

醫病共享決策實踐
在
早期緩和醫療的運用

=秀傳經驗分享=

彰濱秀傳紀念醫院 放射腫瘤科
劉育昌 醫師



劉育昌 醫師

Affiliation & Specialty

秀傳醫療體系彰化院區癌症醫院副院長

秀傳醫療體系彰化院區放射腫瘤科首席主任

秀傳醫療財團法人彰濱秀傳紀念醫院癌症防治中心副主任

秀傳醫療財團法人彰濱秀傳紀念醫院品管中心主任

放射腫瘤專科醫師

台灣癌症安寧緩和專科醫師

中臺科技大學醫學影像暨放射科學系博士

中臺科技大學醫學影像暨放射科學系兼任助理教授

台灣癌症登記會常務理事

台灣癌症登記學會學術委員會副主任委員、教育委員會委員

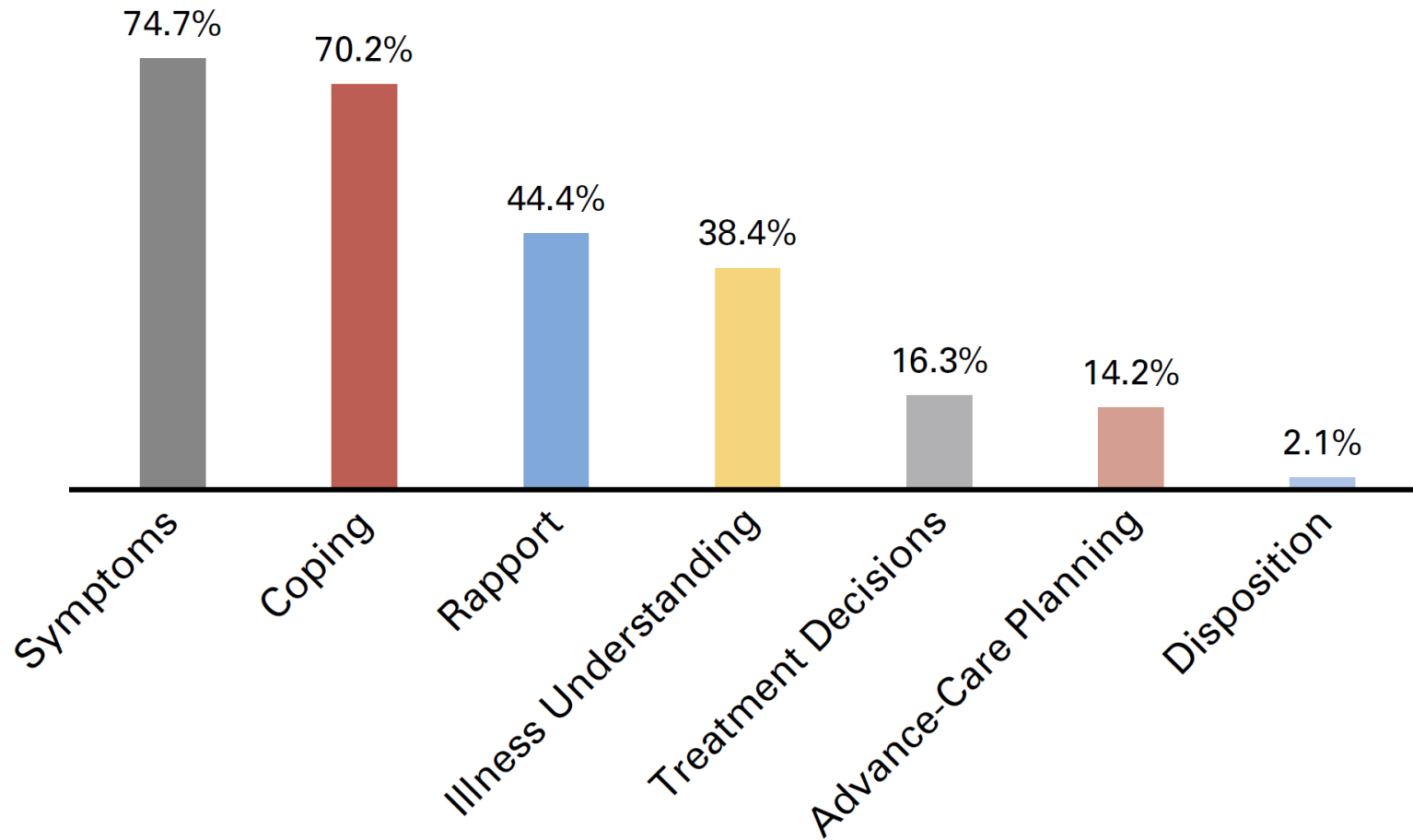


**EARLY PALLIATIVE CARE TEAM
ESTABLISHED IN 108-10 AT
CHANG BING SHOW CHWAN MEMORIAL HOSPITAL**

Outlines

- Patient Decision Making in Early Palliative Care (EPC)
 - Current benefit consensus
 - What's the key to make survival benefit possible?
 - Adherence, leading indicator of survival in EPC?
- Shared Decision Making in EPC
 - Flash back of SDM
 - Current evidence of SDM in EPC
- Chang Bing Show Chwan Experience of SDM Exercise to Push Up Radiotherapy Adherence
 - Problem approach and monitoring
 - Making of the suitable PDA
 - No feeding tube may correlate adherence of radiotherapy
- Additional SDM Facts

Patient Needs about Decision Making in Early Palliative Care (EPC) Scenario



16.3% 的機率會碰上跟病人討論治療相關決策，但是...

Early Palliative Care Improves Quality of Life (QoL) and Symptom Intensity in Advanced Cancer

> [Am J Hosp Palliat Care](#). 2022 Mar 1;10499091221075570. doi: 10.1177/10499091221075570.

Online ahead of print.

Effects of Early Palliative Care in Advanced Cancer Patients: A Meta-Analysis

Hsiu-Hua Shih ¹, Hsiu-Ju Chang ^{2 3}, Tsai-Wei Huang ^{1 4 5}

Affiliations – collapse

Affiliations

- 1 School of Nursing, College of Nursing, 38032Taipei Medical University, Taipei, Taiwan.
- 2 School of Nursing, Department of Nursing, 34914National Yang Ming Chiao Tung University, Taipei, Taiwan.
- 3 School of Nursing, Department of Nursing, National Yang Ming University, Taipei, Taiwan.
- 4 Cochrane Taiwan, 38032Taipei Medical University, Taipei, Taiwan.
- 5 Center for Nursing and Healthcare Research in Clinical Practice Application, Department of Nursing, Wan Fang Hospital, 38032Taipei Medical University, Taipei, Taiwan.

Conclusions: Early palliative care improves QoL, symptom intensity, and TOI in advanced cancer patients. We recommend introducing early palliative care for advanced cancer patients as the approach provides additional clinical benefits compared with usual care.

Better QoL Implicates Better Survival?



Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rucker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

- This systematic review of **a small number of trials** indicates that early palliative care interventions may have more **beneficial effects on QoL and symptom**...effects on **mortality and depression** are **uncertain**...interpret current results with caution owing to **very low to low certainty of current evidence** and between-study differences regarding participant populations, interventions, and methods...

Early Palliative Care: Pro, but Please Be Precise!

Jan Gärtner^a Marion Daun^b Juergen Wolf^c Michael von Bergwelt-Baildon^d
Michael Hallek^c

^aPalliativzentrum Hildegard, Basel, Switzerland; ^bKlinik für Hämatologie, Onkologie und Palliativmedizin, Sektionsleitung Palliativmedizin, Rems-Murr-Klinikum, Winnenden, ^cKlinik I für Innere Medizin, Uniklinik Köln, Centrum für Integrierte Onkologie (CIO) Köln Bonn, Cologne and ^dMedizinische Klinik und Poliklinik III, Klinikum der Universität München, Munich, Germany

...Therefore, it is not a question of “if” PC should be integrated early into oncology, but “**how.**”

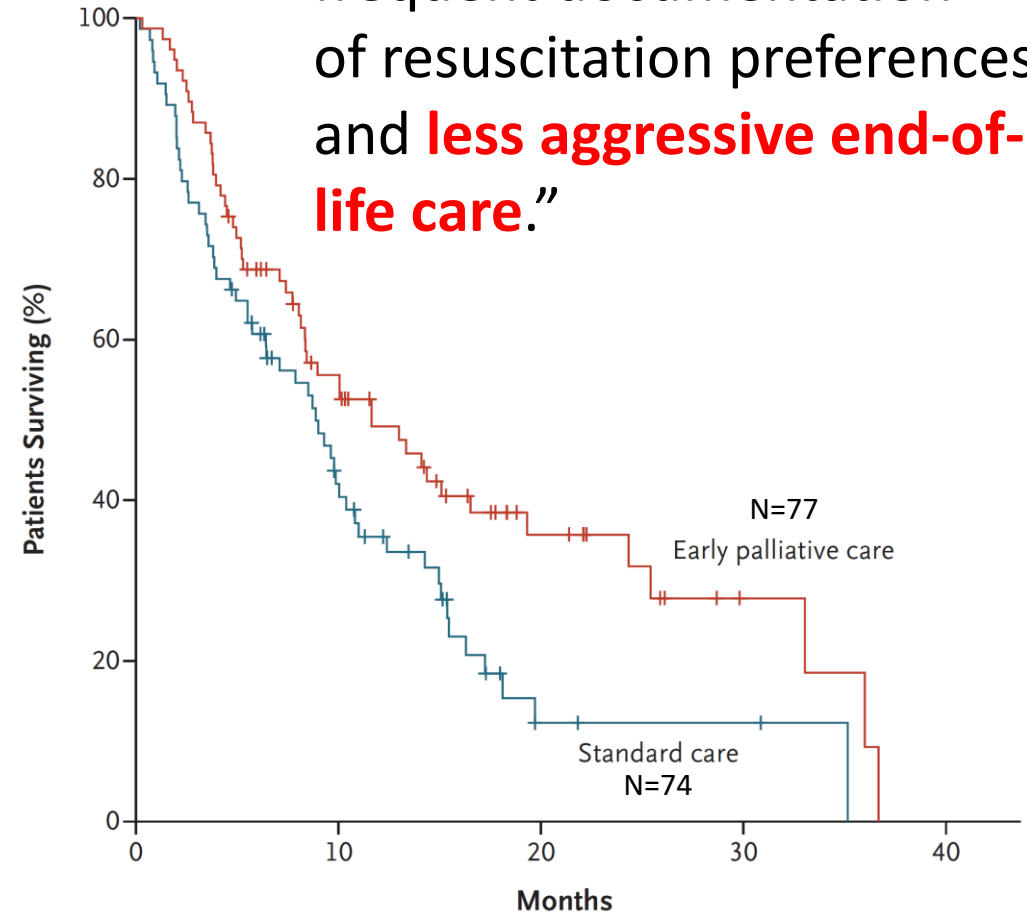
Specialist PC is provided by **specialist teams**...integrated in the care of PC patients depending on the **availability of these services** and the **patients’ needs.**

Should We Pursuit Survival in EPC?

Randomized Trials of Early Specialty Palliative Care Interventions in Patients with Cancer.			
Trial	Population	Intervention	Results
Brumley et al. ⁶	298 homebound patients with a prognosis of <1 yr to live and a recent hospital or ED visit; included 138 patients with cancer	Usual care + in-home multidisciplinary PC (frequency of visits based on individual needs of patients) vs. usual care	Patients assigned to PC had lower rates of ED visits (P=0.01) and hospital admissions (P<0.001) and lower medical costs (difference in mean cost, \$7,552; P=0.004) and were more likely to die at home (P<0.001). There was no significant between-group difference in hospice enrollment.
Gade et al. ⁹	517 patients with ≥1 life-limiting diagnosis and their physician “would not be surprised” if the patient died ≤1 yr; included 159 patients with cancer	Usual care + inpatient multidisciplinary PC consultation vs. usual care	Patients receiving PC reported more satisfaction with care (P<0.001), had fewer ICU stays on hospital readmission (P=0.04), and had a 6-mo net cost savings of \$4,855 per patient (P=0.001). There were no significant between-group differences in hospice use, completion of advanced directives, symptoms and quality of life, or survival.
Bakitas et al. ¹⁰	322 patients with a life-limiting cancer and a prognosis of approximately 1 yr to live	Usual care + phone-based PC administered by advanced-practice nurse in 4 structured sessions and at least monthly follow-up vs. usual care	Patients assigned to PC reported better quality of life (P=0.02) and mood (P=0.02). There were no significant between-group differences in symptom burden or intensity of service (hospital and ICU days or number of ED visits).
Temel et al. ¹¹	151 patients within 8 wk after diagnosis of metastatic lung cancer	Usual care + outpatient PC (provided by physician or advanced-practice nurse) at least monthly and PC consultation if patient hospitalized vs. usual care	Patients receiving early PC had better quality of life (P=0.03), lower rates of depression (P=0.01), less aggressive end-of-life care (P=0.05), and longer median survival (P=0.02).
Zimmermann et al. ¹²	442 patients with metastatic cancer and a physician-provided prognosis of 6 mo to 2 yr to live	Usual care + early ambulatory PC at least monthly vs. usual care with routine PC	Patients receiving early PC reported greater satisfaction with care (P<0.001), better quality of life (P=0.008), and less severe symptoms (P=0.05) at 4 mo.

* ED denotes emergency department, ICU intensive care unit, and PC palliative care.

“...improved mood, more frequent documentation of resuscitation preferences, and **less aggressive end-of-life care.**”

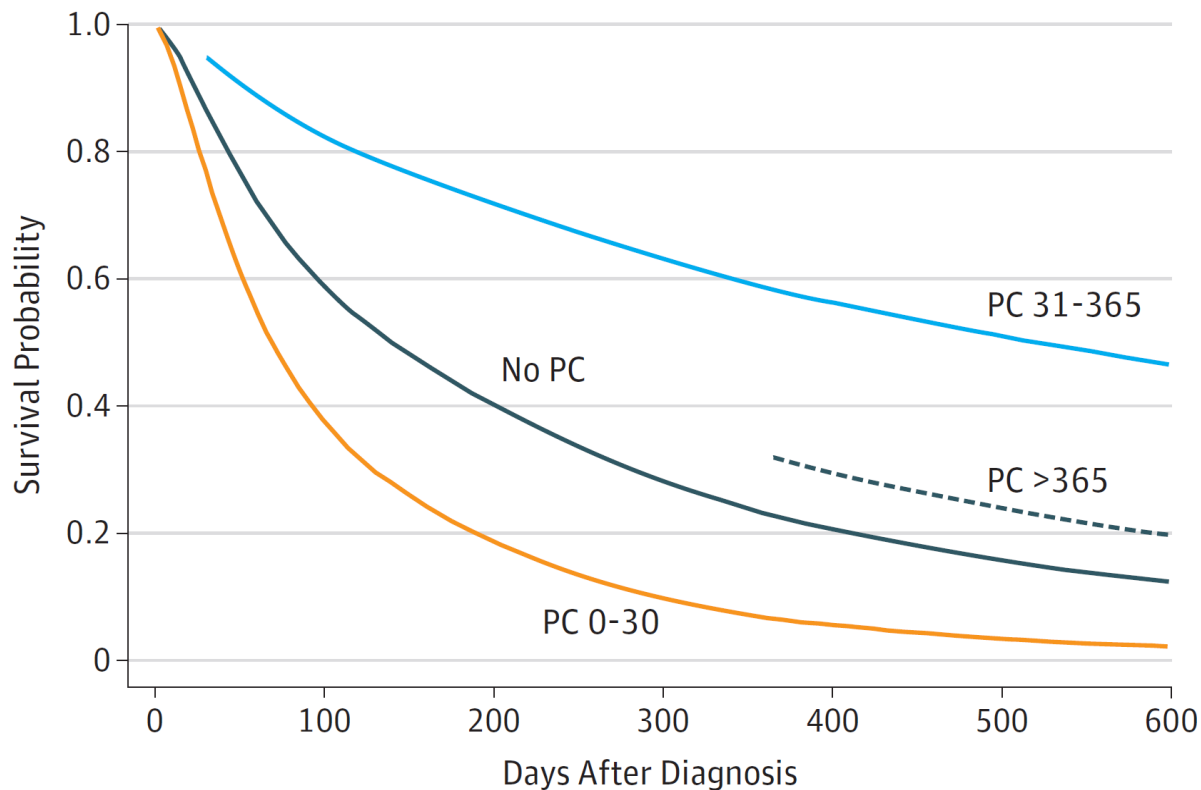


Illness understanding/education
Inquire about illness and prognostic understanding
Offer clarification of treatment goals
Symptom management – Inquire about uncontrolled symptoms with a focus on:
Pain
Pulmonary symptoms (cough, dyspnea)
Fatigue and sleep disturbance
Mood (depression and anxiety)
Gastrointestinal (anorexia and weight loss, nausea and vomiting, constipation)
Decision-making
Inquire about mode of decision-making
Assist with treatment decision-making, if necessary
Coping with life threatening illness
Patient
Family/family caregivers
Referrals/Prescriptions
Identify care plan for future appointments
Indicate referrals to other care providers
Note new medications prescribed

“...**assessing** physical and psychosocial **symptoms**, **establishing goals** of care, **assisting with decision making** regarding treatment, and coordinating care on the basis of the **individual needs of the patient.**”

Association of Early Palliative Care Use With Survival and Place of Death Among Patients With Advanced Lung Cancer Receiving Care in the Veterans Health Administration

Association of Survival With Receipt of Palliative Care (PC)



All-Cause Mortality Among Patients Who Received Palliative Care by Timing of Palliative Care Receipt^a

Timing of Receipt After Diagnosis	Cohort, %	AHR (95% CI) ^b	P Value
8-Level TVC, d			
0-14	29.5	5.67 (5.03-6.39)	<.001
15-30	14.1	1.04 (0.92-1.18)	.50
31-60	14.1	0.61 (0.55-0.67)	<.001
61-90	7.6	0.42 (0.37-0.47)	<.001
91-120	5.2	0.32 (0.27-0.37)	<.001
121-180	7.1	0.41 (0.37-0.45)	<.001
181-365	12.3	0.49 (0.47-0.52)	<.001
>365	10.2	1.00 (0.94-1.07)	.92
3-Level TVC, d			
0-30	43.6	2.13 (1.97-2.30)	<.001
31-365	46.3	0.47 (0.45-0.49)	<.001
>365	10.2	1.00 (0.94-1.07)	.91

Abbreviations: AHR, adjusted hazard ratio; TVC, time-varying covariate.

What's Possible Key to Better Survival in EPC

The
Oncologist®

Symptom Management and Supportive Care

Palliative Care in Advanced Cancer Patients: How and When?

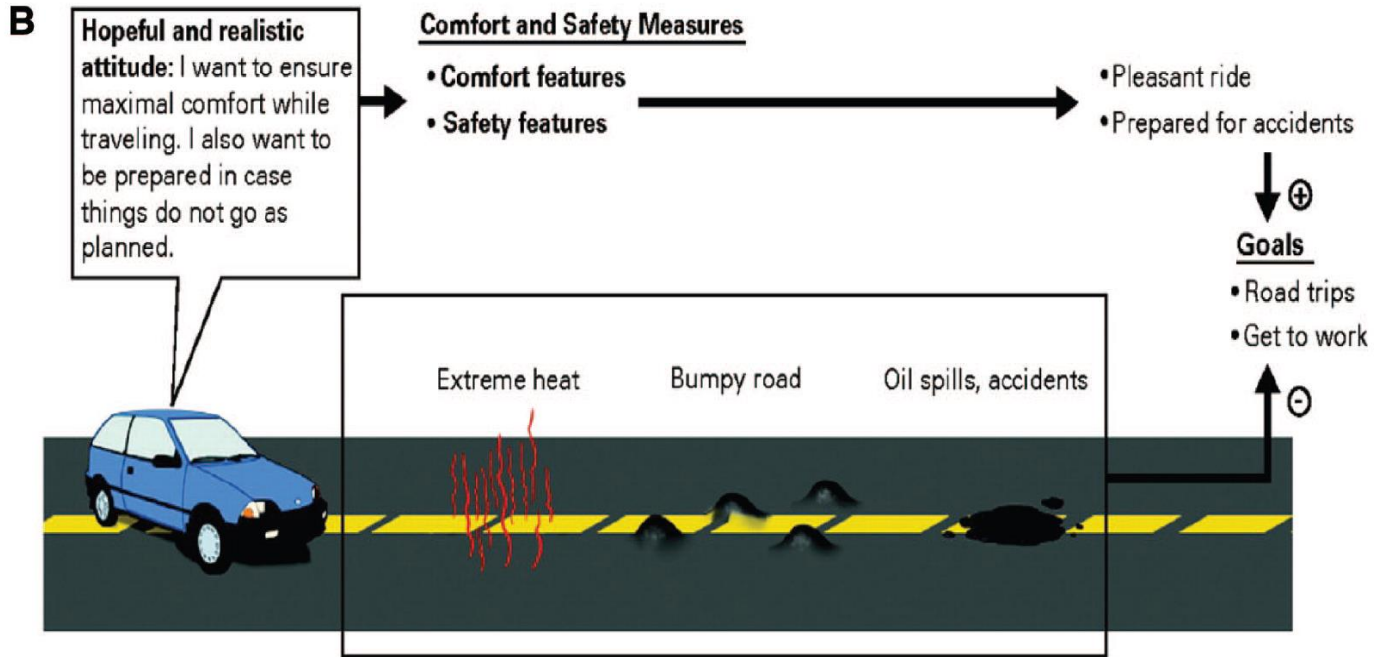
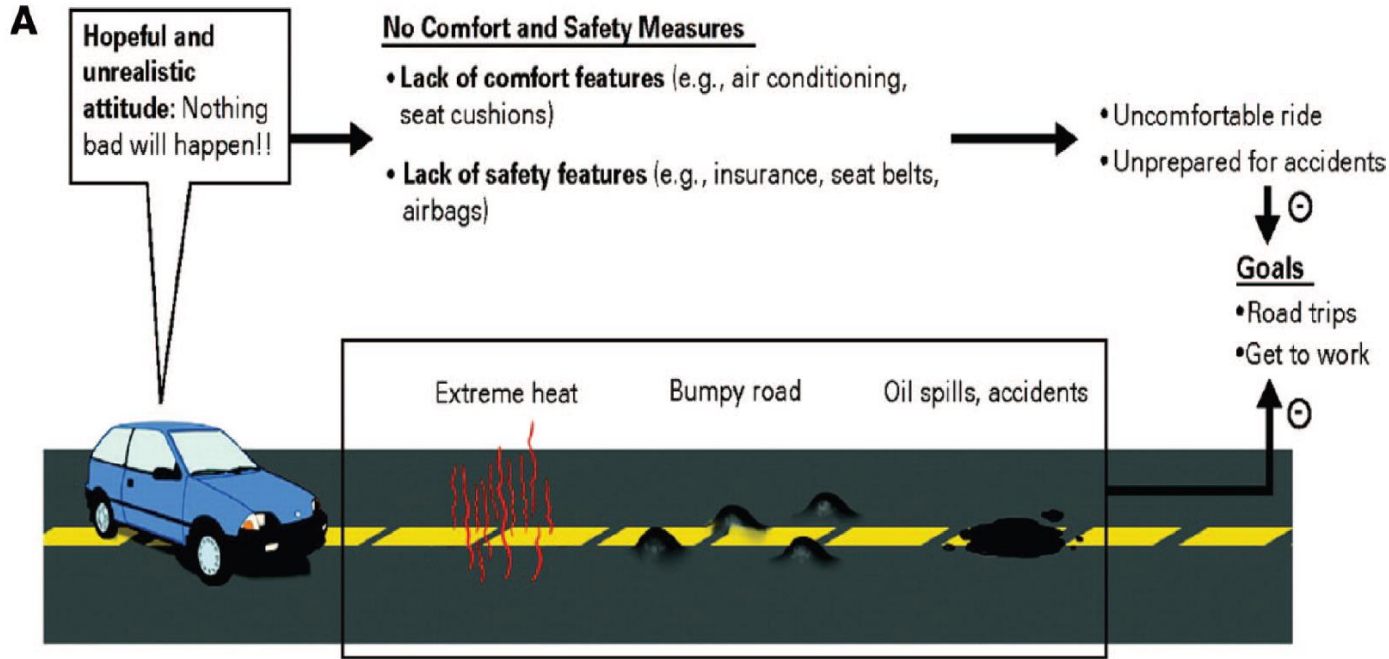
EDUARDO BRUERA, SRIRAM YENNURAJALINGAM

Department of Palliative Care and Rehabilitation Medicine, The University of Texas MD Anderson Cancer Center, Houston, Texas, USA

Key Words. Early palliative care • Efficacy of palliative care • Symptom control • Cost of care • Quality care • Supportive care

- Better symptom control and physical and psychosocial function could lead to a better ability to **adhere to cancer treatment regimens**
- Physical (i.e., pain, dyspnea, fatigue) and emotional (i.e., anxiety, depression) distress have been linked to greater mortality related to cancer and other conditions...palliative care access resulted in **less depression and anxiety**
- Effective transition to **end-of-life** care might **prevent** patients from receiving **potentially harmful interventions**

Goals for the use of a car are analogous to goals of care

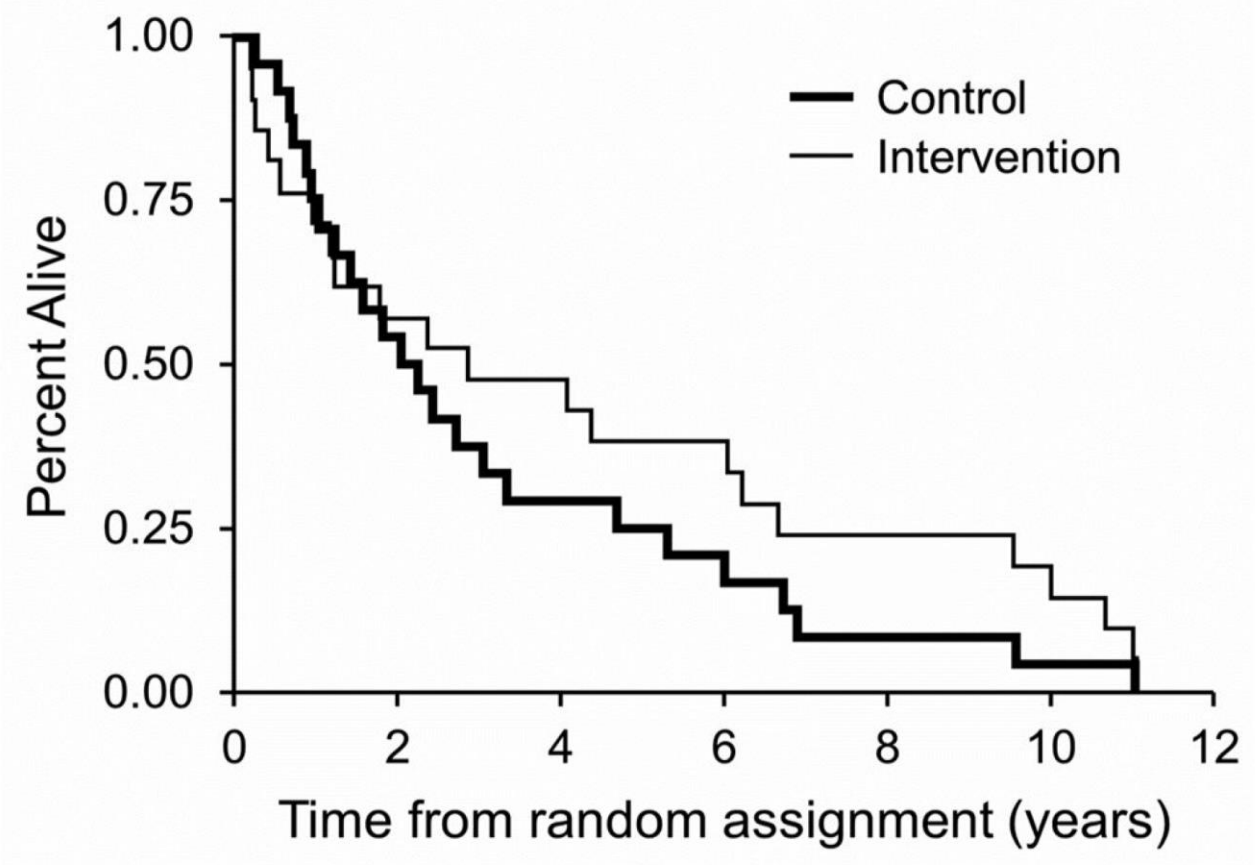


Addressing QoL May Increase Neoadjuvant Chemoradiation **Adherence** in Advanced GI Cancer

- N=61 (Intervention=29, Control=32)
- Structured group sessions for QoL in intervention group
 - 2-3 times per week
 - Led by psychiatrist or psychologist
 - Co-led by social worker
 - Each session
 - Opened with 20 minutes gentle stretching and resistive exercise led by physical therapist
 - Closed with 10-20 minutes guided-relaxation
- More patients in intervention group complete neoadjuvant chemoradiation
 - 81% vs. 37.5% ($p=0.005$)
- Less patients in intervention group hospitalized during chemotherapy
 - 14.3% vs. 50% ($p=0.011$)

Results of Logistical Regression Models, Among Participants Who Received Neoadjuvant Chemoradiation, Estimating the Associations of Group Assignment with Completion of Chemoradiation as Planned and Hospitalization During Chemoradiation, Both Unadjusted and Adjusted for Chemotherapy Regimen

	Odds ratio	SE	p value	95% Confidence Interval
Hospitalized during chemotherapy				
Univariate logistic regression model				
Group	0.167	0.124	0.016	0.039 – 0.718
Multivariate logistic regression model				
Group	0.130	0.107	0.013	0.026 – 0.647
Cisplatinium & 5-FU	0.796	0.835	0.828	0.102 – 6.217
5-FU (+/- leucovorin)	1.794	2.025	0.605	0.196 – 16.392
Completion of CR as planned				
Univariate logistic regression model				
Group	0.141	0.098	0.005	0.036 – 0.554
Multivariate logistic regression model				
Group	0.130	0.107	0.013	0.026 – 0.647
Cisplatinium & 5-FU	0.796	0.835	0.828	0.110 – 6.217
5-FU (+/- leucovorin)	1.794	2.025	0.605	0.196 – 16.392



PERSPECTIVE

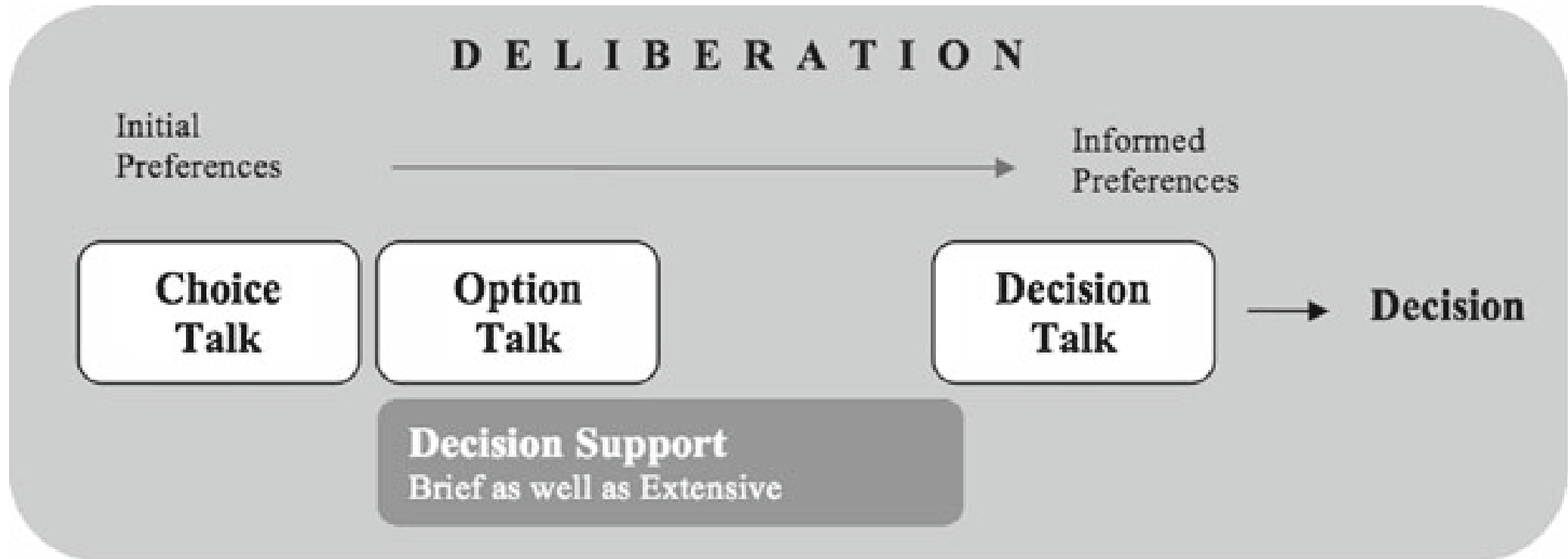
Shared Decision Making: A Model for Clinical Practice

Glyn Elwyn, PhD^{1,2}, Dominick Frosch, PhD^{3,4}, Richard Thomson, MD⁵, Natalie Joseph-Williams, MSc¹, Amy Lloyd, PhD¹, Paul Kinnersley, MD¹, Emma Cording, MB BCh¹, Dave Tomson, BM BCh⁶, Carole Dodd, MSc⁷, Stephen Rollnick, PhD¹, Adrian Edwards, PhD¹, and Michael Barry, MD^{8,9}

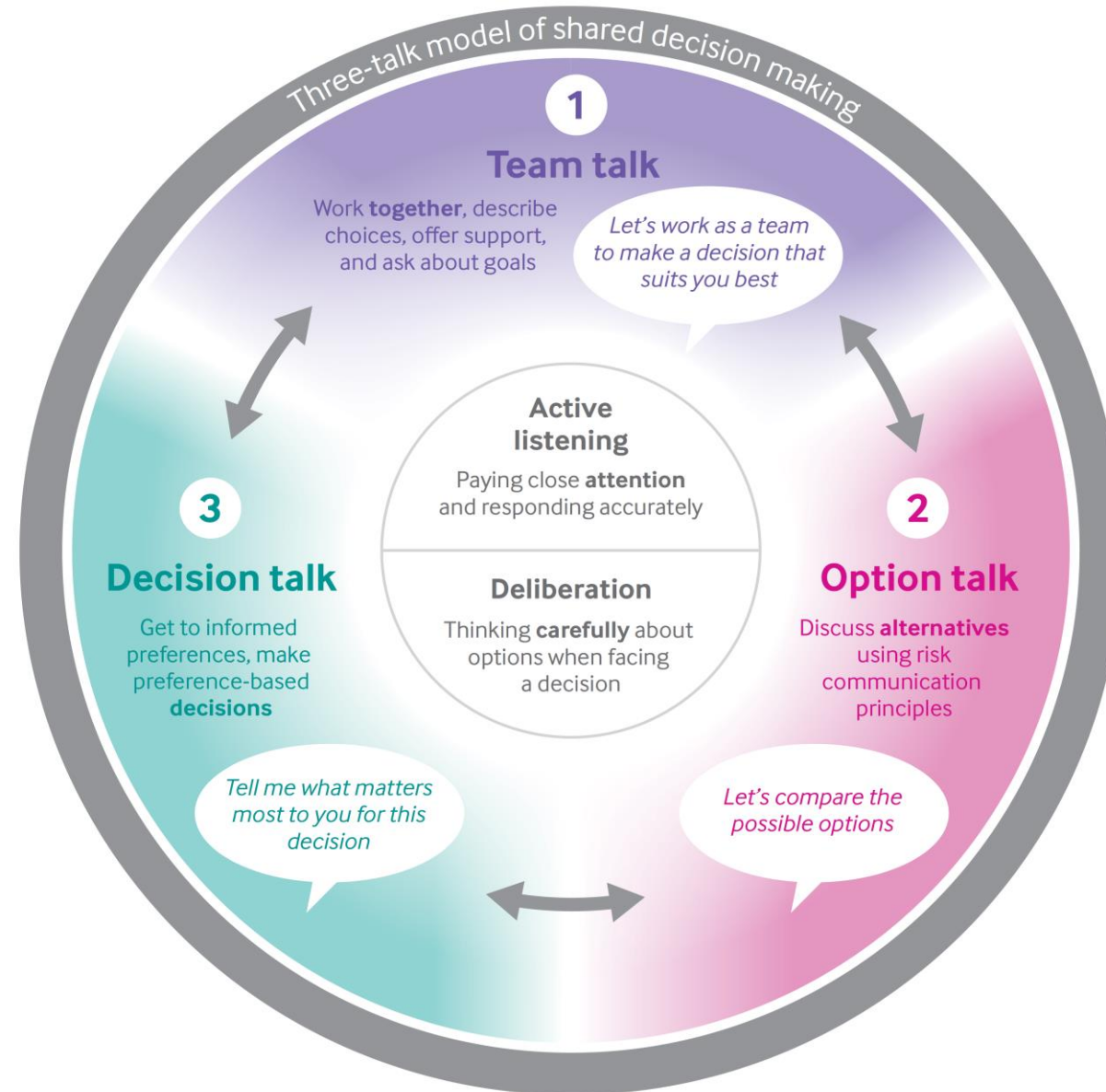
¹Cochrane Institute of Primary Care and Public Health, Neuadd Meirionydd, Cardiff University, Cardiff, UK; ²The Dartmouth Center for Health Care Delivery Science, Dartmouth College, New Hampshire, NH, USA

Shared decision making (SDM) has been defined as: “an approach where **clinicians and patients share the best available evidence** when faced with the task of making decisions, and where **patients are supported to consider options**, to achieve **informed preferences**”

3-Talk Model for SDM 2012



Revised 3-Talk Model 2017



Pioneer Told the Story

Huang et al. *BMC Palliative Care* (2020) 19:17
<https://doi.org/10.1186/s12904-020-0521-7>

BMC Palliative Care

RESEARCH ARTICLE

Open Access

Shared decision making with oncologists and palliative care specialists effectively increases the documentation of the preferences for do not resuscitate and artificial nutrition and hydration in patients with advanced cancer: a model testing study



Hsien-Liang Huang¹, Jaw-Shiun Tsai¹, Chien-An Yao¹, Shao-Yi Cheng¹, Wen-Yu Hu² and Tai-Yuan Chiu^{1*}

BMC Palliat Care. 2020 Feb 4;19(1):17

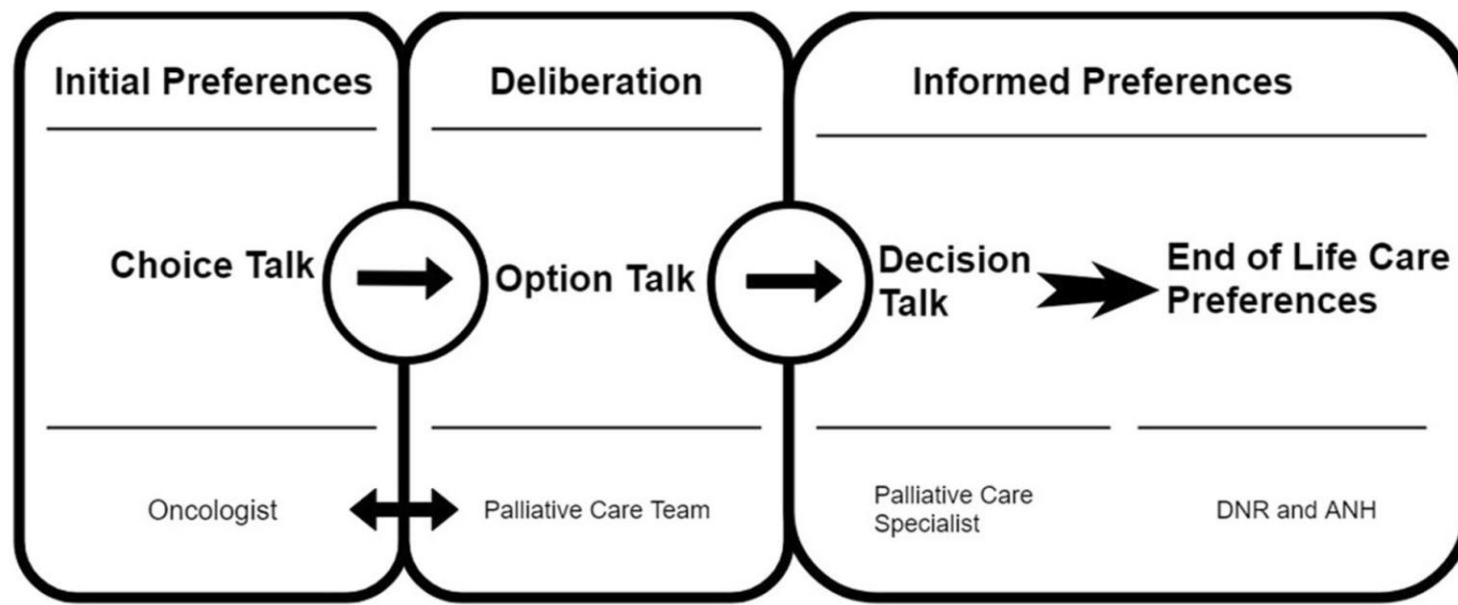
預立醫療自主計畫手冊, 王英偉著. 財團法人中華民國(台灣)安寧照顧基金會, 102年12月二版一刷

【2】醫療狀況二：

當我患有末期疾病，生命很可能只剩下數週，有時會有感覺，但已沒有辦法自行判斷，此時對於醫療的處理，我的期望為：

- 用所有的方法延長生命。
- 嘗試治療，但經常評估，若無效則停止。
- 只願接受較沒有侵入性的治療。
- 只希望接受舒適的治療。
- 其他（請說明）_____

對於下面的處置，您是否願意接受：	需要	還沒有決定	不要
心肺復甦術（包括胸部按壓、電擊、藥物、插管、用於面臨死亡的狀況）			
使用人工呼吸機器、插管…			
血液／腹膜透析（洗腎）			
人工營養／水分（使用鼻胃管或靜脈點滴）			
抗生素（只能治療併發症如肺炎，可能會暫時延長生命，但無法改變臨終結果）			
止痛藥（部分病人可能會變得較昏睡，但成癮或死亡的機會很低）			



SDM with Oncologist and Palliative care specialist (SOP) model

Logistic univariate and multivariate analysis of the variables related to DNR completion

	Univariate				Multivariate			
	OR	95% CI		<i>p</i>	OR	95% CI		<i>p</i>
		Lower	Upper			Lower	Upper	
Education (Ref: Elementary school or below)				0.015*				0.052
Junior high school	0.594	0.238	1.483	0.265	0.630	0.227	1.753	0.377
Senior high school	1.847	0.774	4.411	0.167	1.824	0.675	4.929	0.236
University or above	2.111	0.888	5.016	0.091	2.604	0.903	7.508	0.077
ECOG (Ref: 0 and 1)				0.001*				0.002*
2	1.913	0.965	3.792	0.063	2.541	1.185	5.449	0.017*
3	7.140	2.377	21.451	0.001*	6.695	2.131	21.035	0.001*

DNR Completion Rate


General: 52.3%
SOP model: **80.9%**

Abbreviations: DNR do not resuscitate; ECOG Eastern Cooperative Oncology Group performance status; CI Confidence interval; OR Odds ratio

* *p* < 0.05

LETTER TO THE EDITOR

Shared decision-making in palliative care: desires and facts

Gerard Vreugdenhil^{1,2} 

“A cardiothoracic surgeon describes his **voluntary wish to leave the decision regarding the approach of his urethral obstruction to the urologist**, even after having reorganized his own department in the direction of full SDM. In his view, **SDM is only useful in patients, able and willing to SDM.**”

Decision Making of **Patient** May **NOT** Be **Rational** **Possible Advantage** of SDM in EPC

- If SDM has taken place correctly, most patients **feel better informed** and have **less regrets** regarding their treatment decisions in cancer
- It is likely that while applying SDM appropriately, **all factors involved in clinical decision making become more visible, both in doctors and in patients**. Such a transparency might **reduce** the chance of disproportionate influence by factors such as **recent experiences (last-case bias) and financial drives**
- ... **special attention** can be given to patients with a **lower socioeconomic status**, who may have lower levels of compliance and hence sometimes lower survival

結論

- 導入SDM後，HBSC監測110年嚴重體重流失的頭頸癌病人有5位，其中2位因病人拒絕或主治醫師因素未進行SDM收案，嚴重體重流失病人下降至3人 (109年7人)。
- 進食管可有效改善頭頸癌接受放療病人明顯體重下降的風險，而對放療完成的依從性影響亦有明顯正向的趨勢，有潛力在繼續實踐SDM增加收案數後達到統計意義。

我們真的需要 SDM 嗎？ 醫療觀點

World Journal of Urology (2021) 39:4327–4333

<https://doi.org/10.1007/s00345-021-03782-7>

ORIGINAL ARTICLE



Differences in treatment choices between prostate cancer patients using a decision aid and patients receiving care as usual: results from a randomized controlled trial

Romy E. D. Lamers¹ · Maarten Cuypers² · Marieke de Vries³ · Lonneke V. van de Poll-Franse^{4,5,6} · J. L. H. Ruud Bosch⁷ · Paul J. M. Kil⁸

¹ Department of Urology, University Medical Center, Utrecht, The Netherlands

Abstract

Objective To determine whether or not decision aid (DA) use influences treatment decisions in patients with low and intermediate risk prostate cancer (PC).

Patients and methods In a cluster randomized controlled trial, patients were randomized to either DA use (DA group) or no DA use (control group). Between 2014 and 2016, newly diagnosed patients with low or intermediate risk PC were recruited in 18 hospitals in the Netherlands. DA users had access to a web-based DA that provided general PC information, PC-treatment information, and values clarification exercises to elicit personal preferences towards the treatment options. Control group patients received care as usual. Differences in treatment choice were analysed using multilevel logistic regressions. Differences in eligible treatment options between groups were compared using Pearson Chi-square tests.

Results Informed consent was given by 382 patients (DA group $N=273$, control group $N=109$). Questionnaire response rate was 88% ($N=336$). Active surveillance (AS) was an option for 38%, radical prostatectomy (RP) for 98%, external beam radiotherapy (EBRT) for 88%, and brachytherapy (BT) for 79% of patients. DA users received AS significantly more often than control group. Patients (29 vs 16%, $p=0.01$), whereas the latter more often chose BT (29 vs 18%, $p<0.01$). No differences were found between groups regarding RP and EBRT. DA users who were not eligible for AS, received surgery more often compared to the control group (53 vs 35%, $p=0.01$). Patient and disease characteristics were evenly distributed between groups.

Conclusion DA-using PC patients chose the AS treatment option more often than non-DA-using patients did.

我們真的需要 SDM 嗎？ 病人觀點

Review > Semin Oncol Nurs. 2021 Dec;37(6):151226. doi: 10.1016/j.soncn.2021.151226.

Epub 2021 Nov 7.

Supportive Roles of the Health Care Team Throughout the Illness Trajectory of Bladder Cancer Patients Undergoing Radical Cystectomy: A Qualitative Study Exploring the Patients' Perspectives

Elke Rammant ¹, Valérie Fonteyne ², Vincent Van Goethem ³, Sofie Verhaeghe ⁴, Anneleen Raes ⁵, Mieke Van Hemelrijck ⁶, Nihal E Mohamed ⁷, Karel Decaestecker ⁸, Ann Van Hecke ⁹

Affiliations – collapse

Affiliations

¹ Department of Human Structure and Repair, Ghent University, Ghent, Belgium. Electronic address: elke.rammant@uzgent.be.

Abstract

Objectives: To explore patient perspectives of muscle-invasive bladder cancer (MIBC) on how the health care team and their social network can support them during their cancer trajectory.

Data sources: Sixteen semi-structured interviews were conducted with MIBC survivors who underwent radical cystectomies at Ghent University Hospital. The interviews were audiotaped, transcribed verbatim, and analyzed with an iterative content analysis approach.

Conclusion: Information to support people affected by bladder cancer (BC) in several aspects of their disease trajectory (eg, shared decision-making and self-management of their urinary diversion) was most important throughout the interviews (although type and source of required information varied). The clinical nurse specialist was important for informational and emotional support because receiving sufficient information might help patients reduce emotional stress. People affected by BC are still reluctant to consult a psychologist, and several barriers were indicated for this. Also physical needs in the early postoperative phase could be reduced with appropriate information. Communication skills of clinicians in the hospital and knowledge of general practitioners about the important aspects of BC care are also important aspects that should be further optimized. Furthermore, peer support groups and family members can offer important support throughout the BC pathway.

Implications for nursing practice: This study provides an overview of how people affected by BC want to be supported by their health care team and their social network. This overview can serve as a basis to develop educational interventions for both patients and health care professionals to guide restructuring of BC pathways and can also be used to develop future intervention studies to improve BC outcomes.

SDM Do Help General Surgeons to Communicate!

> [Ann Surg.](#) 2016 Jan;263(1):1-6. doi: 10.1097/SLA.0000000000001491.

Recommendations for Best Communication Practices to Facilitate Goal-concordant Care for Seriously Ill Older Patients With Emergency Surgical Conditions

Zara Cooper¹, Luca A Koritsanszky, Christy E Cauley, Julia L Frydman, Rachelle E Bernacki, Anne C Mosenthal, Atul A Gawande, Susan D Block

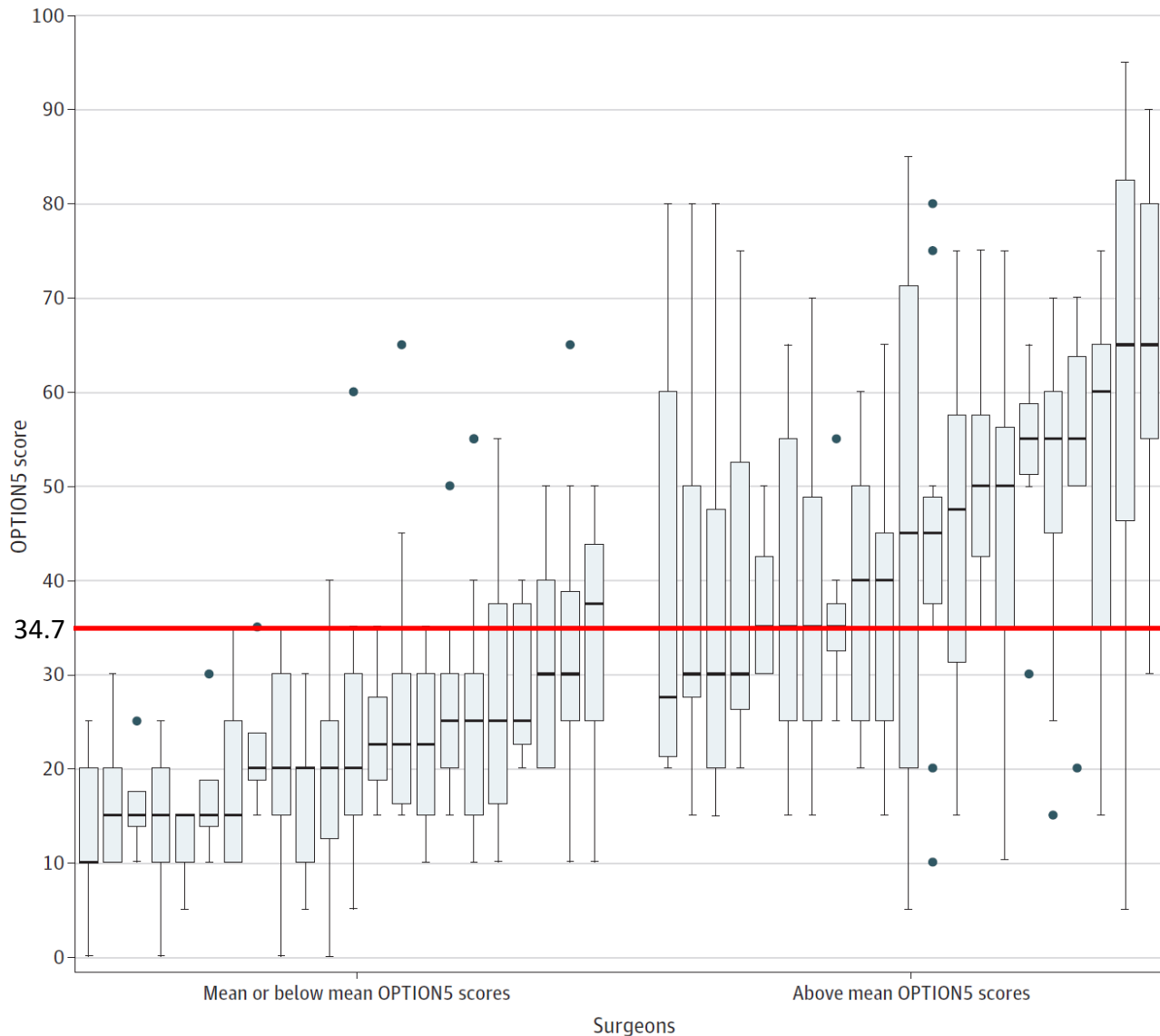
Affiliations

Affiliation

- 1 *Ariadne Labs, Boston, MA †Department of Surgery, Brigham and Women's Hospital, Boston, MA ‡Center for Surgery and Public Health, Brigham and Women's Hospital, Boston, MA §Department of Surgery, Massachusetts General Hospital, Boston, MA ¶Harvard Medical School, Boston, MA ||Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston, MA **Department of Surgery, Rutgers New Jersey Medical School, Newark, NJ ††Department of Psychiatry, Brigham and Women's Hospital, Boston, MA ‡‡Department of Medicine, Brigham and Women's Hospital, Boston, MA.

- 9 key elements
- (1) formulating prognosis
- (2) creating a personal connection
- (3) disclosing information regarding the acute problem in the context of the underlying illness
- (4) establishing a shared understanding of the patient's condition
- (5) allowing silence and dealing with emotion
- (6) **describing surgical and palliative treatment options**
- (7) **eliciting patient's goals and priorities**
- (8) making a treatment recommendation
- (9) affirming ongoing support for the patient and family.

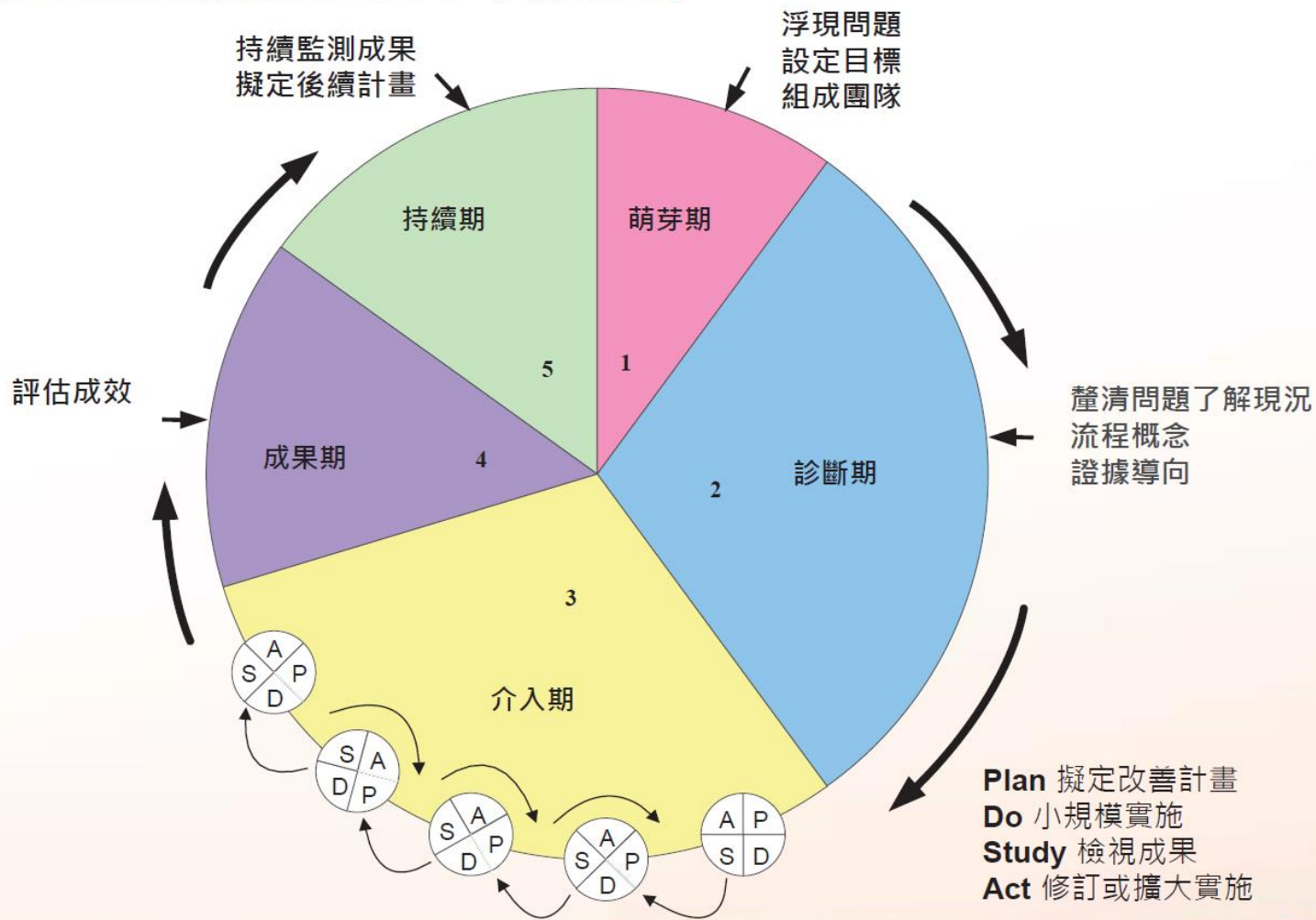
General Surgeon Use of SDM in Real World



- Use of shared decision-making increased when surgeons appeared reluctant to operate
- Longer conversations were associated with slightly higher OPTION5 scores
- 57% of high-scoring transcripts were 26 minutes long or less

378 surgical consultations were analyzed
Mean [SD] patient age, 71.9 [7.2] years

醫療品質改善模式



攜手共進 · 追求品質

決策輔助工具測試

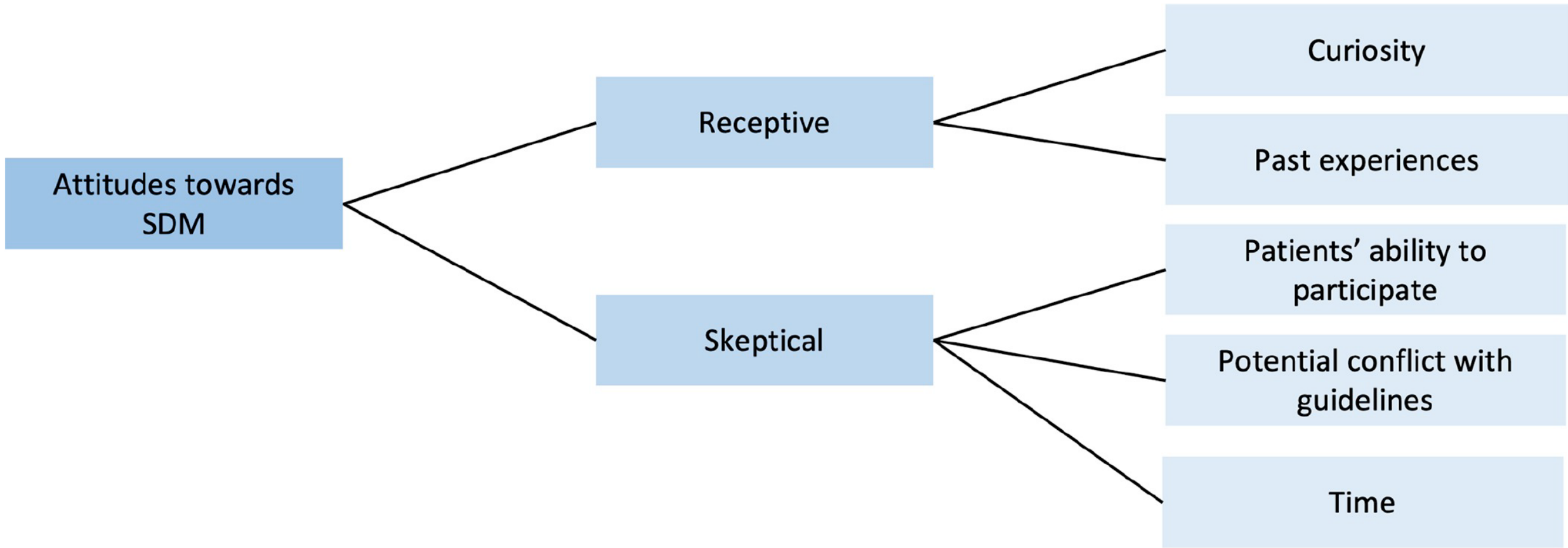
臺北市立聯合醫院 神經內科 / 失智症中心

劉建良 主任

2019/6/28

- 選擇一個影響醫療成效或是切乎病人生活品質的
重要問題
- 團隊、團隊、團隊
- SDM 與一般照護比較，的確可能改變病人的決定
- 聆聽 PDA 使用者及參與實踐 SDM 人員的心聲

醫療人員對SDM的態度



SDM 實踐的成功要素

PLOS ONE

RESEARCH ARTICLE

Practitioners' views on shared decision-making implementation: A qualitative study

Anshu Ankolekar¹, Karina Dahl Steffensen^{2,3,4}, Karina Olling², Andre Dekker¹, Leonard Wee¹, Cheryl Roumen¹, Hajar Hasannejadasi¹, Rianne Fijten^{1*}

1 Department of Radiation Oncology (MAASTRO), GROW School for Oncology, Maastricht University Medical Centre+, Maastricht, The Netherlands, **2** Center for Shared Decision Making, Lillebaelt Hospital–University Hospital of Southern Denmark, Vejle, Denmark, **3** Institute of Regional Health Research, University of Southern Denmark, Odense, Denmark, **4** Department of Oncology, Lillebaelt Hospital–University Hospital of Southern Denmark, Vejle, Denmark

根據病人需要靈活使用/更新決策輔助工具

讓醫病共享決策的行動覺起

- 從實證了解醫師已經做了哪些，還有哪些沒做需要學習
- 醫病共同開發決策輔助工具 (病人想的跟醫師認為的不一樣)

強而有力的領導

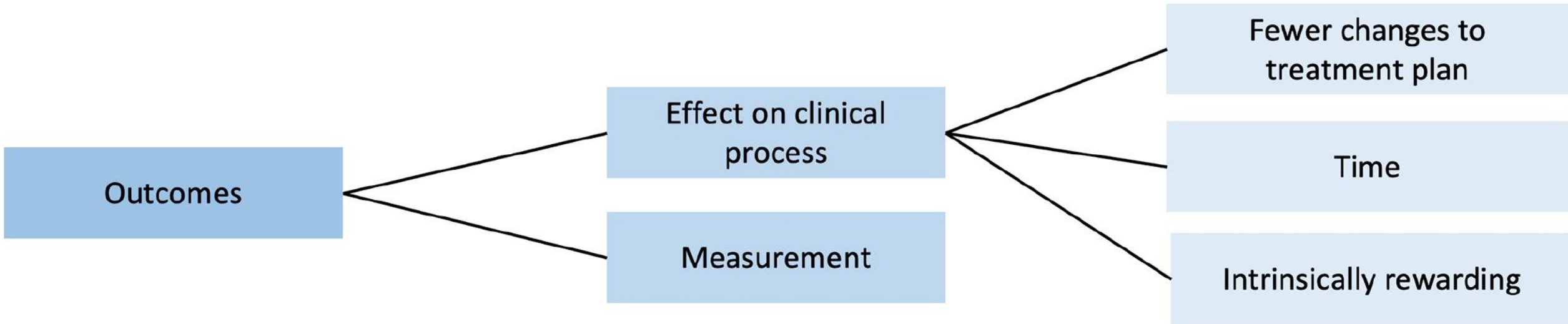
工欲善其事，必先利其器

- SDM種子醫師教育訓練
- 使用決策輔助工具

Results

Prior to SDM implementation, participants had a range of attitudes from skeptical to receptive. Those with more direct long-term contact with patients (such as nurses) were more positive about the need for SDM. We identified four main factors that influenced SDM implementation success: raising awareness of SDM behaviors among clinicians through concrete measurements, supporting the formation of new habits through reinforcement mechanisms, increasing the flexibility of PDA delivery, and strong leadership. According to our participants, these factors were instrumental in overcoming initial skepticism and solidifying new SDM behaviors. Improvements to the clinical process were reported. Sustaining and transferring the knowledge gained to other contexts will require adapting measurement tools.

SDM 的成效指標？



Reference

- J Clin Oncol. 2017 Mar 10;35(8):834-841
- Cochrane Database Syst Rev. 2017 Jun 12;6(6):CD011129
- Am J Hosp Palliat Care. 2022 Mar 1;10499091221075570
- Oncol Res Treat. 2019;42(1-2):11-18
- JAMA Oncol. 2019 Dec 1;5(12):1702-1709
- Oncologist. 2012 Feb; 17(2): 267–273
- J Pain Symptom Manage. 2015 Sep;50(3):321-7
- N Engl J Med. 2013 Dec 12;369(24):2347-51
- N Engl J Med. 2010 Aug 19;363(8):733-42
- BMC Palliat Care. 2020 Feb 4;19(1):17
- 預立醫療自主計畫手冊, 王英偉著. 財團法人中華民國(台灣)安寧照顧基金會, 102年12月二版一刷
- J Gen Intern Med. 2012 Oct;27(10):1361-7
- BMJ. 2017 Nov 6;359:j4891
- Acta Oncol. 2019 Feb;58(2):225-226
- World J Urol. 2021 Dec;39(12):4327-4333
- Semin Oncol Nurs. 2021 Dec;37(6):151226
- Ann Surg. 2016 Jan;263(1):1-6
- JAMA Surg. 2022 Mar 23;e220290
- 劉建良，決策輔助工具測試，醫策會108年醫病共享決策輔助工具(PDA)工作坊-PDA內容製作，108/6/28
- [https://sdm.patientsafety.mohw.gov.tw/Files/PublicContent/19/108.06.28-%E6%B1%BA%E7%AD%96%E8%BC%94%E5%8A%A9%E5%B7%A5%E5%85%B7%E6%B8%AC%E8%A9%A6-%E5%8A%89%E5%BB%BA%E8%89%AF%E4%B8%BB%E4%BB%BB\(PDA\)\(%E9%96%8B%E6%96%B0%E8%A6%96%E7%AA%97\).pdf](https://sdm.patientsafety.mohw.gov.tw/Files/PublicContent/19/108.06.28-%E6%B1%BA%E7%AD%96%E8%BC%94%E5%8A%A9%E5%B7%A5%E5%85%B7%E6%B8%AC%E8%A9%A6-%E5%8A%89%E5%BB%BA%E8%89%AF%E4%B8%BB%E4%BB%BB(PDA)(%E9%96%8B%E6%96%B0%E8%A6%96%E7%AA%97).pdf)
- PLoS One. 2021 Nov 11;16(11):e0259844