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Engaging Patients to Ask More Questions: What's the Best Way? A Pragmatic Randomized Controlled Trial

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Abstract

Purpose—Hand conditions are common, and often require a discussion of the tradeoffs of different treatment options. Our goal was to evaluate whether providing patients with a Question Prompt List (QPL) for common hand conditions improves their perceived involvement in care compared with providing patients with 3 generic questions.

Methods—We performed a prospective, single-center, pragmatic randomized controlled trial. We created a QPL pamphlet for patients with common hand conditions. New patients with common hand conditions were enrolled between April 2019 and July 2019 and were randomized into either the QPL group (with 35 hand-specific questions) or the AskShareKnow group (3 generic questions: [1] What are my options? [2] What are the possible benefits and harms of those options? [3] How likely are each of these benefit and harms to happen to me?). Both groups received the questions prior to meeting with their surgeon. We used the Perceived Involvement in Care Scale (PICS), a validated instrument designed to evaluate patient participation in decision-making, as our primary outcome. The maximum PICS score is 13, and a higher score indicates higher perceived involvement.

Results—One hundred twenty-six patients participated in the study, with 63 patients in the QPL group and 63 patients in the AskShareKnow group. The demographic characteristics were similar in the 2 groups. The mean AskShareKnow group PICS score was 8.3 ± 2.2 and the mean QPL PICS score was 7.5 ± 2.8 , which was not deemed clinically significant.

Conclusions—The QPLs do not increase perceived involvement in care in patients with hand conditions compared with providing patients with 3 generic questions.

Clinical relevance—Various approaches have been evaluated to help improve patient involvement in their care. In hand surgery, 3 generic questions were no different than a lengthy QPL with respect to patient involvement in their care.

Keywords

Question prompt list; shared decision making; hand surgery; patient engagement

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The authors have complied with the ethical standards as detailed in Instructions to the Author set forth by the *Journal of Hand Surgery*.

MANY HAND CONDITIONS with multiple treatment options currently lack strong evidence as to which is superior with respect to both risks and benefits.¹⁻⁴ For example, carpal tunnel syndrome can be treated with orthosis wear, corticosteroid injections, or surgery with trade-offs for each treatment option.⁵⁻⁷ Treatment strategies for trigger finger include nonsteroidal anti-inflammatory drugs, hand therapy, orthosis wear, corticosteroid injections, and surgery.^{4,6,8,9} In situations in which there are trade-offs between multiple treatment options with varying outcomes and experiences, a patient's values and preferences should drive the treatment decision.

Implementing collaborative decision-making models, such as shared decision making (SDM), has become increasingly more common to focus care delivery on the values and preferences of patients.^{10,11} Shared decision-making involves physicians collaborating with patients to determine which treatment option best aligns with what is most important to the patient.¹⁰ Patient education and engagement in their health care decisions are critical aspects of SDM,¹¹ and increasing engagement of patients in their health care can lead to improved functional and psychological outcomes.¹² In orthopedic surgery, SDM has been demonstrated to help align patient goals with their treatment decisions and improve satisfaction.¹¹ In elective orthopedic surgery, patients value having an active role in their treatment decisions and have been shown to have better overall quality of life and significantly less regret when they have participated in SDM.^{1,13-15} Patients are increasingly using the Internet as their initial source of information regarding their conditions, which allows them to feel more involved in their health decisions during the clinic visit.¹⁶ However, prior work has found that online information about certain hand conditions can be misleading and biased.¹⁷

Question Prompt Lists (QPLs) are written examples of questions related to a particular condition or specialty that serves as an outline of questions that a patient can ask his or her physician.¹⁸⁻²² The QPLs have been established to aid in patient-physician communication and SDM by encouraging active patient participation in their consultations and subsequent decision making.¹⁸⁻²² The QPLs have been found to significantly increase the amount of information provided to patients from their physician,²³ and when used in oncology clinics, patients receiving QPLs both ask more questions in general and ask about topics related to their diagnosis, treatment, and prognosis.¹⁹ Although QPLs have been extensively studied in patients with advanced cancer, to date, there are no studies evaluating QPLs in hand surgery patients. The AskShareKnow (ASK) model is a method that was created to facilitate patient involvement and to promote question asking during their clinic visits.²⁴ Patients are provided with 3 generic questions that would help them obtain information needed for decision making.²⁴ The ASK model has been shown to increase information given about treatment options to patients and the consideration of patient preferences.²⁵ The ASK model is simple, efficient, and generalizable, so we chose to compare it with a QPL for patients with hand conditions.

Our goal was to evaluate whether a QPL created for patients with common hand conditions improves their involvement in care. We hypothesized that perceived involvement in care would increase in patients who received the QPL compared with patients receiving 3 generic questions.

METHODS

Question prompt list

We created a QPL pamphlet for patients with common hand conditions, the development and validation of which is described in a prior study.²⁶ Briefly, we used qualitative methodology to develop our QPL by providing a written questionnaire to a patient advisory board, hand therapists, and hand surgeons. We conducted cognitive interviews with a group of clinic patients and revised our QPL based upon this feedback. We quantitatively evaluated our final QPL using the System Usability Score to assess its usability.²⁶ The final QPL is at a sixth-grade reading level. Our QPL pamphlet contains written examples of questions that patients visiting a hand surgeon may want to ask during their office visit (Appendix A; available on the *Journal's* Web site at www.jhandsurg.org).

Patient selection

We performed a prospective, pragmatic randomized controlled trial that was approved by our institutional human research committee. A pragmatically designed randomized controlled trial is conducted to resemble clinical care in the administration of the study and to compare 2 clinically acceptable interventions. This provides results that are more applicable to real-world settings (comparative effectiveness) versus a highly controlled setting that lacks generalizability (explanatory trial focused on efficacy).^{27,28} Therefore, comparison of 2 tools used and studied in medicine today (QPL and ASK group) provides results that can more readily inform care. We invited 134 patients visiting 2 hand surgeons (R.K. and J.Y.) at our institution between April 2019 and July 2019 to participate. New patients presenting to the clinic were approached to participate in the study based on presenting diagnosis. Patients were selected by a trained research assistant (A.R. and S.E.). Inclusion criteria and exclusion criteria are listed in Table 1. Written consent was obtained from all participants.

Data collection

We followed the Consolidated Standards of Reporting Trials (CONSORT) criteria when designing our randomized controlled trial. Patients were randomized to the ASK or QPL group using a computer algorithm. The ASK group was given a list of 3 generic questions to ask their hand surgeon. These questions were (1) What are my options? (2) What are the possible benefits and harms of those options? and (3) How likely are each of these benefit and harms to happen to me? These questions were developed and studied by Shepherd et al,²⁴ who demonstrated that these questions increased patient involvement in care. The 3-question handout is at a fifth-grade reading level. The intervention group was given the QPL pamphlet created by the research team. Both groups of patients were consented by a trained research assistant, and then given their respective handouts 5 minutes prior to meeting with their hand surgeon. Patients in each group then had a standard office visit with their hand surgeon. After the visit was concluded and treatment was decided, the surgeon left the room and a research assistant administered the Perceived Involvement in Care Scale (PICS). The PICS was used as our primary outcome variable and is a validated tool that elicits patient perceptions of their participation in their visit.²⁹ The PICS asks patients to answer 13 yes or no questions, with yes scoring 1 point and no scoring 0 points. The scale is scored from 0 to 13, with higher scores representing greater involvement in care.²⁹

Statistical analysis

An *a priori* sample size estimate was performed and based on a prior shared decision-making study conducted in orthopedic surgery that found a difference of 1 point on the PICS scale to be clinically significant.³⁰ A sample size of 63 patients in each group gives a power of 0.80 with alpha 0.05 to detect a 1-point difference in the PICS. A 2-tailed *t* test was used to determine whether there were statistically significant differences between the ASK and the QPL groups. A *P* value less than .05 was used to determine statistical significance. We planned an intention-to-treat analysis; however, all patients were treated as they were assigned.

RESULTS

One hundred thirty-four patients were approached for enrollment by a trained research assistant. Eight patients declined to participate, leaving 126 participants who were consented and enrolled in the study. These patients were randomized to the ASK or QPL groups with 63 patients in each group. No patients were lost to follow-up.

The mean patient age was 49 years (SD, ±18.2). Of the 126 participants, 69 (55%) were female. Demographics between both groups appeared similar (Table 2 and Appendix B; available on the *Journal's* Web site at www.jhandsurg.org). There was no significant difference in the mean PICS score between the 2 groups. The mean PICS score for the QPL and ASK groups were 7.5 and 8.3, respectively (*P* = .08).

DISCUSSION

Question Prompt Lists have been shown to be beneficial in other fields by stimulating discussion and improving patients' knowledge of their condition.^{31,32} The ASK generic questions have also been demonstrated to improve patient involvement in their care. Our results did not demonstrate a significant increase in patient-perceived involvement in care using a hand surgery-specific QPL compared with providing patients with 3 generic questions.

Our results imply that a QPL for the hand surgery patient population may not be necessary in lieu of 3 generic questions. Shepherd et al²⁴ found that providing patients with 3 generic questions increased information given by physicians about different treatment options and facilitated patient involvement without significantly increasing the length of the clinic visit. We chose a pragmatic design for our study comparing these three questions to a QPL to assess their comparative effectiveness. In our study, both the QPL group and the 3 generic questions group had similarly high perceived involvement in care, and we did not find the QPL to have more impact using this measure. However, there are other benefits of QPLs shown in previous studies that we did not evaluate. These include anxiety reduction, increased trust in physician, and patient satisfaction.^{31,33} Most other investigations of QPLs have been in oncology patients, in which decisions may be more difficult to comprehend than in hand conditions. As such, the benefits of QPLs in these groups of oncology patients may be larger or more easily realized than in patients with hand conditions.

The QPL is typically a lengthy list of sample questions that addresses issues or questions a patient may have for their physician regarding a certain topic (some QPLs have over 100 questions).³¹ Although the QPL we developed and implemented has fewer questions for the patient to read through (36 questions) than the QPLs in the oncology literature, it requires more time to read than the 3 generic questions. The increased length of the QPL compared with the 3 generic questions could have negative effects on the patients' survey responses to the PICS, negating the positive effects of the QPL. Our finding of no difference between the 2 groups indicates that the questions in the QPL did not lead to increased perceived involvement of patients compared with the 3 generic questions.

Our study has limitations. First, it was performed at a single academic institution in a suburban area. Our sample was predominantly Caucasian and well educated, which may limit the generalizability of the study. Studies have shown that Black patients typically have shorter visits with their clinicians, ask fewer questions, and participate less during their visit.³³ Intercultural differences between physicians and patients can be a significant barrier to the shared decision-making process,³⁴ so the effects of the QPL in different ethnic populations is unclear. Patients with low incomes have been shown to ask fewer questions than those with a higher income.³⁵ It is possible that these populations may have more significant benefits from the QPL than our sample, leading to a greater treatment effect seen in these populations. Likewise, the differences in the magnitude of the QPL's effect between oncological patients and patients with hand conditions may be explained by the groups' differing condition severities. Another limitation of our study is that the treating surgeon was not blinded to patient's treatment groups. Although the QPL and generic 3 questions were not reviewed with the surgeon, they were intended to encourage discussion between the patient and their physician. This being the case, although the surgeon was not aware of which tool the patients were given, it is possible that the patients' questions reflected their assigned tool, thereby introducing bias. This potential bias may have affected the patient-surgeon interaction; however, because the outcome measure was the same, a standardized survey for both groups, and the tools were implemented in a way that reflects clinical practice, the authors do not believe this bias to have meaningfully affected the results. Another limitation of our study is that we did not keep track of the length of time of the patient visits; therefore, we are unable to make a determination as to whether the QPL increased the length of time of the clinic visit compared with the 3 questions. However, a difference in time between the 2 groups should not matter because the 3 questions were found to be just as effective as the QPL.

The goal was to create a pragmatic study to evaluate how extensive an intervention must be to increase patient involvement in their care. Because Shepherd et al²⁴ have already shown that providing patients with 3 generic questions increases patient involvement compared with a control group, we designed our study so that we could provide surgeons with an intervention that they could incorporate into their clinics, whether it was the QPL or the 3 generic questions. Our results imply that a lengthy QPL for patients with common hand conditions may not be necessary, and that providing 3 generic questions is adequate. Further studies should be done in the future to investigate other effects of the QPL in this patient population, such as length of clinic visit, reducing anxiety, or increasing patient satisfaction.

Although SDM has been shown to help align patients' treatments with their values, implementation into all areas of clinical practice is still not widespread. An important aspect of SDM is participation by the patient, and studies have shown that some patients are less engaged than they prefer and are sometimes reluctant to ask questions during their clinic visit owing to fears of being seen as challenging or difficult by their physicians.^{36–38} Asking questions can help patients gain more information about their diagnosis and the different treatment options, helping them to make an informed treatment decision.²⁵ A structured process, such as handouts, encouraging patients to ask more questions may assist patients in becoming more involved in their consultation and weaken the stigma that patients should not ask questions.³⁹ Providing 3 generic questions to patients may be a sufficient and simple way to improve SDM in the hand surgery population. Although the QPL did not increase patient-perceived involvement in care in our hand surgery patient population, it is possible that it could increase other metrics affecting care (eg, decisional conflict) and/or perceived involvement in other orthopedic fields. Areas of future research should include the implementation of QPLs in more diverse patient populations and as measured by other metrics affecting care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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TABLE 1.

Study Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Age 18 and older	Pregnant Women
English Speaking	Not Fluent in English
New Patients	Visual or Hearing Impairment
Common Hand Diagnosis:	
Trigger Finger	
Carpal Tunnel Syndrome	
Dupuytren's Disease	
Ganglion Cyst	
Wrist Arthritis	
CMC Joint Arthritis	
Cubital Tunnel Syndrome	
Metacarpal and Phalanx Fractures and Nonunions	
Distal Radius Fractures or Malunions	
Scaphoid Fractures or Nonunions	
Wrist or Hand Ligament Injury	
De Quervain Tenosynovitis	
TFCC Injury	
Wrist Overuse Syndrome	

CMC, carpometacarpal; TFCC, triangular fibrocartilage complex.

TABLE 2.

Demographics

		Control	Study
Race	White	37 (58.7%)	39 (61.9%)
	White/Other	2 (3.2%)	1 (1.6%)
	Hispanic	4 (6.3%)	8 (13%)
	Asian	13 (20.6%)	10 (15.9%)
	Black	1 (1.6%)	1 (1.6%)
	Other	4 (6.3%)	2 (3.2%)
	Deferred	2 (3.2%)	2 (3.2%)
Income	<50K	13 (20.6%)	8 (13%)
	50–99K	8 (13%)	10 (15.9%)
	100–149K	11 (17.5%)	14 (22.2%)
	150–199K	5 (7.9%)	4 (6.3%)
	200–249K	13 (20.6%)	8 (13%)
	>250K	12 (19%)	15 (23.8%)
	Deferred	1 (1.6%)	4 (6.3%)
Employment	Full-time	38 (60.3%)	35 (55.6%)
	Part-time	6 (9.5%)	4 (6.3%)
	Disabled	2 (3.2%)	2 (3.2%)
	No Work Outside Home	4 (6.3%)	2 (3.2%)
	Retired	11 (17.5%)	16 (25.4%)
	Student	2 (3.2%)	3 (4.8%)
	Deferred	0 (0%)	1 (1.6%)
Education	Middle School	0 (0%)	1 (1.6%)
	Some High School	1 (1.6%)	1 (1.6%)
	High School Graduate	17 (27%)	12 (19%)
	Trade school	3 (4.8%)	4 (6.3%)
	Bachelor's	17 (27%)	23 (36.5%)
	Master's	18 (28.6%)	13 (20.6%)
	Doctorate	7 (11.1%)	8 (13%)
	Deferred	0 (0%)	1 (1.6%)
Insurance	Medicaid	1 (1.6%)	3 (4.8%)
	Medicaid and Medicare	3 (4.8%)	0 (0%)
	Medicare	6 (9.5%)	14 (22.2%)
	Medicare and Other	1 (1.6%)	1 (1.6%)
	Medicare and Private	4 (6.3%)	3 (4.8%)
	Private	46 (73%)	37 (58.7%)
	Private, Other	1 (1.6%)	0 (0%)
	Other	1 (1.6%)	4 (6.3%)

		Control	Study
	Deferred	0 (0%)	1 (1.6%)

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