They want to be seen as individuals and believed about what they are suffering.³⁴ Health care professionals should be able to create an atmosphere in which the patient feels at ease to share these concerns. To do that, they must be genuinely curious about the patient, willing to develop a partnership, and willing to consider the patient's point of view in light of their own. Patient representative participants also highlighted the fact that health care professionals must understand the basics of health literacy to be able to assess the literacy levels of their patient population, adapt information, and translate it into plain language as necessary.^{34–36} Moreover, these representatives argued that there are many types of patient, and health professionals must be flexible in their approach to communication, respecting the style of each individual and being ready to change their behaviour with time and the decision to be made.¹⁵ They also stressed that socio-economic level, race or any conditions such as obesity should not influence the encounter.

Risk communication competencies

The other broad type of competency required in health professionals is risk communication competencies, which include discussing the concept of uncertainty in treatment outcomes with the patient and effectively communicating information about the risks and benefits of different treatment or health care options.³⁷ Participants agreed that health care professionals need to evaluate the research evidence in relation to each particular patient, and that the patient needs to know how to use the decision support tools offered by health care professionals to help them participate in making health-related decisions. However, as the patient representative participants pointed out, language levels are often overestimated in the transmission of information or the design of decision support tools. It was also agreed that cultural differences pose a challenge: studies show that consultations are shorter when there is an ethnic or socio economic gap between doctor and patient.^{38–40}

Conclusions and future directions

Participants in this workshop did not reach consensus on a set of core competencies for implementing shared decision making but identified 2 broad types of competency categories focused on relational skills and risk communication, thus laying the groundwork for continuing activities directed towards this goal. This preliminary work of organizing competencies into 2 major themes was an important step in working toward the establishment of a set of potential shared decision making competencies. While the lack of consensus in our discussions was partly due to the lack of research evidence establishing which competencies are effective, it is interesting to note that a recent study identified communication competencies consisting of observable (and therefore evaluable) behaviours and organized them into 5 key themes, 5 subthemes and 106 positive and negative observable behaviours (EXHIBIT 1).⁴¹

Participation in this workshop of diverse experts and stakeholders from different disciplines (educators, policy makers, clinicians, patient representatives, graduate students and researchers in shared decision making) and countries (Canada, France, United States, United Kingdom and Germany), attests to the timeliness and importance of the topic of developing

a set of core competencies for shared decision making. In addition, the increasing development of new shared decision making training programs worldwide highlights the need to develop a consensus on core competencies. However, before a consensus can be reached, there is a need to further reflect on the definition of shared decision making and its potential role in the movement to improve health care through patient involvement. Questions remain about the challenge of building consensus on how best to measure shared decision making. Finally, additional interdisciplinary research is needed to increase the evidence base for recommending core competencies for training programs in this area.

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Lessons for practice

- Ready-made programs for training clinicians in shared decision making are in high demand, but existing programs vary widely in their theoretical foundations, length, and content.
- There is no consensus on what core competencies are required by clinicians for effectively involving patients in health-related decisions.
- An international, interdisciplinary group of 25 individuals met to discuss theoretical approaches to making health-related decisions, compare notes on existing programs, take stock of stakeholders concerns, and deliberate on core competencies.
- Participants did not reach consensus on the definition of shared decision making but agreed that there were 2 broad types of competencies that clinicians need for implementing shared decision making: relational competencies and risk communication competencies.
- Further multidisciplinary research could broaden and deepen our understanding of core competencies for shared decision making training.

Approaches to treatment decision making described by Charles et al.

TABLE 1

Analytical stages	Approaches			
	Paternalistic	(in between approaches)	Shared	(in between approaches)
1. Exchange of information	Flow	One way	Two way	One way
	Direction		Physician ↔ patient	Physician → patient
	Type		Medical and personal	Medical
	Amount		Everything relevant for decision making	Everything relevant for decision making
2. Deliberation	Physician alone or with other physicians		Physician and patient (plus potential others)	Patient (plus potential others)
3. Deciding on treatment	Physician		Physician and patient	Patient

Adapted from Charles et al. ⁴

EXHIBIT 1**Communication Skills: Themes and Subthemes**

Communication skills: themes and subthemes	
Listening skills	<ul style="list-style-type: none"> • Uses both general and active listening skills to facilitate communication
Language skills	
Verbal	<ul style="list-style-type: none"> • Can be understood by the patient • Is able to converse at an appropriate level for the patient's age and educational level • Uses appropriate tone for the situation to ensure good communication and patient comfort
Written	<ul style="list-style-type: none"> • Clearly articulates and communicates thoughts in writing (e.g. educational materials)
Non verbal skills	
Expressive	<ul style="list-style-type: none"> • Is conscious of the effect of body language and eye contact on the patient and adjusts it appropriately when it inhibits communication
Receptive	<ul style="list-style-type: none"> • Is aware of and responsive to body language, particularly feelings not expressed verbally
Cultural and age appropriateness	<ul style="list-style-type: none"> • Adapts communication to the individual patient according to culture, age and disability
Attitudinal skills	<ul style="list-style-type: none"> • This permeates all levels of communication. It includes the ability to hear, understand and discuss an opinion, idea or value that might be different from one's own, and maintaining respect for the patient's right to decide for himself or herself. Communication should convey respect for the patient.

Adapted from Laughlin et al. ⁴¹