David T. Rubin, Tariq Ahmad and Lyndsay Hughes.

THE PSYCHOLOGY OF CHANGE IN IBD

Working with the mind when the gut needs a change was the topic for a satellite symposium at the ECCO Congress, sponsored by Pfizer.

Chair Prof David T. Rubin started by explaining the objectives for the symposium.

– To explore the psychology of physician and patient decision making in IBD management, and provide practical guidance for clinicians in recognizing the need for and navigating a change in the management of IBD, he said.

Barriers to shared decision making

IBD is a complex disease with significant quality of life (QoL) considerations, said Health psychologist Lyndsay Hughes.

– Symptom and treatment issues make patients worry about having a normal life. The extent of QoL impact may be different for each patient.

It is therefore important to involve patients in treatment decisions, Ms Hughes continued.

– Higher concordance is achieved through shared decision making – which in turn leads to higher satisfaction with the consultation and better adherence to the treatment, she explained.

However, there are a number of barriers: Older age, non-Western background, lower levels of education, lower health literacy and numeracy and inaccurate information processing from patients and healthcare professionals were those Ms Hughes described.

– And most patients do not want *complete* autonomy.

Individual knowledge and experience feeds into motivation. The relative weight of each component will differ between individuals. Errors and biases in this information may lead to unfavourable perceptions.

– Even if individual patients are presented with the same information, they will perceive, interpret and weight it differently – leading to different outcomes. ➤

This could lead to a reluctance to change treatment, she underlined.

Behaviour change techniques can support choice talk – i.e. create awareness that a choice exists – and decision talk supported to explore what is important to the patient.

– We also need to consider our *own* attitudes towards shared decision making, Ms Hughes finally stated.

Treat-to-target enhances share decsision making

Challenging ourselves to change, was the title of Prof Rubin's lecture.

– To improve patient care, a change in the way we approach treatment and outcomes is required, he started by establishing.

When providing care for patients, there are many factors we take into account. For the patient, there is fear of the unknown and the disease. For the clinician, there is the disease – and several other considerations – costs of drugs, fear of doing harm and treatment failure and urgency for decision were among those Prof Rubin described.

– For the patient, all of this adds up to a desire for treatment. For the clinician, all adds up to a therapeutic recommendation. At the centre of this, *trust* is needed!

Treat-to-target has been implemented successfully in chronic diseases such as diabetes, hypertension and cholesterol levels – and now also in IBD. Prof Rubin presented data from 60 patients with UC on mucosal healing as a treatment target, and they showed that adjustments in medical therapy led to remarkably higher outcomes.

– But doctor and patient often have different definitions on what remission *is*. In IBD, treatment targets should include both clinical endpoints *and* patient's goals.

Treat to target enhances shared decision making and vice versa. If one starts with acknowledging patient's preferences, the patient feels educated, informed and supported in making the right choice. Hence, the doctor-patient relationship is strenghtened – and patient satisfaction and adherence to therapy is increased.

– Adaptation of treat-to-target immediately after IBD diagnosis could also help ensure that treat-to-target is a familiar concept if a move to an advanced therapy is required, Prof Rubin pointed out.

This shows that we can manage such a strategy clinically.

– Treat-to-target needs an engaged patient, and close monitoring. The latter is important also when the target is reached!

If a patient refuses a recommended treatment, this is often due to fear, denial or misinformation. When the physician probes for reasons, Prof Rubin recommended to acknowledge fears, educate, follow up and offer second opinion.

Empower yourself with knowledge

There is an ever changing and increasingly complex IBD treatment landscape, said Dr Tariq Ahmad. Several new therapies have emerged in the 21st century.

Why do we need to change treatment? There are several reasons for change – lack of efficacy, adverse events, access and practicality were those Dr Ahmad mentioned.

– However, changing treatment can be a daunting prospect for patients. Some patients may prefer a treatment they are familiar with, compared to try something new, he continued.

What can we do to help our patients get ready for change?

– To be able to effectively discuss treatment options, we may need to empower ourselves with *knowledge* on new therapies. We need to understand patient preferences and drivers of decision making, and understand how to best discuss risks and benefits. We also need to introduce the new treatment concepts with a positive, but balanced, tone, Dr Ahmad said.

Benefits and risks of tofacitinib

Dr Ahmad continued with discussing the benefits of tofacitinib.

– It is a new therapy that works differently to other IBD treatments – taken orally in tablet form. Tofacitinib is effective in patients irrespective of their past response to other drugs. Some patients have symptom improvement soon after starting treatment – even as early as the third day.

Also the safety of tofacitinib is well understood, and it has been used to treat other inflammatory diseases since 2012.

He underlined the importance of discussing the risks of tofacitinib.

– Tell the patient that before starting tofacitinib: We will ensure your vaccinations are up to date to lower the chance of re-activating certain infections. To reduce the risks of tofacitinib, it shouldn't be used alongside biologics or other immunosuppressants. Abnormal blood tests – such as increased lipid levels – can occur, but close monitoring will ensure you receive good care.

Tofacitinib is associated with an increased risk of shingles, particularly in older patients. Fortunately, in the majority it is manageable. Non-melanoma skin cancer has occurred in some patients taking tofacitinib, so discussing the patient's family history could be important.

– The safety of tofacitinib is generally similar to anti-TNF treatment, excluding shingles.

The nocebo effect

The switch to a biosimilar is also a change of treatment in the patient's perspective.

– We should be honest and talk about cost-savings. The use of biosimilars means *more* patients can be treated, and treatment can be optimised, Dr Ahmad underlined.

How we present switching to biosimilars to our patients is important. This has to do with the nocebo effect, which he called "the ugly twin of placebo".

– The cost of the drug can influence how people experience benefit. A study has shown that the same product to treat pain in two groups, the patients experienced less reduction in pain when they were told they were receiving a cheaper product.

He explained that negative treatment expectations result in negative symptoms, i.e. the nocebo effect.

– This leads to lower adherence and increased discontinuations.

In his summary, Dr Ahmad encouraged to foster a good clinician-patient relationship.

– Gain knowledge of new therapies, discuss risks and benefits and use visual aids and contextualise.

He underlined that it is not just what the doctor says, but also how the doctor says it.

– Body language has been shown to be the most important factor.

Create a balanced but positive discussion in order to avoid a nocebo effect.

– Align an approach with your multidisciplinary team – ensure consistent messaging and care!

And with that, the symposium had come to the end.

Per Lundblad