

What are Decision Aids; can they help your patients with their health care choices?

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Medicine is striving to achieve greater patient involvement in their health care choices. With such endeavors come tools that attempt to make this process easier. Two such tools are discussed briefly in this review, Patient Decision Aids (PDAs) being the main focus, contrasted with Health Education Material (HEM). This paper will try to give you a brief background on each and their usefulness in your medical practice.

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Patient decision aids (DAs) are growing in number and new DAs are cropping up all the time. The purpose of this review is to clarify how DAs differ from health education material and to help determine their usefulness in a health care setting - do they really help your patients make a decision when they are presented with more than one option?

A literature search performed on Pubmed using the terms patient decision aids, randomized control trial, with the limits of English language and human trials, yielded 55 hits. A more refined list of searches using the above qualifiers plus, in successive order, atrial fibrillation yielded 6 hits, prostate cancer 7 hits and lastly breast cancer 10 hits. During the literature search it was found that the Cochrane database has a site that is dedicated to the evaluation of patient decision aids, and is updated on a regular basis (www.cochranelibrary.net). An additional source of information on available DA's is the Ottawa Health Research Institute (OHRI) where DA's are listed alphabetically (www.ohri.ca/home.asp).

Patient decision aids are tools that help patients make *specific and deliberative* choices among treatment options. They are designed as adjuncts to, not replacement of, physician counseling. They give information on the available options and outcomes that are relevant to the patient's illness, *based on their category of risk*. Patient DAs may include some or all of the following: background information on the disease or illness, costs of the treatment options, category of risk stratification and probability of an outcome based on risk category. They also often include worksheets that aid a patient in assessing their values, and a sampling of different opinions from other patients (i.e. what they would chose in the same situation)¹.

Decision aids are being used predominantly in North America and Europe. The driving force behind their development is the desire to have patients more involved in the health care process and enable them to give their physicians their informed *choice* instead of their informed *consent*¹. The ethical issues around this topic are many. The patient cannot give informed choice unless they are fully aware of what is being presented to them, they can give informed consent simply by agreeing with what the doctor has offered them. Patient decision aids are also an attempt to reduce geographic variations in practice and to reduce costs by not having patients undergo treatments that they do not really want and would not choose for themselves if they had more information.

Patient DAs differ from health education material (HEMs) in that they are more specific and they have a more personalized focus on the patient. HEMs are broader in perspective, giving information on the disease process itself. HEMs are not intended to help the patient make a specific decision with regards to their preference for treatment¹. Do PDAs work; are they effective? It was found that DAs improve patient

knowledge, which is of significant importance because many patients, when given the usual care and tested for their level of knowledge, were not even at the level of being able to give informed consent². DAs also give the patient better insight into what to expect based on the treatment option they choose^{2,3}, they reduce patient conflict in that the patient feels better informed and more confident with the decision they make, and lastly they increase patient participation². Consequently, PDAs are not the method of choice for all patients; not all patients want to be active participants¹.

These three points seem to make a good argument for the use of DAs, but some other issues identified give some reason to further evaluate DA's before widespread implementation. DAs do not, at this point, increase patient satisfaction², nor is there an improvement in the emotional state of patients, in their general or condition-specific health outcomes, or in their persistence with their chosen decision¹. There was also no difference found when factors of agreement between the decisions made and the patient's values (or the patient's regret over their decision) were studied⁴.

It has been suggested that we need to delineate inclusion criteria as to what makes up a successful DA, and we need stringent factors that are to be used when a decision aid is being evaluated. Patient decision aids are not currently sophisticated enough to be used widely. More research needs to be done with regards to the areas of medicine that would benefit most from the development of DAs. Also current gaps in the DA library, some areas being over represented while others are not represented at all, need to be remedied. Research also needs to be done regarding physician opinions on this subject, the costs of developing these aids, and their cost effectiveness¹.

Conclusion

In conclusion, with more decision aids being developed every year it would seem as though DAs are here to stay. Stay abreast with the new developments on the Cochrane web site: www.cochranelibrary.com.

Acknowledgement

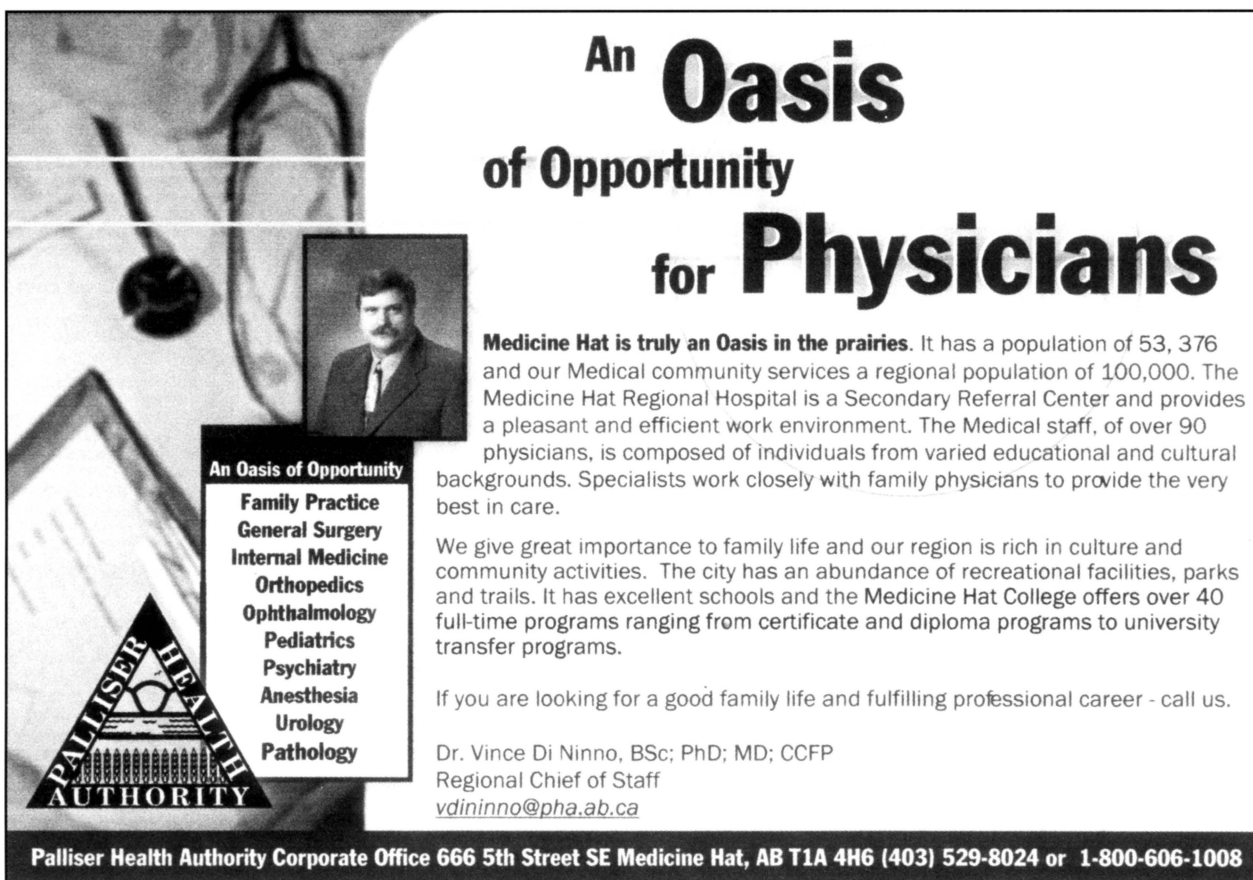
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