WEBVTT

1
00:00:03.010 --> 00:00:07.620
- In this module for counseling
for EPL treatment options,

2
00:00:07.620 --> 00:00:11.300
we will review the evidence
for offering patients choices

3
00:00:11.300 --> 00:00:13.340
for early pregnancy loss management,

4
00:00:13.340 --> 00:00:15.220
as opposed to directing them

5
00:00:15.220 --> 00:00:17.880
towards one modality over another,

6
00:00:17.880 --> 00:00:19.550
and present a counseling approach

7
00:00:19.550 --> 00:00:23.520
to identify patient priorities
in making this decision.

8
00:00:23.520 --> 00:00:25.330
The vast body of literature

9
00:00:25.330 --> 00:00:27.630
reporting on the safety and efficacy

10
00:00:27.630 --> 00:00:30.780
of all EPL treatment
options has established

11
00:00:30.780 --> 00:00:32.210
that there is no one option

12
00:00:32.210 --> 00:00:34.660
that is medically superior to another.

13
00:00:34.660 --> 00:00:38.040
In this example of clear
clinical equipoise,

14
00:00:38.040 --> 00:00:41.690
choosing management becomes a
preference-sensitive decision,

15
00:00:41.690 --> 00:00:44.430
and the best choice reflects
the patient's values

16
00:00:44.430 --> 00:00:46.253
and preferences for management.

17
00:00:47.270 --> 00:00:49.930
We know from large
miscarriage management trials

18
00:00:49.930 --> 00:00:51.820
that patients have very strong

19
00:00:51.820 --> 00:00:54.600
and widely divergent preferences.

20
00:00:54.600 --> 00:00:55.880
Randomized control trials

21
00:00:55.880 --> 00:00:58.520
had great difficulty
in recruiting patients

22
00:00:58.520 --> 00:01:02.010
as they strongly prefer to
choose their own treatment.

23
00:01:02.010 --> 00:01:04.800
And they also reported higher satisfaction

24
00:01:04.800 --> 00:01:07.690
when they were treated
according to their preference.

25
00:01:07.690 --> 00:01:11.460
However, despite evidence that
supports equivalent safety

26
00:01:11.460 --> 00:01:13.730
and acceptability of all options,

27
00:01:13.730 --> 00:01:15.930
estimates of actual treatment patterns

28
00:01:15.930 --> 00:01:19.430
from the last such
published research in 2010,

29
00:01:19.430 --> 00:01:22.660
suggested that practice
favors only two options;

30
00:01:22.660 --> 00:01:26.750
expecting care and aspiration
in the operating room.

31
00:01:26.750 --> 00:01:28.980
In addition, these treatment patterns

32
00:01:28.980 --> 00:01:31.620
do not appear to be in
line with what is known

33
00:01:31.620 --> 00:01:34.350
regarding the diversity
of patient preferences.

34
00:01:34.350 --> 00:01:36.140
If it were, we would expect to see

35
00:01:36.140 --> 00:01:38.480
an equitable distribution of management

36
00:01:38.480 --> 00:01:40.510
across all four options.

37
00:01:40.510 --> 00:01:43.210
When we ask participants
during research interviews

38
00:01:43.210 --> 00:01:44.210
about how to create

39
00:01:44.210 --> 00:01:47.270
a patient-centered
decision-making process,

40
00:01:47.270 --> 00:01:49.580
they repeatedly emphasize the importance

41
00:01:49.580 --> 00:01:51.970
of being offered options

42
00:01:51.970 --> 00:01:54.840
and having the freedom
to decline intervention

43
00:01:54.840 --> 00:01:57.080
or choose treatment willingly.

44
00:01:57.080 --> 00:01:58.477
One woman told us,

45
00:01:58.477 --> 00:01:59.860

"I think sometimes the doctors

46
00:01:59.860 --> 00:02:01.960
have you do things that are unnecessary

47
00:02:01.960 --> 00:02:03.870
or sometimes they prescribe things to you

48
00:02:03.870 --> 00:02:05.700
that are unnecessary.

49
00:02:05.700 --> 00:02:07.950
I like the way it was
presented to me as options,

50
00:02:07.950 --> 00:02:09.670
and they were optional,

51
00:02:09.670 --> 00:02:13.220
they weren't necessary or required."

52
00:02:13.220 --> 00:02:14.740
Additional qualitative studies

53
00:02:14.740 --> 00:02:17.430
done alongside large miscarriage trials

54
00:02:17.430 --> 00:02:19.420
reveal that many different factors

55
00:02:19.420 --> 00:02:21.140
and competing priorities

56
00:02:21.140 --> 00:02:23.720
affect patient's
preferences for treatment.

57
00:02:23.720 --> 00:02:25.960

For some, the physical experience,

58
00:02:25.960 --> 00:02:30.440
pain, bleeding, procedural
safety, time to completion

59
00:02:30.440 --> 00:02:31.710
will be important,

60
00:02:31.710 --> 00:02:34.240
while for others, feelings about privacy

61
00:02:34.240 --> 00:02:37.350
or past experiences with
miscarriage or abortion

62
00:02:37.350 --> 00:02:38.800
will affect how they feel

63
00:02:38.800 --> 00:02:40.990
about different management choices.

64
00:02:40.990 --> 00:02:42.830
We return to our patient Maya

65
00:02:42.830 --> 00:02:45.390
who we met in our diagnosis module.

66
00:02:45.390 --> 00:02:48.370
They were told immediately
about the ultrasound evaluation,

67
00:02:48.370 --> 00:02:50.310
which showed a demise.

68
00:02:50.310 --> 00:02:52.420
And now it is time to discuss treatment.

69

00:02:52.420 --> 00:02:54.910
How do we counsel Maya about options

70
00:02:54.910 --> 00:02:57.200
in a patient-centered way?

71
00:02:57.200 --> 00:02:59.650
For this preference-sensitive decision,

72
00:02:59.650 --> 00:03:03.380
I recommend using a shared
decision-making framework

73
00:03:03.380 --> 00:03:06.750
for your discussions with
patients about management choices.

74
00:03:06.750 --> 00:03:08.960
Begin with an information exchange

75
00:03:08.960 --> 00:03:12.040
where you present all the
information about their options

76
00:03:12.040 --> 00:03:13.840
and important medical information

77
00:03:13.840 --> 00:03:17.190
that may affect their care specifically.

78
00:03:17.190 --> 00:03:19.590
Next, elicit from them information

79
00:03:19.590 --> 00:03:23.470
about personal circumstances,
values, and priorities

80
00:03:23.470 --> 00:03:26.410
that may affect their

preferences for management.

81
00:03:26.410 --> 00:03:29.570
During deliberation, you
may want to openly address

82
00:03:29.570 --> 00:03:31.440
your own preferences or biases

83
00:03:31.440 --> 00:03:33.400
toward certain treatment options

84
00:03:33.400 --> 00:03:36.570
as many patients value
their provider's opinion.

85
00:03:36.570 --> 00:03:39.350
Finally, together, the
provider and patient

86
00:03:39.350 --> 00:03:43.810
reach a treatment decision
that is best for them.

87
00:03:43.810 --> 00:03:46.300
This is one example of a decision tool

88
00:03:46.300 --> 00:03:48.430
that could be used during counseling

89
00:03:48.430 --> 00:03:51.400
to elicit patient
priorities for management.

90
00:03:51.400 --> 00:03:52.670
This can be used by patients

91
00:03:52.670 --> 00:03:55.550
with a high level of health

literacy on their own

92
00:03:55.550 --> 00:03:58.080
to select factors important to them,

93
00:03:58.080 --> 00:03:59.600
or as a discussion guide

94
00:03:59.600 --> 00:04:02.140
for providers to ask
about different priorities

95
00:04:02.140 --> 00:04:03.590
in choosing an option

96
00:04:03.590 --> 00:04:06.700
that is most in line with
their values and preferences.

97
00:04:06.700 --> 00:04:09.530
So imagine having this
discussion with Maya.

98
00:04:09.530 --> 00:04:12.180
You review the pros and
cons of each option,

99
00:04:12.180 --> 00:04:14.510
including the relative chance of success

100
00:04:14.510 --> 00:04:17.980
for their specific
diagnosis, embryonic demise.

101
00:04:17.980 --> 00:04:19.390
Using the decision tool,

102
00:04:19.390 --> 00:04:21.830
you elicit from them what they prioritize

103
00:04:21.830 --> 00:04:23.370
in choosing management.

104
00:04:23.370 --> 00:04:25.500
Maya tells you that they strongly prefer

105
00:04:25.500 --> 00:04:27.220
not to have a procedure

106
00:04:27.220 --> 00:04:31.530
due to discomfort with the
invasive nature of aspiration.

107
00:04:31.530 --> 00:04:33.300
The shared decision-making process

108
00:04:33.300 --> 00:04:35.410
continues with deliberation.

109
00:04:35.410 --> 00:04:38.220
In considering options
other than aspiration,

110
00:04:38.220 --> 00:04:40.630
you talk with Maya
about how expecting care

111
00:04:40.630 --> 00:04:42.670
is far too unpredictable for them,

112
00:04:42.670 --> 00:04:46.110
but that medication management
may strike the right balance

113
00:04:46.110 --> 00:04:49.640
between predictability
and being non-invasive.

114
00:04:49.640 --> 00:04:52.220
Negotiation and agreement follows.

115
00:04:52.220 --> 00:04:54.980
It's best to acknowledge
your own personal preferences

116
00:04:54.980 --> 00:04:56.500
and biases in advance

117
00:04:56.500 --> 00:04:59.160
to establish self-awareness

118
00:04:59.160 --> 00:05:03.040
for a non-judgemental and
non-directive discussion.

119
00:05:03.040 --> 00:05:05.340
For example, Maya tells you

120
00:05:05.340 --> 00:05:08.060
they want a quick resolution
to their miscarriage.

121
00:05:08.060 --> 00:05:11.210
And while you may prefer
to offer an aspiration

122
00:05:11.210 --> 00:05:12.860
immediately in your office

123
00:05:12.860 --> 00:05:16.380
to allow Maya to leave today
with a sense of finality,

124
00:05:16.380 --> 00:05:18.540
Maya still declines.

125

00:05:18.540 --> 00:05:21.640
Putting the patient's
preferences above your own

126
00:05:21.640 --> 00:05:25.280
is key to successful
shared decision-making.

127
00:05:25.280 --> 00:05:27.910
And together you agree
that medication management

128
00:05:27.910 --> 00:05:30.170
is the best choice for Maya.

129
00:05:30.170 --> 00:05:32.020
Shared decision-making is a framework

130
00:05:32.020 --> 00:05:35.720
that aims to increase
patient's knowledge, autonomy,

131
00:05:35.720 --> 00:05:38.500
and control of treatment decisions.

132
00:05:38.500 --> 00:05:41.290
It allows for equal
exchange of information

133
00:05:41.290 --> 00:05:44.580
and creates a partnership
and balance of power

134
00:05:44.580 --> 00:05:48.870
during the intimate and personal
experience of miscarriage.

135
00:05:48.870 --> 00:05:50.000
We recommend reviewing

136
00:05:50.000 --> 00:05:52.110
the additional modules in our program,

137
00:05:52.110 --> 00:05:55.100
including the overview of EPL management,

138
00:05:55.100 --> 00:05:59.050
at home EPL care, and
medication management for EPL

139
00:05:59.050 --> 00:06:01.880
to become familiar with
each treatment modality

140
00:06:01.880 --> 00:06:04.513
and how to discuss them with patients.