Communication and Shared Decision Making

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I. Shared decision making (SDM): historical background
   A. 1950s to 1970s post–World War II: model of care
      delivery for patient–physician relationship was pre-
      dominantly patriarchal (McKinstry, 1992).
      1. Patients decline to become involved in selecting
         their own treatment
      2. In this case the patient is essentially saying, "It's
         up to you, doctor. You're the expert."
   B. Early 1970s: shared model of care is taking hold,
      particularly in cancer setting (Feldmann, 1973)
      1. Paternalistic model of care is becoming
         unpopular.
   C. Major factors for the emergence of SDM as the
      dominant model of care in today's health care
      1. Rising cost of health care (Ford, 1977)
      2. Increasing health care consumerism in the
         United States, Europe, Australia, and Canada
         (McDevitt, 1986; Price, 1981)
      3. Increased desire for consumer involvement,
         autonomy, and control over their care
         (Tariman et al., 2012).
      4. Emphasis of patient-centered care as an indicator
         of high-quality care (Institute of Medicine, 2001)
      5. Explosion of cancer treatment choices (Tariman
         et al., 2012)

II. Shared decision making: definition
   A. A care delivery model that facilitates treatment
      decision making during the patient encounter
      (Charles, Gafni, & Whelan, 1997, 1999)
   B. Steps in the SDM process (Agency for Healthcare
      Research and Quality, 2014)
      1. Step 1: Involve your patient in the treatment
         decision process: inform them of choices and
         invite them to be involved in the decisions.
      2. Step 2: Assist your patient in comparing and
         evaluating treatment options: discuss the risks
         and benefits of each option.
      3. Step 3: Assess your patient's goals, values, and
         priorities: understand and incorporate what
         matters most to your patient.
   4. Step 4: Make a decision with your patient: decide
      the best course of treatment as a team.
   5. Step 5: Evaluate the treatment decision: plan to
      follow up and revisit the decision, monitor pro-
      gress, and revise as needed. Communication is a
      critical aspect of SDM (Siminoff & Step, 2005).
   6. Integrates a socially based process into the
      dynamics of the physician–patient relationship
   7. Examines antecedent factors that have potential
      to influence communication (e.g., prior medical
      care experiences, language and acculturation,
      cognitive status, education level)
   8. Emphasizes jointly constructed communication
      climate
   9. Outcome focuses on treatment preferences
      established by the patient and the treatment
      team (providers, nurses, interdisciplinary team)
   C. Key elements (Charles et al., 1999)
      1. At least two participants: clinician and patient;
         often includes other treatment team members
         and patient's family
      2. Both parties share information
      3. Both parties take steps to build consensus about
         preferred treatment, weighing risks and benefits
      4. Mutual agreement is reached between patient
         and clinician on treatment approach (verbal
         and/or written)
   D. SDM is the preferred model of care delivery by law-
      makers and policymakers because it supports the
      patient's autonomy and empowers the patient to
      take responsibility of one's own health (Légaré
      et al., 2014)
   E. SDM has demonstrated short- and long-term ben-
      efits (Kane et al., 2014):
      1. Short-term benefits
         a. Increased confidence in treatment decisions
         b. Higher satisfaction with treatment decisions
         c. Enhanced trust with providers
         d. Improved self-efficacy
         e. Mental health—less stress and anxiety related
            to treatment decision making
2. Long-term benefits
   a. Patient treatment adherence
   b. Quality of life
   c. Disease remission
F. SDM care delivery model is advantageous for older adults (Ramsdale et al., 2017):
   1. Facilitates collaboration, communication, and patient-centeredness
   2. Minimizes the fragmentation that impairs the current provision of cancer care
   3. This is particularly important with older adults, given their potential for not proactively participating in their care based on a multitude of factors (generational, lessened communication abilities), as well as having multiple providers due to many comorbidities.
III. Barriers to SDM (McCarter et al., 2016)
A. Barriers perceived by oncology nurses
   1. Practice barrier—nonnursing responsibilities (e.g., charting, administrative tasks) take away time from patients; lack of provider confidence in the ability to participate effectively.
   2. Patient barrier—lack of readiness for patient to participate in SDM; lack of knowledge to participate; age-related challenges (cognition, mindset) (Tariman et al, 2012)
   3. Institutional policy barrier—lack of institutional policy that allows specific block of nurse’s time for patient education on therapy or lack of support for the process.
   5. Administration as a barrier—nursing administrators do not provide adequate support for nurses to actively participate in SDM process.
   6. Structural barrier—noisy environment (hospital); lack of privacy; lack of systemic alerts/triggers in the electronic medical record (to incorporate decision aids).
B. Barriers perceived by oncologists (Charles, Gafni, & Whelan, 2004)
   1. Lack of time
   2. Patient anxiety
   3. Patient lack of information and/or misinformation
   4. Patient unwillingness or inability to participate
   5. Inability to talk in language patients can easily understand (Joseph-Williams, Elwyn, & Edwards, 2014)
   6. Lack of commonality in approaches to SDM, while maintaining flexibility for modifications (Légaré & Witteman, 2013)
IV. Patient preferences for decision making in oncology care
A. Patients with cancer prefer to have a role in cancer care and treatment decision making (Singh et al., 2010; Tariman et al., 2010)
B. Degner and Beaton’s Pattern of Treatment Decision Making questionnaire (Fig. 6.1) (Degner & Beaton, 1987; Degner, Sloan, & Venkatesh, 1997) is the most widely used instrument to elicit patient’s preferences for participation in cancer treatment decision-making process (Tariman et al., 2010)
V. Influential factors in treatment decision making in older adults; ages 60+ (Puts et al., 2015):
   A. Convenience and success rate of treatment
   B. Seeing necessity of treatment
   C. Trust in the physician
   D. Following the physician’s recommendation

**DEGNER and BEATON’s Pattern of Decision Making**

**Active: Patient Controlled**
Card A
I prefer to make the final treatment decision.
Card B
I prefer to make the final treatment decision after seriously considering my doctor’s opinion.

**Collaborative: Jointly Controlled**
Card C
I prefer that my doctor and I share responsibility for deciding which treatment is best.

**Passive: Provider Controlled**
Card D
I prefer my doctor to make the final treatment decision, but only after my doctor has seriously considered my opinion.
Card E
I prefer to leave all treatment decisions to my doctor.

*Fig. 6.1* The most widely used instrument to elicit patient’s preferences for participation in health care decision making. (From Degner, L. F., & Beaton, J. I. [1987]. *Life death decisions in health care*. New York: Hemisphere Publishing.)
VI. Patient information needs
   A. Information priorities in patients diagnosed with cancer (Tariman et al., 2014):
      1. Diagnosis
      2. Prognosis
      3. Treatment options
   B. Clinician characteristics that have a negative impact on patient outcomes
      1. Increased level of fatigue
      2. Burnout
      3. Expression of worry

VII. Quality of communication and clinician factors
   A. Clinician characteristics that have a positive impact on quality of communication and/or patient outcomes (De Vries et al., 2014)
      1. Communication skills training
      2. An external locus of control (focus on outward aspects from their own being, such as institutional and administrative factors)
      3. Empathy
      4. Socioemotional approach
      5. Shared decision-making style
   B. Clinician characteristics that have a negative impact on patient outcomes
      1. Increased level of fatigue
      2. Burnout
      3. Expression of worry

VIII. Decision aids and SDM (Kojovic & Tariman, 2017)
   A. Decision aids for health treatment and screening decisions (Stacey et al., 2014)
      1. Explicit values clarification exercises improve informed values-based choices
      2. Positive effect on patient–practitioner communication
      3. Variable effect on length of consultation
      4. Increase patient’s involvement and improve knowledge and realistic perception of outcomes
      5. Less is known about the degree of detail that decision aids need in order to have positive effects on attributes of the decision or decision-making process, but they are proven to have positive effects.
   B. Delineate the roles of nurses during SDM, particularly advocacy and patient education on treatment options
   C. Annual education and training of nurses on SDM (as well as all treatment team members)
   D. Develop and test a conceptual model of the roles of oncology nurses during SDM
   E. Develop a measurement tool to assess the role competence of oncology nurses in SDM; nurses need more support and training to feel competent as part of the process (Katz, Tariman, Hartle, & Szubski, 2017)

REFERENCES


