SCIENTIFIC ARTICLE

Preferences for Shared Decision Making in Older Adult Patients With Orthopedic Hand Conditions

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Purpose The practice of medicine is shifting from a paternalistic doctor–patient relationship to a model in which the doctor and patient collaborate to decide optimal treatment. This study aims to determine whether the older orthopedic population desires a shared decision-making approach to care and to identify patient predictors for the preferred type of approach.

Methods This cross-sectional investigation enrolled 99 patients, minimum age 65 years, at a tertiary hand specialty practice between March and June 2015. All patients completed the Control Preferences Scale, a validated system that distinguishes among patient preferences for patient-directed, collaborative, or physician-directed decision making. Bivariate and logistic regression analyses assessed associations among demographic data; clinic encounter variables such as familiarity with provider, trauma, diagnosis, and treatment decision; and the primary outcome of Control Preferences Scale preferences.

Results A total of 81% of patients analyzed preferred a more patient-directed role in decision making; 46% of the total cohort cited a collaborative approach as their most preferred treatment approach. Sixty-seven percent cited the most physician-directed approach as their least preferred model of decision making. In addition, 49% reported that spending more time with their physician to address questions and explain the diagnosis would be most useful when making a health care decision and 73% preferred additional written informational material. Familiarity with the provider was associated with being more likely to prefer a collaborative approach.

Conclusions Older adult patients with symptomatic upper-extremity conditions desire more patient-directed roles in treatment decision making. Given the limited amount of reliable information obtained independently outside the office visit, our data suggest that written decision aids offer an approach to shared decision making that is most consistent with the preferences of the older orthopedic patient.

Clinical relevance This study quantifies older adults' desire to participate in decision making when choosing among treatments for hand conditions. *(J Hand Surg Am. 2016;■(■):■–■.*

Key words Control Preferences Scale, elderly, hand, older, shared decision making.

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The doctor–patient relationship is evolving. The traditional paternalistic interaction in which the doctor dictates treatment is fading as patient populations have sought to become more actively involved in determining the course of their medical care.[1,2] This change is likely multifactorial and linked to shifting societal values and increased access to medical information, and health care providers realize that patients often want to participate in health care decisions.[3] Proposed shared decision making (SDM) models offer a distinct way to practice that may improve patient satisfaction, decrease patient–physician decision conflict, and improve the likelihood that patients pursue the intervention that best aligns with their personal values and goals.[4]

Shared decision making relies on unbiased education of patients regarding the disease, available treatment options, and the risks and benefits of each option. Shared decision making requires a patient to clarify his or her values and goals. To this end, decision aids exist in a variety of media including paper handouts, information videos, and interactive computer programs.[5] With strict development and validation criteria, decision aids are distinct from pamphlets explaining what a single recommended treatment entails.[6]

Shared decision making has only recently been investigated in orthopedic surgery.[7] In clinic visits where patients faced the decision between operative and nonsurgical treatment for joint arthritis, SDM improved patients' confidence in their decisions and decreased time to decision making.[8] Within the field of hand and upper-extremity surgery, recent data indicated discordance between surgeon and patient preferences in decision making for trigger finger and carpal tunnel syndrome (CTS).[9,10] In nontraumatic conditions with an elective operative option and in traumatic conditions without a consensus optimal treatment, patient preference and values ought to be a priority.[9]

As the population ages, the number of older adult patients seeking treatment for electively treated conditions such as osteoarthritis or traumatic conditions without a consensus optimal treatment such as distal radius fractures will continue to rise. The United States has a rapidly aging population: By 2030 there will be 75 million people aged greater 65 years, more than double the number in 2000.[11] Current data on this population's desire to engage in a more patient-directed role in health care decision making remains conflicting.[2,3,12–15] This study aimed to determine the preferred decision-making role among older adult patients seeking upper-extremity specialty care. We also sought to determine whether a patient's preferred decision-making role varied according to patient demographics, health literacy, or diagnosis type. We tested the null hypotheses that this patient population would prefer the traditional physician-directed role in decision making and that no demographic or clinical variables would affect the desired level of participation in their care.

MATERIALS AND METHODS

This institutional review board–approved, cross-sectional, observational investigation enrolled 99 patients to assess their desired level of participation in medical decision making and the factors influencing that choice. All patients presented to 1 of 6 orthopedic hand surgeons at a tertiary hand practice from March 2015 through June 2015. Eligible patients were English-speaking, aged 65 years or older, and able to complete surveys with minimal assistance. Patients were excluded if they were not fluent in English or had any mental comorbid condition (n = 2) that impaired their ability to consent or participate in medical decision making. Each enrolled patient completed study-related measures a single time at their first appointment within the study time frame.

Measurement tools

Patients completed surveys characterizing factors that could influence their decision-making preferences, including demographic data (age, race, sex, education level, work status, marital status, and living situation), current medical information sources, and preferred medium for medical information (physician encounters, pamphlets, videos, Web sites, articles, or books). Health literacy was assessed with 3 standardized questions addressing ability to complete health forms,[16] and the EQ-5D-3L (a standardized self-reported measure of health developed by the EuroQol group) was used to quantify perceived general health status.[17] Upper-extremity disability was evaluated using the Patient-Rated Wrist Evaluation (PRWE), a validated patient-reported questionnaire that quantifies patients' pain and function.[18–20] Although patients had both hand and wrist conditions, the PRWE was chosen instead of the Quick–Disabilities of the Arm, Shoulder, and Hand because of the ability of the PRWE to consider pain and function individually. Notably, the PRWE queries tasks performed with the "hand" and has demonstrated construct validity in hand conditions.[21,22] Preferences for participation in medical decision making were quantified using the Control Preferences Scale (CPS). This validated survey uses 5 illustrated cards (A, B, C, D, and E) to present a range of potential roles of a patient with respect to the physician during a clinic visit.[23] All cards illustrate and