

# What should educators teach to improve preventive health care?

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Since 2017 the Prevention in Practice<sup>1</sup> series of articles has been published in *Canadian Family Physician*. In part, this series is grounded in our experiences as physician-educators or members of the Canadian Task Force on Preventive Health Care (CTFPHC). In this article we describe how teachers and learners can use the Prevention in Practice article series to build their mastery of preventive health care concepts. While this topic is addressed in a book for public health practitioners,<sup>2</sup> to the best of our knowledge, no guidebook exists for the teaching of preventive care in family medicine. This points to a gap in the training curriculum.

In our most recent previous article,<sup>3</sup> we called for action to improve the teaching of screening and preventive care during medical school and residency training, as this is when learners begin to develop their clinical reasoning and communication skills. In this article we identify 6 themes for teaching preventive health care. For each theme we suggest educators and learners cocreate actionable learning objectives. Using one of these themes as an example, we expand on what should be taught (Figure 1).

## Case description

Pat, a third-year medical student assigned to your clinic, has just interviewed Bara, age 55 years. (Readers of this series will recall Bara from the May 2022 Prevention in Practice article.<sup>3</sup>) In brief, Bara's friend had a mammographically detected cancer and, while Bara does not have an elevated risk of cancer, she worries about this. At last year's visit, you and Bara discussed the potential harms and benefits associated with screening for breast cancer with mammography, including the harm of overdiagnosis. In the end, Bara had a mammogram and nothing suspicious was seen. Today, Pat tells you Bara would like another referral. Pat has already filled out the form

and hands it over for signing. You wonder: what competencies should the student acquire for the optimal management of this patient?

That Pat seems to agree with Bara's request for an annual mammogram is itself problematic. Pat has not given much thought to the frequency of screening tests, nor to the possibility that a "more, more, more" approach to screening can lead to harm.<sup>4</sup> Pat does not know that decreasing the frequency of screening mammography can reduce the harm of false alarms (false positives) while preserving the benefit.<sup>5</sup> Thus, if more were truly better, the CTFPHC would have strongly recommended that doctors hunt for occult cancer with annual mammography. In its 2018 guideline update on screening for breast cancer, the CTFPHC recommended mammography for women every 2 to 3 years from 50 to 74 years of age, conditional on shared decision making (SDM).<sup>6</sup>

On the general topic of screening and screening intervals, learners need to engage in critical thinking. But what is critical thinking?

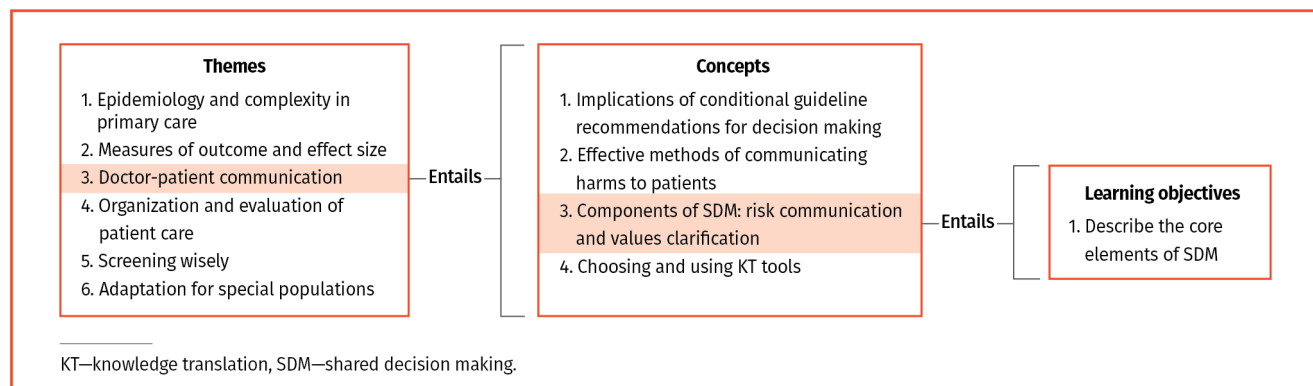
An international panel of experts defined critical thinking as the ability and willingness to assess claims and make objective judgments based on well-supported reasons. It is the ability to look for flaws in arguments and resist claims that have no supporting evidence. It also fosters the ability to be creative and constructive to generate possible explanations for findings, think of implications, and apply new knowledge to a broad range of social and personal problems.<sup>7</sup> Referring to this work, Sharples et al considered critical thinking a skill crucial to evidence-based practice, describing it as follows:

Critical thinking encompasses a broad set of skills and dispositions, including cognitive skills (such as analysis, inference, and self regulation); approaches to specific questions or problems (orderliness, diligence, and

## Key points

- ▶ Many flawed assumptions or beliefs persist about the value of preventive health care interventions.
- ▶ It is essential to promote critical thinking to improve learning outcomes and clinical decision making.
- ▶ The Prevention in Practice series of articles in *Canadian Family Physician* is a resource for educators who want guidance on what to teach medical students or residents.
- ▶ Key questions and learning objectives can be developed for themes arising from this series of articles.



**Figure 1.** Developing learning objectives: An example using the doctor-patient communication theme.

reasonableness); and approaches to life in general (inquisitiveness, concern with being well informed, and open mindedness).<sup>8</sup>

As educators, we should ask learners to reflect on their approach to clinical encounters like this one with Bara. Knowing when to engage in SDM in relation to the strength and direction of a recommendation is central to optimizing care. To stimulate critical thinking, you can ask Pat to review an infographic on the benefits and harms of mammography screening.<sup>9</sup> This infographic is a visual representation of the effect of screening mammography, revealing the magnitude of the potential for benefit versus harm from this intervention.

Developing educational strategies and content to explain key concepts in preventive health care is challenging. **Table 1**<sup>10-31</sup> presents 6 themes and associated concepts for teaching. These themes were derived inductively by analyzing the Prevention in Practice article series and the articles we recommended for additional reading. In a stepwise approach, knowledge of each theme is required to achieve learning objectives embedded in subsequent themes. We recommend teaching these concepts to first-year medical students.

### Theme-specific learning objectives

Each theme in **Table 1** can be used to develop key questions to guide dialogue between teachers and learners.<sup>10-31</sup> In residency, these can be used in educational sessions during an academic half-day and then revisited during clinical supervision. **Table 2** provides an example for the SDM subtheme. In this example, knowledge from theme 1 (epidemiology and complexity in primary care) and theme 2 (measures of outcome and effect size) represents a foundation to build upon for theme 3 and subsequent themes.

### Teaching SDM in operationalizing screening recommendations

Medical students and residents should be taught about SDM in the context of learning how to put conditional

recommendations into practice. This will enable them to better integrate evidence into decision making in practice and thus enable them to achieve competency 3.5 of the scholar role described in the CanMEDS–Family Medicine 2017 framework.<sup>32</sup>

Annually, 2 of us (R.G., G.T.) deliver educational lectures and workshops for medical students and residents at McGill University in Montréal, Que. In our lectures we explain how to operationalize the process of SDM and set expectations regarding when it should be offered (**Figure 2**).<sup>33</sup>

During the residency program we deliver a 2-hour session called SDM-FM, which is composed of a lecture and workshop. In SDM-FM, preventive interventions are used to explain when and how to operationalize key components of SDM. These components include risk communication and values clarification through the elicitation of patient preference. For the risk communication component, infographics are used to visualize risk-benefit data. We explain that, in addition to infographics, patient decision aids are tools for use at the point of care.

In the workshop we elaborate on values clarification. Through simulation and feedback, we demonstrate how decision aids facilitate the elicitation and integration of patient preference in decision making. We use role-playing scenarios based on mammography screening for breast cancer in women at 50 years of age. Residents practise their skills in these role-playing situations using decision aids from the CTFPHC or from the Ottawa Hospital Research Institute's inventory of decision aids.<sup>34,35</sup>

During SDM-FM sessions we explain that screening for breast cancer is a decision that is sensitive to patient preferences, where preferences are inclinations toward or away from an option. While this is relatively easy to understand in the context of clinical decision making, the concept of patient values is less intuitive. We explain that *values* refer to how patients view the clinical outcomes that can arise from the options to screen or not to screen. Values help determine preferences. Thus, in SDM-FM sessions we explain how values clarification considers both patient values and patient preferences.



**Table 1. Teaching preventive health care: Themes and concepts in sequence.**

THEMES	CONCEPTS (NOT A COMPLETE LIST)	ARTICLES
1. Epidemiology and complexity in primary care  Subthemes: <ul style="list-style-type: none"> <li>• Ecology of medical care</li> <li>• Lower prevalence of serious disease</li> <li>• Lower test accuracy in early stages of disease</li> <li>• Variability of disease progression</li> </ul>	<ul style="list-style-type: none"> <li>• Complex adaptive environment of primary care</li> <li>• Natural history of disease and the heterogeneity of its progression</li> <li>• Implications of overdiagnosis (eg, as an outcome of the hunt for cancer)</li> <li>• Risk variation in different populations</li> </ul>	Better decision making in preventive health screening. Balancing benefits and harms <sup>10</sup>  Overdiagnosis: causes and consequences in primary health care <sup>11</sup>
2. Measures of outcome and effect size  Subthemes: <ul style="list-style-type: none"> <li>• Quantitative information on benefits and harms of preventive interventions</li> <li>• Quality of evidence</li> <li>• Resolving conflicts in evidence or guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• Magnitude of benefits and harms—measures of outcome and effect size (eg, change in absolute risk of an outcome, not only relative risk)</li> <li>• Lead time and length time bias (eg, 5-year survival as an outcome is a misuse of a measure in screening for disease)</li> <li>• GRADE framework for guideline recommendations</li> <li>• Tools for critical thinking on guidelines (eg, G-TRUST)</li> </ul>	Understanding and communicating risk. Measures of outcome and the magnitude of benefits and harms <sup>12</sup>  Update on task force terminology and outreach activities. Advancing guideline usability for the Canadian primary care context <sup>13</sup>  Choosing guidelines to use in your practice <sup>14</sup>  Screening: when things go wrong <sup>15</sup>  Preventive health care and the media <sup>16</sup>
3. Doctor-patient communication  Subthemes: <ul style="list-style-type: none"> <li>• SDM: What is it? When and when not to engage</li> <li>• Evaluation and implementation of knowledge translation tools</li> </ul>	<ul style="list-style-type: none"> <li>• Implications of conditional guideline recommendations for decision making</li> <li>• Effective methods of communicating harms to patients</li> <li>• Components of SDM: risk communication and values clarification</li> <li>• Choosing and using KT tools</li> </ul>	Shared decision making in preventive health care. What it is; what it is not <sup>17</sup>  Eliciting patient values and preferences to inform shared decision making in preventive screening <sup>18</sup>  Patient perspectives. Exploring patient values and preferences <sup>19</sup>  To share or not to share. When is shared decision making the best option? <sup>20</sup>  Teaching shared decision making. An essential competency <sup>21</sup>  Knowledge translation tools in preventive health care <sup>22</sup>
4. Organization and evaluation of preventive care  Subthemes: <ul style="list-style-type: none"> <li>• Efficiency of the process</li> <li>• Quality of the process</li> </ul>	<ul style="list-style-type: none"> <li>• Practice organization to support effective preventive care</li> <li>• Assessment of quality of preventive health care in primary care practice setting</li> <li>• Evaluation and choice of measures of quality of care in screening</li> <li>• Interpretation of quality measures in physician practice settings</li> </ul>	Practice organization for preventive screening <sup>23</sup>  Quality of the screening process. An overlooked critical factor and an essential component of shared decision making about screening <sup>24</sup>  Measuring what really matters. Screening in primary care <sup>25</sup>
5. Screening wisely  Subtheme: <ul style="list-style-type: none"> <li>• Overscreening</li> </ul>	<ul style="list-style-type: none"> <li>• How patient circumstances influence decision making (eg, start and stop ages)</li> <li>• Patient perception of risk versus actual risk</li> <li>• Resource use in preventive screening</li> </ul>	Age to stop? Appropriate screening in older patients <sup>26</sup>  Periodic preventive health visits: a more appropriate approach to delivering preventive services <sup>27</sup>  Rethinking screening during and after COVID-19. Should things ever be the same again? <sup>28</sup>  Too soon or too late? Choosing the right screening test intervals <sup>29</sup>

Table 1 continued on page 586



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THEMES	CONCEPTS (NOT A COMPLETE LIST)	ARTICLES
6. Adaptation for special populations  Subtheme: • Adaptation of screening recommendations to specific patients	• The importance of context	Improving preventive screening with Indigenous peoples <sup>30</sup>  Preventive screening in women who have sex with women <sup>31</sup>
GRADE—Grading of Recommendations Assessment, Development and Evaluation; G-TRUST—Guideline Trustworthiness, Relevance, and Utility Scoring Tool; KT—knowledge translation; SDM—shared decision making.		

Table 2. Key questions and linked learning objectives for the SDM subtheme of doctor-patient communication

KEY QUESTIONS TO ENGAGE LEARNERS	LEARNING OBJECTIVES	KEY POINTS FROM THE ARTICLE SERIES
Many screening recommendations from the Canadian Task Force on Preventive Health Care can be qualified as <i>conditional</i>  Question 1: Conditional on what?	1a. Explain what is meant by the concept of a conditional recommendation for a screening intervention  1b. Distinguish between <i>conditional</i> and <i>strong</i> recommendations in terms of when to engage in SDM	• SDM should be considered when there are at least 2 medically valid options yielding a balance between benefits and harms (equipoise) • If the recommendation is conditional and in favour of the intervention: offer a discussion about it • If the recommendation is conditional and against the intervention: engage in SDM only when a patient asks about it
SDM is a structured process used to improve decision making  Question 2: What are the core elements of SDM?	2a. Describe the core elements of SDM  2b. Demonstrate the ability to engage in SDM with a patient	• The core elements of SDM are risk communication and values clarification • To get at these elements, use infographics and decision aids
Patient preferences for treatment of conditions detectable through screening are highly variable  Question 3: How would you explain the following concepts: patient values and patient preferences?	3a. Describe what is meant by patient values and preferences using examples  3b. Demonstrate how to elicit patient values and preferences	• Values clarification considers both patient values and patient preferences • Values refer to how patients value the clinical outcomes arising from the various options • Values help determine preferences • Preferences are inclinations toward or away from an option
Some patients do not understand the meaning of values in the context of decision making about screening interventions  Question 4: With respect to a screening decision, how would you help a patient clarify their values?	4a. Explain the relationship between values and the health outcomes of screening interventions using examples  4b. Demonstrate the ability to facilitate a patient decision	• In the context of SDM, values pertain to the importance patients place on the potential beneficial and harmful outcomes that can result from a screening intervention or test. Patients' preferences are the health care options they most favour • For screening decisions, clarifying values focuses on determining patients' desires to diagnose disease early as well as their understanding and aversion to the risks and implications of false-positive test results and overdiagnosis • Clarifying patients' values often helps inform their preferred options, but it can also be challenging for patients who prefer not to be involved in decision making
Tools can facilitate the process of SDM  Question 5: How can infographics or decision aids be incorporated into the office visit?	5a. Explain the difference between an infographic and a decision aid  5b. Demonstrate an ability to use tools at the point of care to improve decision making	• Many screening recommendations highlight the close balance between benefits and harms
SDM is not appropriate for all situations  Question 6: When is SDM probably not the right approach?	6a. Using an example, explain when SDM should be introduced and when it should not be introduced  6b. Explain the difference between sharing information and SDM	• In strong recommendations, the balance between benefit and harm is not close to even • While SDM is often underused, it may be introduced in situations where it probably should not be used • When SDM is not warranted, sharing information remains a good practice
SDM—shared decision making.		



**Figure 2.** When to engage in SDM based on the strength and direction of a GRADE<sup>33</sup> guideline recommendation

		Direction of recommendation	
		Intervention recommended	Intervention not recommended
Strength of recommendation	Strong	No need for SDM (eg, screening for cervical cancer in patients ≥30 y)	No need for SDM (eg, screening for cognitive impairment)
	Conditional	Offer SDM routinely (eg, screening for breast cancer in patients ≥50 y)	Offer SDM when asked (eg, screening for breast cancer in patients <50 y)

GRADE—Grading of Recommendations Assessment, Development and Evaluation; SDM—shared decision making.


Little is known about the willingness of family medicine residents to engage in SDM. In 2021 one of us (R.G.) explored the willingness of resident physicians at McGill University to engage in SDM and whether that willingness could be increased. Using an attitude measure with evidence of validity, we found that willingness to engage in SDM among family medicine residents varies greatly.<sup>36</sup> Six months after our educational intervention (SDM-FM), we found a small improvement in the willingness of residents to engage in SDM.<sup>37</sup> At a practical level, these findings suggest educators should view SDM as a skill for continual development during medical school and residency training, and they should not rely on one-off interventions such as a lecture or workshop.

## Case resolution

The medical student, Pat, reviews the infographic and decision aid on breast cancer screening for women in their 50s. As with many of our patients, the infographic helps learners realize when they have overestimated the benefits and underestimated the harms of this specific intervention.<sup>38,39</sup> Pat also appreciates observing how you discuss screening for breast cancer with Bara, following the process of SDM. As a medical student, Pat has not had an opportunity to develop longitudinal relationships that build trust and facilitate SDM with patients. Acknowledging the absence of a high-quality doctor-patient relationship can make it easier for teachers to understand one of the challenges learners face as they try to implement SDM in their practices.

## Conclusion

In this article our focus has not been the *how* of teaching, but rather *what concepts* to teach in preventive health care. Learners will benefit from educational interventions designed to improve the delivery of preventive health care. We acknowledge that this is a complex topic that requires critical thinking beyond the algorithms we often

teach when providing care to patients. We welcome feedback on this article from the community. 

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### Competing interests

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La traduction en français de cet article se trouve à <https://www.cfp.ca> dans la table des matières du numéro d'août 2022 à la page e241.

### Suggested reading

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