

Shared Decision Making Among Individuals With Cancer in Non-Western Cultures: A Literature Review

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Since the early 1990s, a transition in health care has occurred in the West toward adopting models of decision making where patient involvement and choice are emphasized (Edwards, Davies, & Edwards, 2009). The right of patients to have a role in their medical care in many Western countries was secured not only through professional ethical guidelines, but also through legislation (Sainio, Lauri, & Eriksson, 2001). Shared decision making, which emphasizes patient autonomy and empowerment in making treatment decisions, became the advocated approach in Western culture.

Research among Western patient samples supports the importance of bringing attention to patient preferences for and participation in decision making (Epstein & Street, 2007). Studies conducted in the United States and Canada show that promoting patient involvement in decision making about his or her cancer improves the patient's knowledge about cancer and treatment (O'Connor et al., 1999; Waljee, Rogers, & Alderman, 2007; Whelan et al., 2004), satisfaction (Frosch, Kaplan, & Felti, 2001; O'Connor et al., 2003), adherence to treatment, and health-related quality of life (Andersen, Bowen, Morea, Stein, & Baker, 2009; Hack, Degner, Watson, & Sinha, 2006).

Background

Shared decision making is a process in which physicians and patients share information with each other, contribute to the treatment decision-making process by expressing treatment preferences, deliberate together over alternative options, and agree on the final treatment to be implemented (Charles, Gafni, & Whelan, 1997; Charles, Whelan, Gafni, Willan, & Farrell, 2003; Sheridan, Harris, & Woolf, 2004). Charles, Gafni, and Whelan (1999) defined shared decision making as an interactional process in which the patient and physician have a legitimate investment in the treatment decision and share treatment preferences and rationale. Charles et al.'s (1999) definition of the shared decision-making

Purpose/Objectives: To examine the extent to which shared decision making is a concept addressed within the published, empirical oncology decision-making research originating from non-Western countries from January 2000 to January 2012 and provide an overview of the outcomes of this research.

Data Sources: MEDLINE®, CINAHL®, Google Scholar, PsycINFO, Web of Science, and PubMed were searched for oncology decision-making literature published in English from January 2000 to January 2012.

Data Synthesis: Charles's three-stage conceptual framework of shared decision making was used as an organizational framework for the 26 articles meeting the initial criteria and reporting on at least one decision-making stage.

Conclusions: Although most patients wanted to be informed of their diagnosis, patient preferences for information and participation in decision making differed from that of physicians and varied among and within cultures. Few studies in this review addressed all three stages of shared decision making. Physician and patient attitudes, preferences, and facilitators and barriers to potential successful adoption of shared decision making in non-Western cultures require additional study.

Implications for Nursing: Nurses should assess patients from non-Western countries regarding their knowledge of and desire to participate in shared decision making and provide decision support as needed.

Knowledge Translation: Shared decision making may be new to patients from non-Western cultures, necessitating assessment, education, and support. Non-Western patients may value having family and friends accompany them when a cancer diagnosis is given, but assumptions based on culture alone should not be made. Nurses should determine patient preferences for diagnosis disclosure, information, and participation in decision making.

process included three stages: information exchange, deliberation about alternative options, and reaching agreement on a final decision. The stages may occur separately or simultaneously.

Because the concept of shared decision making originated within Western ideals of patient autonomy and empowerment, the concept may not be applicable

in non-Western cultures where values differ. For example, research published in the late 1990s showed that disclosure of a cancer diagnosis to patients was undesirable in some non-Western countries (e.g., Japan, Saudi Arabia) (Mitchell, 1998; Younge, Moreau, Ezzat, & Gray, 1997). Mobeireek, al-Kassimi, al-Majid, and al-Shimemry (1996) reported that the majority (75%) of the 249 physicians involved in their study in Saudi Arabia preferred to discuss the diagnosis of serious illness, such as cancer, with a close family member rather than the patient, even when the patient was competent.

Western ideals and values such as choice, disclosure, and autonomy have become more popular in non-Western cultures (Yun et al., 2004) because of technological advances that have accelerated globalization (Van Der Bly, 2007). Advances in treatment and decreases in cancer-related mortality have changed the general attitude toward cancer in many regions of the world (Schernhammer, Haidinger, Waldhör, Vargass, & Vutuc, 2010).

Therefore, the purpose of this literature review is to examine the extent to which shared decision making was a concept addressed in published, empirical oncology decision-making research originating from non-Western countries from January 2000 to January 2012 and provide an overview of the outcomes of this research. The review was guided by Charles et al.'s (1999) conceptual framework, the most comprehensive and widely used model of shared decision making in the literature (Makoul & Clayman, 2006).

Methods

To identify relevant studies published in English from January 2000 to January 2012, a search was conducted using MEDLINE®, CINAHL®, Google Scholar, PsycINFO, Web of Science, and PubMed, along with a manual search of reference lists of articles retrieved. Medical subject heading terms used individually and in various combinations were *neoplasm, religion, culture, communication, decision making, computer assisted decision support systems, health education, patient satisfaction, patient participation, physician-patient relations, and physicians*. Key words also used were *cancer, shared decision making, patient decision making, computer assisted decision making, therapy, patient education, patient involvement, patient-physician communication, patient information, medical information, healthcare provider, patient attitude, patient autonomy, cancer diagnosis disclosure, physician attitude, and healthcare provider attitude*. The search initially retrieved 1,245 articles published in English.

Studies initially were reviewed to determine if the study was conducted in a non-Western country and if the study involved original collection of data from adult patients with cancer or physicians caring for adult patients with cancer. Inclusion was not restricted

to controlled trials because the purpose of this review was to broadly explore non-Western researcher study of shared decision making. Twenty-six studies were identified that met these criteria. The researchers excluded 1,189 studies because they were Western, 12 studies were excluded because they included nonadult participants, and 18 studies were excluded because the data collection was not original.

The 26 studies were read to determine whether each addressed at least one of the three stages of Charles et al.'s (1999) shared decision-making process (information exchange, deliberation about alternative options, and reaching agreement on a final decision). No other articles were excluded based on this criterion.

Findings

Twenty-two of the 26 studies reviewed used quantitative survey methods, and four studies used qualitative methods. The majority of studies focused on patient or physician preferences for disclosure of the cancer diagnosis and prognosis to patients ($n = 22$), whereas very few ($n = 4$) focused on patient preferences for participation in treatment decision making, assessment of patient information needs, or examination of the role of family and others in treatment decision making.

No studies identified focused on physician or patient views on shared decision making or on physician attitudes toward patient participation in treatment decision making. Only one quantitative study explicitly used Charles et al.'s (1999) conceptual framework of shared decision making as a guide (Back & Huak, 2005).

The majority of studies reviewed ($n = 25$) used samples of patients with a variety of cancers. One study focused solely on patients with breast cancer (Lam, Fielding, Chan, Chow, & Ho, 2003). Studies originating in Asian and Middle Eastern countries represented the greatest number of studies in this review. This article focuses on similarities and differences in how decision making is addressed and the subsequent outcomes of the research among the published articles from these countries.

Findings are organized by the three stages of information exchange, deliberation about treatment options, and agreement on the treatment to implement (Charles et al., 1997, 1999). Two-proportion z test was used to make simple statistical comparisons (Knapp, 1978).

Information Exchange: Disclosure of Diagnosis and Prognosis

Patient attitudes: Differences within and among cultures were found in patient preferences for truthful disclosure of a cancer diagnosis. Across the 17 quantitative studies that examined patient preferences for truthful disclosure of a cancer diagnosis (see Table 1), patient preferences for

Table 1. Studies of Patient Attitudes Toward and Perceptions of Information Exchange and Participation in Treatment Decision Making

Study	Methods	Sample	Findings
China			
Jiang et al., 2007	Survey	864 participants; 382 patients with heterogeneous cancers and 482 family members	91% of patients said that diagnosis of early-stage cancer should be disclosed to the patient, and 61% said that a diagnosis of terminal cancer should be disclosed to the patient. Men were more likely than women to want disclosure of the diagnosis of terminal illness.
Lam et al., 2003	Survey	154 women diagnosed with stage 0–III breast cancer	55% of patients indicated that they were offered a surgical treatment choice; among them, 73% perceived a real choice and 27% indicated having no real choice. 33% wanted to make their own decisions, 50% wanted to share the decision, and 8% wanted to delegate it. Older women preferred a more passive role, and education level did not affect preference for participation. 80% participated as much, 13% more than, and 6% less than they wanted.
Iran			
Beyraghi et al., 2011	Semistructured focus group	8 patients with heterogeneous cancers and 5 family members	Most patients considered truth-telling a patient right, but all patients wanted the physician to take total control of the decision-making process for treatment. Patients complained about inadequate information.
Montazeri et al., 2002	Survey	167 patients with heterogeneous cancers	97% of patients indicated that they would like information on diagnosis and treatment. 27% wanted to know about available treatment options, and 90% said that they did not receive any written information on cancer and cancer treatment.
Japan			
Fujimori et al., 2007	Survey; researcher-developed measure	529 patients with heterogeneous cancers	Patients wanted doctors to discuss the treatment plan with them, establish rapport, and break bad news honestly. 96% of patients preferred to be aware of the treatment plan and assume responsibility for their care; 70% preferred their doctors to decide on the method of treatment. 78% wanted to be with their family when bad news was given to them.
Kawakami et al., 2001	Survey; researcher-developed measure	114 patients with heterogeneous cancers	76% of patients were informed about the diagnosis by the physician before the initiation of the treatment; 24% were not informed about the diagnosis. Patient understanding, consideration for the patient, and quality of life were major reasons for disclosure. Lack of ability to understand information and family wishes were major reasons for nondisclosure.
Watanabe et al., 2008	In-depth interviews	24 patients with heterogeneous cancers	Patients were classified into one of five categories: active decision makers; doctor selection; willfully entrusting the physician to make the decision; compelled to make a decision without sufficient knowledge, understanding, or time; and forced to surrender the decision. Patient preferences varied from complete physician control to complete patient control. Some physicians forced patients to make treatment decisions without providing them with relevant and sufficient information.
Korea			
Yun et al., 2004	Survey; researcher-developed measure	380 patients with heterogeneous cancers	87% knew that they had cancer, and 13% were not aware of their diagnosis. 96% wanted to be informed of their terminal illness. Patients diagnosed more than one year prior preferred more disclosure.
Yun et al., 2010	Survey	481 patients with heterogeneous terminal cancers	58% of patients were aware of their terminal status; 28% guessed terminal status from their worsening condition. 79% preferred to know about their terminal status.

(Continued on the next page)

Table 1. Studies of Patient Attitudes Toward and Perceptions of Information Exchange and Participation in Treatment Decision Making (Continued)

Study	Methods	Sample	Findings
Lebanon			
Doumit & Abu-Saad, 2008	Interpretive phenomenology	10 patients with terminal cancer receiving palliative care	Patient-family communication and truth-telling were reported as major stressors. All patients were aware of their condition. Patients wanted open communication with families and did not like family hiding the truth; patients expressed a need to communicate and to know diagnosis and prognosis, as well as their right to receive the truth.
Pakistan			
Jawaid et al., 2010	Survey; researcher-developed measure	147 patients with heterogeneous cancers aware of their diagnosis	76% wanted to know the diagnosis; 19% indicated no desire to know. 84% wanted to be informed through their physician; 10% wanted to be informed through family; 25% supported informing families without informing the patients. 57% wanted to know all treatment options; 69% wanted to be actively involved.
Kumar et al., 2010	Survey; researcher-developed measure	230 patients with cancer	Almost 92% were aware of their diagnosis; almost 40% felt fully informed. 27% thought cancer was contagious; 39% believed it to be from sin or God's curse. 73% wanted physicians to make treatment decisions with or without their input; 9% wanted their family to make treatment decisions for them.
Saudi Arabia			
Al-Amri, 2009	Survey	114 patients newly diagnosed with heterogeneous cancers	99% wanted to know everything about their illness. 77% wanted their family to know about their diagnosis. 99% did not support the idea of being treated without knowing their diagnosis and had a strong desire to know about treatment options.
Al-Amri, 2010	Survey	332 patients with heterogeneous cancers	98% wanted to know all information about their diagnosis and prognosis. 70% of women and 39% of men wanted family to know about the diagnosis. Patients from Eastern regions were more likely to desire disclosure of the diagnosis. No differences were found based on education level.
Singapore			
Back & Huak, 2005	Prospective audit	369 patients with heterogeneous cancers	18% asked for nondisclosure of the diagnosis, and 37% for nondisclosure of prognosis. Age, gender, and non-English speaking were predictors of prognosis nondisclosure requests.
Chiu et al., 2006	Survey	200 patients with heterogeneous cancers	Highest ratings given for physician competence and skills as well as physicians providing treatment options in detail, telling bad news directly, giving patients their full attention, being honest about the severity of illness, and telling the prognosis in person. Women rated supportive aspects of the decision-making process higher than did men.
Taiwan			
Tang & Lee, 2004	Survey; researcher-developed measure	364 patients with heterogeneous cancers	91% were informed about their diagnosis; 45% were informed about the prognosis. Information about extent of the disease was disclosed to only 20% of patients. 30% wanted to know all possible information about their disease. Patients indicated a low preference for family being informed of the diagnosis.
Thailand			
Phungrasamsi et al., 2003	Survey; measures not described	106 patients with cancer receiving radiation therapy	63% had been told by the physician that they had cancer, 35% were not aware of their diagnosis, 97% of those aware of diagnosis agreed they wanted to know, and 82% wanted their relatives to be with them when they were told.
Turkey			
Atici et al., 2009	Survey; researcher-developed measure	104 patients with heterogeneous cancers	82% indicated a desire to be informed of the diagnosis and treatment. 78% knew their diagnosis; 12% had not been informed of their diagnosis. The treatment information given focused on treatment delivery and side effects. 7% had not been informed about treatment; 8% preferred no information.
Erer et al., 2008	Survey; researcher-developed measure	104 adult patients with breast cancer as main diagnosis	86% supported disclosure of diagnosis and treatment information to patients; 92% supported physician disclosure of treatment options; 79% supported patients taking part in treatment decision making; 65% supported sharing decisions with the physician when more than one treatment option is available.

receiving truthful disclosure from their physician varied from 76% among Pakistani patients (Jawaid, Qamar, Masood, & Jawaid, 2010) to 99% among Saudi patients (Al-Amri, 2009). Across Middle Eastern and East and South Asian cultures, however, patients expressed the desire to have family or friends accompany them when the diagnosis was disclosed (Al-Amri, 2009, 2010; Fujimori et al., 2007; Phungrassami et al., 2003).

Physician attitudes: The percentage of physicians who preferred to disclose a cancer diagnosis to patients, as opposed to family members, varied from as low as 41% among Chinese physicians (Jiang et al., 2006) to as high as 91% among Indian physicians (Kumar et al., 2009) within the five quantitative studies from East and South Asia as well as the Middle East that examined this preference (Arbabi et al., 2010; Jiang et al., 2006; Kumar et al., 2009; Ozdogan et al., 2006; Qasem, Ashour, Al-Abdulrazzaq, & Ismail, 2002) (see Table 2).

Not only were Middle Eastern physicians reluctant to inform patients about their diagnosis, but one study reported that 79% of Kuwaiti physicians indicated they would withhold the truth from a patient if the patient's family asked them to do so (Qasem et al., 2002). Thirty-nine percent of Turkish cancer specialists in another study (Ozdogan et al., 2006) indicated that they rarely told the truth to their patients, and the majority of Iranian physicians involved in a study conducted by Beyraghi, Mottaghipour, Mehraban, Eslamian, and Esfahani (2011) believed that disclosure of the cancer diagnosis to patients is a mistake.

Similarly, one study from South Asia (Kumar et al., 2009) found that 63% of Indian radiation oncologists would only give information to a patient if asked, and only 33% of these physicians would disclose the diagnosis to a patient against a family's wishes. At the same time, 94% of these physicians believed that patients wanted to know their diagnosis (Kumar et al., 2009).

Within-culture variation: Variability regarding disclosure of the diagnosis to patients existed not only among different cultures but also within the same culture. For example, responses of Chinese oncologists differed by cancer stage (Jiang et al., 2006). Although the majority ($n = 232$, 88%) of Chinese oncologists in Jiang et al.'s (2006) study preferred truthful disclosure to patients regarding the diagnosis of early-stage cancer, fewer than half preferred truthful disclosure of terminal cancer. A similar result was found among Japanese physicians in a study by Kawakami et al. (2001) in which Japanese physicians were more likely to be truthful to patients in cases of early-stage rather than terminal cancer.

In addition, patient beliefs differed from those of healthcare providers who shared their nationality. For example, the percentage of Chinese patients who supported truthful disclosure of terminal cancer to patients ($n = 382$, 61%) was higher than the percentage ($n = 232$,

41%) of Chinese oncologists who supported truthful disclosure of terminal cancer ($t = 4.97$, $p < 0.01$) (Jiang et al., 2006, 2007). A similar pattern emerged among Middle Eastern patients in that the majority of Iranian patients with cancer in Beyraghi et al.'s (2011) study considered truth telling to be a patient right whereas, as noted earlier, the majority of physicians involved in the same study considered truthful disclosure of the cancer diagnosis to patients to be a mistake.

Association of demographic or clinical variables with attitudes: Evidence was inconsistent regarding the effect of clinical and individual variables on patient and physician preferences for the disclosure of the diagnosis to patients. Three studies originating in East and South Asian countries found that young adult patients were more supportive of truthful disclosure and more likely to be informed than older patients (Back & Huak, 2005; Yun et al., 2004, 2010). In contrast, three additional studies (two from the Middle East and one from Thailand) found no association between patient preferences for disclosure and age (Atici, Erer, & Erdemir, 2009; Erer, Atici, & Erdemir, 2008; Phungrassami et al., 2003). None of the studies in which education level was examined found an association with patient disclosure preferences (Al-Amri, 2010; Atici et al., 2009; Erer et al., 2008; Phungrassami et al., 2003; Yun et al., 2004). These findings spanned the East and South Asian as well as Middle Eastern countries represented by these studies.

With respect to gender, one study from Singapore and another from China found that men were more likely to prefer truthful disclosure than women (Back & Huak, 2005; Jiang et al., 2007), but five additional studies from the Middle East as well as from East and South Asia found no association between gender and patient disclosure preferences (Al-Amri, 2010; Atici et al., 2009; Erer et al., 2008; Phungrassami et al., 2003; Yun et al., 2004).

Three studies originating from East and South Asian countries found that patients with early-stage cancer were more likely to prefer truthful disclosure of the diagnosis than patients with terminal cancer (Back & Huak, 2005; Jiang et al., 2007; Yun et al., 2004). One of these studies (Yun et al., 2004) also examined the influence of the type of cancer on patient disclosure preferences and found that women with breast cancer were more likely to support truthful disclosure than patients with other types of cancer.

Diagnosis disclosure may depend on physician specialty, although these data were inconsistent as well, even within the same geographic region. Studies from Turkey and Kuwait identified that a diagnosis disclosure was preferred more by surgeons than medical or radiation oncologists (Ozdogan et al., 2006; Qasem et al., 2002), whereas an additional study performed in Iran (Arbabi et al., 2010) found that oncologists disclosed bad news more often than surgeons or radiologists.

Table 2. Studies Examining Physician Attitudes Toward and Perceptions of Information Exchange

Study	Methods	Sample	Findings
China			
Jiang et al., 2006	Survey	232 cancer clinicians	88% supported disclosing the diagnosis to patients with early-stage cancer. 41% supported disclosing the diagnosis to patients with terminal cancer. Female physicians were more likely than male to support diagnosis disclosure to patients with terminal cancer.
India			
Kumar et al., 2009	Survey; researcher-developed measure	35 radiation oncologists	91% indicated comfort with full disclosure and discussing cancer diagnosis with patients. 48% believed that patients should be involved in resuscitation discussions.
Iran			
Arbabi et al., 2010	Survey; researcher-developed measure	50 physicians from various specialties and 50 nurses who provided care for patients with cancer	86% of the physicians tended to reveal the diagnosis to patients. 56% of the physicians usually revealed the diagnosis to the patient, 20% always revealed the diagnosis, and 2% never revealed the diagnosis. 8% of physicians had been trained to disclose bad news and tended to disclose the diagnosis more than nontrained physicians. 44% of physicians preferred disclosing the diagnosis to patients privately. Older and more experienced physicians were more likely to disclose the diagnosis to the patient than others. Oncologists disclosed bad news more often than surgeons or radiologists.
Beyraghi et al., 2011	Semistructured focus group	7 oncologists and 6 nurses	Most physicians believed that the disclosure of the cancer diagnosis is a mistake. Physicians believed the diagnosis should be disclosed using vague terms, and the majority opposed using the word "cancer." Most physicians believed in patient involvement in treatment decision making.
Kuwait			
Qasem et al., 2002	Survey; researcher-developed measure	217 physicians likely to be in contact with patients with cancer in their practice	67% indicated they preferred full and complete disclosure of cancer diagnosis to patients; 79% of those indicated they would withhold the truth if the family requested. Concealment was more common among physicians in medical compared to surgical specialties.
Turkey			
Ozdogan et al., 2006	Survey	131 cancer specialists	45% reported that they usually disclose the truth, 39% rarely tell the truth, and 7% said that they always tell the truth. Family request for nondisclosure, training in breaking bad news, and medical specialty were the most important factors affecting physician disclosure preferences.

Patient attitudes and satisfaction with treatment option information:

Quantitative studies originating in the Middle East as well as East and South Asian countries examined patient desires for information about cancer and treatment (Al-Amri, 2009; Chiu et al., 2006; Erer et al., 2008; Fujimori et al., 2007; Jawaid et al., 2010; Montazeri, Vahdani, Haji-Mahmoodi, Jarvandi, & Ebrahimi, 2002; Tang & Lee, 2004). Patients who wanted as much information as possible varied from as low as 27% among Iranian patients (Montazeri et al., 2002) to as high as 92% among Turkish patients (Erer et al., 2008).

Patients wanted information to be honest, detailed, and delivered in a clear, unhurried, and open manner (Chiu et al., 2006; Fujimori et al., 2007). Patient percep-

tions of information sufficiency were addressed in studies from Middle Eastern as well as East and South Asian countries (Beyraghi et al., 2011; Kumar, Shaikh, Khalid, & Masood, 2010; Montazeri et al., 2002; Watanabe, Takahashi, & Kai, 2008). Although the two studies from Iran included in this review were conducted almost a decade apart (Beyraghi et al., 2011; Montazeri et al., 2002), Iranian patients still complained about a lack of sufficient education as a result of sparse resources and lack of written education materials. Japanese patients thought they had been forced to make decisions without having enough information (Watanabe et al., 2008). None of the studies included in this review addressed physician attitudes or barriers to giving information to patients.

Deliberation About Treatment Options

Seven of the 26 studies reviewed examined patient preferences for participation in cancer treatment decision making. Five of the seven studies originated from Asian countries, and the other two were from Iran and Turkey (Beyraghi et al., 2011; Erer et al., 2008; Fujimori et al., 2007; Jawaaid et al., 2010; Kumar et al., 2010; Lam et al., 2003; Watanabe et al., 2008). Comparison among these studies was difficult because none of the studies used a common measure of patient preferences. In spite of that, the authors found a contrast in patient preferences for participation in decision making between Middle Eastern and Asian countries. For example, Chinese women with breast cancer reported a desire for a larger role in sharing decision making with their physician (50%, $n = 154$) (Lam et al., 2003), and only 9% ($n = 230$) of Pakistani patients wanted their family to make treatment decisions for them (Kumar et al., 2010). Iranian patients, on the other hand, indicated a desire for their physician to make treatment decisions for them (Beyraghi et al., 2011).

Lam et al. (2003) was the only study to examine the effect of age and education on patients' preferred decision-making roles. They found that older Chinese women with breast cancer wanted a more passive role when compared to younger women, but education level did not affect women's preferences for participation in decision making.

Patient perceptions of decision-making roles: Two studies, both conducted in East Asian countries, addressed patient perceptions of their role in the treatment decision-making process. Among 84 Chinese women offered a surgical treatment choice, 73% ($n = 61$) perceived a real choice had been given to them (Lam et al., 2003). Eighty percent ($n = 124$) of the total sample for that study indicated they participated as much as they wanted, 13% ($n = 20$) participated more than they wanted, and 6% ($n = 10$) participated less than they wanted (Lam et al., 2003). Japanese patient perceptions varied between patients who perceived they were active decision makers and patients who perceived that they were not given the opportunity to participate to the level they desired (Watanabe et al., 2008). No study in this review addressed patient perceptions of barriers or facilitators to patient participation, physician attitudes toward patient involvement, or actual barriers or facilitators to patient involvement in treatment decision making.

Agreement on the Treatment to Implement

The same East Asian studies that examined patient perception of their role in decision making (Lam et al., 2003; Watanabe et al., 2008) were the only two studies in this review to report on patient reflections on their past decision-making process, as well. As they reflected, Japanese patients felt that the decision was not their own and instead was the physician's (Watanabe et al.,

2008). Although some patients in the study felt they had no input and had not been invited by their physicians to be involved in decision making (Watanabe et al., 2008), other patients willingly delegated the decision to their physicians because they felt incompetent to make their own treatment decisions. Among the 84 Chinese women who were offered a surgical treatment choice (Lam et al., 2003), 27% perceived that they actually had no real choice, and 39% of these women indicated that their surgeons implied one treatment was superior.

Discussion

The 26 studies demonstrated limited adoption of all three stages (information exchange, deliberation about treatment options, and agreement on a final decision) of shared decision making within physician-patient relationships. In fact, the studies originating from East Asia were the only ones identified in this review to address all three stages of shared decision making in cancer care. In contrast, more recent studies of decision making originating from Middle Eastern countries, for the most part, reported a resistance to shared decision making similar to studies from that region published in the late 1990s (Mobeireek et al., 1996; Younge et al., 1997).

Information exchange, the primary focus of studies identified in this review, is the initial stage of shared decision making and encompasses the difficult experience of disclosing and receiving a cancer diagnosis. Studies in this review continued to report an overall reluctance of physicians in non-Western countries to reveal a cancer diagnosis or news of advanced cancer directly to patients. Most often, family wishes were cited as the reason for withholding this information. This finding supports an earlier survey of oncologists that found non-Western physicians to be more likely than Western physicians to uphold family wishes to withhold a cancer diagnosis (Baile, Lenzi, Parker, Buckman, & Cohen, 2002).

Non-Western physicians in the 26 studies also indicated, for the most part, that they believed their patients preferred not to receive cancer information. That contrasted, however, with the findings of research reviewed in this article that focused on information exchange from the patient's point of view. Patients from a variety of non-Western countries wanted the diagnosis disclosed to them directly as well as to receive information about cancer and treatment options. A cross-cultural contrast noted between non-Western and Western patients was that non-Western patients had a strong desire to include family and friends in the diagnosis and treatment discussions with their physicians (Kim & Alvi, 1999; Parker et al., 2001). That difference was not explored in the studies reviewed, but the heavily family-centered nature of Middle Eastern and Asian cultures, in contrast to highly valued individualism in the West, offers a plausible explanation.

Consistent with Western studies of patient decision making (Hubbard, Kidd, & Donaghy, 2008), the few non-Western articles that addressed patient preferences for decision participation in this review found great variability within and among cultures. Although most patients appeared to desire a role in the decision-making process, some patients also desired to remain passive. In addition, consistent with Western findings (Lally, 2009), patients expressed a desire to participate in decision making with their physician but also desired that the physicians make the treatment decision. These results underscore the importance of physician support for patient involvement and provision of information, as well as physician responsibility for inviting and encouraging patients to be active players in their treatment decision-making process.

A topic often addressed in Western cancer treatment decision-making literature is patient reflection on the role they believe they played in the decision-making process (Hawley et al., 2009; Pieterse, Baas-Thijssen, Marijnen, & Stiggelbout, 2008; Ramfelt, Lützen, & Nordström, 2005). Two studies in this review from East Asia addressed this question and found that, similar to Western studies, a certain percentage of patients reported participating in treatment decision making to either a greater or lesser extent than they optimally desired (Lam et al., 2003; Watanabe et al., 2008). When those same studies examined whether patients and physicians agreed on the final treatment decision, many patients indicated they had accepted a final treatment decision that was more their physician's decision than their own. These findings again bear similarities to studies conducted in Western countries (Beaver et al., 2009; Swainston, Campbell, van Wersch, & Durning, 2012; Wright, Holcombe, & Salmon, 2004).

Although the studies in this review each addressed at least one component of shared decision making with various outcomes, none addressed shared decision making as a complete concept or presented analysis of either physician or patient perceptions of barriers and facilitators to any aspect of shared decision making.

Limitations

Every effort was made to conduct a comprehensive search of the literature and systematically examine articles for their inclusion of at least one stage of shared decision making, but only studies published in English were able to be included and, therefore, relevant non-English studies may have been missed.

Implications for Nursing

Although shared decision making in non-Western countries is emerging, it exists in various stages of ac-

ceptance and use among physicians and patients. When caring for patients who have emigrated to the West from a non-Western region, nurses must remember that not all patients are knowledgeable about or value shared decision making to the degree Westerners might. Nurses should assess and educate non-Western patients as needed about the stages of shared decision making. Patient preferences for family presence when the diagnosis and other news is given also should be assessed, and support for joint participation should be provided when desired.

Nurses also should be aware of variability in patient desire for information sharing and participation in treatment decision making, even within similar Western or non-Western cultures and settings, and assess patient desires for information and participation. Preparation and discussion of the degree to which patients wish to participate in decision making are likely to alleviate potential distress from what patients may perceive as a lack of direction in their care. Decision support with education materials and decision aids also should be offered when appropriate.

Nurse researchers should continue to pilot decision aids among non-Western patients to determine feasibility (Au et al., 2011). Shared decision-making research in non-Western countries also would benefit from greater use of conceptual frameworks to guide the research, power analysis to support the sufficiency of the study sample, and use of consistent measurement instruments with documented validity and reliability as studies progress.

Conclusion

Published research originating from non-Western countries from January 2000 to January 2012 indicated little adoption of all three stages of shared treatment decision making in the care of patients with cancer. This review revealed a continued reluctance among physicians in non-Western countries toward sharing cancer information with patients despite patients' desires for truthful information and resources. Of note, non-Western cancer treatment decision-making literature paid limited attention to issues of the physician-patient role in deliberation, achievement of agreement on treatment decisions, or barriers and facilitators to shared decision making. Therefore, shared decision making may be beginning to emerge as globalization brings Western views to patients in non-Western countries, but shared decision making may not be fully available to many patients in those countries.

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ted September 2012. Accepted for publication December 31, 2012.)

Digital Object Identifier: 10.1188/13.ONF.454-463

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