MIE 2011 ORAL PRESENTATION:

MEDICATION DECISION-MAKING ON HOSPITAL WARD ROUNDS

MELISSA T. BAYSARI\textsuperscript{1,2}
JOHANNA I. WESTBOOK\textsuperscript{1}
RICHARD O. DAY\textsuperscript{2}

\textsuperscript{1}AUSTRALIAN INSTITUTE OF HEALTH INNOVATION, UNIVERSITY OF NEW SOUTH WALES, SYDNEY, AUSTRALIA
\textsuperscript{2}DEPARTMENT OF CLINICAL PHARMACOLOGY AND TOXICOLOGY, ST VINCENT'S HOSPITAL, SYDNEY AUSTRALIA

AUGUST 30\textsuperscript{TH}, OSLO NORWAY
MEDICATION SELECTION

Patient preferences and expectations?
THE SHARED DECISION-MAKING

1. Doctor driven decision-making: Paternalistic (classic) model, doctor outlines outcomes and makes the decision

2. Shared decision-making: Doctor provides patient with information, patient informs doctor of their preferences, doctor and patient make the decision together
WHY IS SDM THE BEST APPROACH?

Uncertainty surrounds many treatment options for medical conditions

• Do patients know this?

Patients vary in their preferences for health states, tolerances for pain/discomfort, and long-term outcomes

Many of these preferences are not known to doctors
DOES SDM WORK?

Can lead to greater patient satisfaction
Can lead to improved health outcomes (e.g. greater blood pressure control)
  • Via increased adherence?
  • Via increased perceived control over one’s illness?

But SDM is not often practiced
  • Most research has been done in primary care
A time for providers from different specialties to communicate & make joint decisions
STUDY AIM

To investigate medication decision-making on hospital ward-rounds

Research questions:

• When and with whom are medications discussed?
• Do patients play an active role in medication decision-making?
• Does decision-support aid in medication discussions?
SETTING & CPOE DETAILS

All wards using the CPOE system MEDCHART

MEDCHART = electronic medication management system that links prescribing, pharmacy review and drug administration

Includes basic decision support

• ‘Reference Viewer’ look up tool
PARTICIPANTS

14 medical teams (46 doctors)

- Cardiology, clinical pharmacology, lung transplantation, colorectal surgery, gastroenterology (x2), gerontology teams (x2), haematology, infectious diseases, nephrology, neurology, palliative care (x2)

Typical team = 1 consultant
  + 1 or more registrar
  + 1 or more resident
  + occasional intern or medical student

5/37 ward rounds without a consultant
PROCEDURE

Medical teams shadowed while on ward rounds (58.5 h)
All verbal communication about medications noted:

- Where discussion took place
  Patient’s bed, hallway

- Who was involved
  Dr & Dr, Dr & nurse, Dr & pharmacist, Dr & patient

Nature of conversation between Dr and patient
Whether content of alert was discussed
Whether Reference Viewer tool was used

MIE 2011, Melissa Baysari
COMMUNICATION BETWEEN PROVIDERS

176 verbal behaviours about medications
23% at patient’s bedside

91% between doctor & doctor
7% between doctor and nurse
2% between doctor and pharmacist
<table>
<thead>
<tr>
<th>Type of verbal behaviour</th>
<th>Example</th>
<th>observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient what medication they are currently taking or will take</td>
<td>your constipation?”</td>
<td>65 (51.5%)</td>
</tr>
<tr>
<td>medication they would like to take</td>
<td>your constipation?”</td>
<td></td>
</tr>
<tr>
<td>they are currently taking</td>
<td>everyday?”</td>
<td></td>
</tr>
<tr>
<td>commented on their medications</td>
<td>attacks, what does it all mean?”</td>
<td></td>
</tr>
<tr>
<td>medications</td>
<td>want to take you off the Calcium tablets”</td>
<td></td>
</tr>
</tbody>
</table>
IMPACT OF DECISION SUPPORT

Alert content was never discussed

Reference viewer was used on 5 occasions

- Doctor looked up trade names and relayed these to patient
- Doctor used tool to review medication information (n=4)
DISCUSSION

between 2 or more doctors away from the patient bedside

Nurses & pharmacists were rarely involved in decision making

Lots of communication between patient & doctor but very little SDM

Decision support played only a small role in decision making
WHY NO SDM?

Hospital medical problems don’t have clear decision points (compared to, for example, preventative screening)

Relationship between doctor and patient is not longstanding

Time on ward-rounds is limited

Hospital patients may not want to participate (they are usually elderly and have serious illnesses)

Should all patients still be offered the opportunity to be involved?
ACKNOWLEDGMENTS

This research is supported by NH&MRC Program Grant 568612.

Thanks to Dr Darren Roberts for help with participant recruitment