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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 predominantly 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 progress, 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 lawmakers 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 benefits (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.
4. Scope-of-practice barrier—Federal, state, and board of nursing laws and regulations that prohibit nurse practitioner from autonomous practice.
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

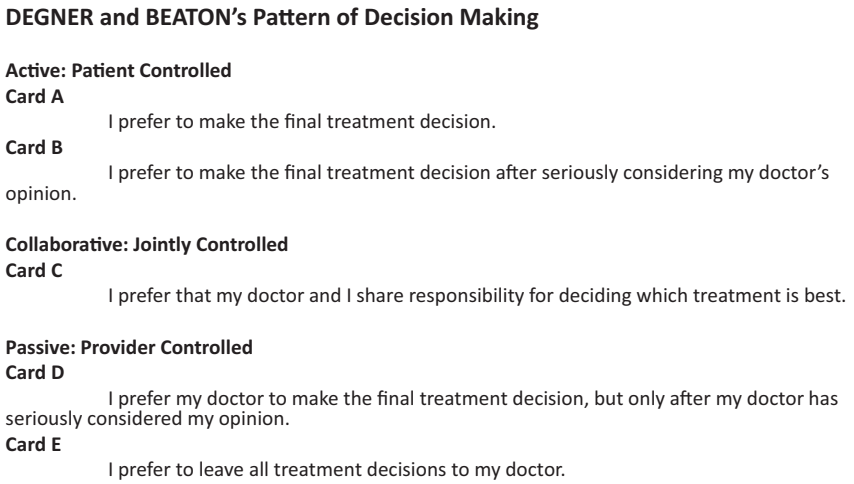

Fig. 6.1 The most widely used instrument to elicit patient's preferences for participation in health care decision making. (From Degner, L. F., & Beaton, J. I. [1987]. *Life death decisions in health care*. New York: Hemisphere Publishing.)

VI. Patient information needs
  A. Information priorities in patients diagnosed with cancer (Tariman et al., 2014):
    1. Diagnosis
    2. Prognosis
    3. Treatment options
  B. Assertion of independence and how to maintain self-care are priority information needs in older adults diagnosed with cancer (Sattar et al., 2018; Tariman et al., 2015)

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.

IX. Nursing roles during SDM (Tariman et al., 2016; Tariman & Szubski, 2015)
  A. Patient needs assessment
  B. Information sharing with oncology team
  C. Patient education
  D. Advocacy
  E. Psychological support
  F. Outcome evaluation
  G. Management of side effects
  H. Complex role contingent on several variables within the context of uncertainty

X. Opportunities to improve outcomes related to SDM
  A. Develop institutional policy supporting SDM model in current practice
  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)

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