



Review

Empirical relationships between health literacy and treatment decision making: A scoping review of the literature



Leslie J. Malloy-Weir^{a,*}, Cathy Charles^a, Amiram Gafni^a, Vikki A. Entwistle^b

^a Department of Clinical Epidemiology & Biostatistics, McMaster University, Hamilton, Canada

^b Health Services Research Unit, University of Aberdeen, Fosterhill, Scotland, UK

ARTICLE INFO

Article history:

Received 21 June 2014

Received in revised form 26 September 2014

Accepted 8 November 2014

Keywords:

Health literacy

Treatment decision making

Shared decision making

Patient decision aids

ABSTRACT

Objectives: This study asked: What is known from the existing literature about the empirical relationships between health literacy (HL) and the three stages of the treatment decision making (TDM) process: information exchange, deliberation, and deciding on the treatment to implement?

Methods: A scoping review of the literature was conducted. Four databases were searched and a total of 2772 records were returned. After de-duplication and three levels of relevance screening, 41 primary studies were included.

Results: Relationships between HL and information exchange were studied more often than relationships between HL and deliberation and deciding on the treatment to implement. Across the 41 studies, there was little overlap in terms the measure(s) of HL adopted, the aspect of TDM considered, and the characteristics of the study populations – making comparisons of the findings difficult. Multiple knowledge gaps and measurement-related problems were identified; including, the possibility that the process of TDM influences HL.

Conclusion: The importance of HL to the three stages of TDM is unclear because of the knowledge gaps and measurement-related problems that exist.

Practice implications: There are many uncertainties about how TDM, or the design and use of patient decision aids, should respond to patients with different levels of HL.

© 2014 Elsevier Ireland Ltd. All rights reserved.

Contents

1. Background	297
2. Methods	297
2.1. Research design	297
2.2. Identification of the scoping review question (Stage 1)	297
2.3. Identification of relevant studies (Stage 2)	297
2.4. Study selection (Stage 3)	297
2.5. Charting the data (Stage 4)	298
2.6. Collating, summarizing, and reporting the results (Stage 5)	298
3. Results	298
3.1. Temporal and geographical distribution of the 41 studies	298
3.2. Research designs and study populations	298
3.3. Definitions and measures of HL	298
3.4. Empirical relationships examined between HL and the three stages of the TDM process	304
3.4.1. Findings relevant to the information exchange stage of the TDM process	304
3.4.2. Findings relevant to the deliberation stage of the TDM process	306
3.4.3. Findings relevant to the deciding on the treatment to implement stage of the TDM process	306
4. Discussion and conclusion	307
4.1. Discussion	307

* Corresponding author. Tel.: +1 905 525 9140x22952; fax: +1 905 546 5211.

E-mail addresses: malloylj@mcmaster.ca (L.J. Malloy-Weir), charlesc@mcmaster.ca (C. Charles), gafni@mcmaster.ca (A. Gafni), vikki.entwistle@abdn.ac.uk (V.A. Entwistle).

4.2. Conclusion.....	307
4.3. Practice implications.....	308
Acknowledgements.....	308
References.....	308

1. Background

Internationally, there has been a growing trend toward the implementation and, in some cases legislation, of shared decision making (SDM) in the clinical encounter [1,2]. Although the term SDM has been variously defined, one of the key features of SDM is that both physicians and patients “take steps to participate in the process of treatment decision-making” [3^(p686)].

Related to the movement to implement SDM, is a growing international movement to promote the implementation of patient decision aids (PDAs) in clinical practice [2]. PDAs have been defined by the International Patient Decision Aid Standards Collaboration [4^(para1)] as, “tools designed to help people participate in decision making about health care options. They provide information on the options and help patients clarify and communicate the personal value they associate with different features of the options”.

Relevant to the shift to implement SDM and PDAs in clinical practice, is the notion that health literacy (HL) is important to treatment decision making (TDM). Claims to support this notion can be found in statements made in the academic literature; for example: “health literacy is *required* for patients to *effectively use decision aids*” [5^(p2)]; “health literacy is a *prerequisite* for *informed health care decision making*” [6^(p1)]; and “[I]mproving health literacy has the *potential to promote*”, among other things, “*more informed decision making*” [7^(p200)]. These statements generally imply that HL influences TDM.

Reflecting and/or reinforcing the notion that HL is important to TDM are provisions found within the 2010 U.S. Patient Protection and Affordable Care Act (ACA), Section 936, which is titled “Program to Facilitate Shared Decisionmaking”, includes provisions supporting the development, updating, and production of PDAs that “present up-to-date clinical evidence about the risks and benefits of treatment options” in a manner that, among other things, “reflects the varying needs of consumers and diverse levels of *health literacy*” [8^(p1090)]. Implied in these provisions is the notion that people with different levels of HL have different needs that should be respected with regard to the way that information about treatment options and their risks and benefits are presented in PDAs. That is, a particular PDA developed for patients with a high level of HL may not meet the needs of patients with a low level of HL.

Ethical arguments for enabling people to participate in decision making about their treatment are now widely accepted. However, many uncertainties remain about how this is best done, in part because of uncertainties about relationships between HL and TDM [9,10]. Policy initiatives, such as the 2010 U.S. ACA, make it particularly important to attend to these uncertainties. In this study we sought to answer: *What is known from the existing literature about the empirical relationship(s) between HL and TDM?*

2. Methods

2.1. Research design

A scoping review of the literature was undertaken using the approach described by Arksey and O'Malley [11]. Scoping reviews allow researchers to: (1) examine, or map, the extent, range, and nature of research activity in a topic area of interest; (2) “identify gaps in the existing literature”; and (3) “determine the value of undertaking a full systematic review” [11^(p.21)]. In the adopted approach, five stages are outlined. A description of how these five stages were applied in this review follows.

2.2. Identification of the scoping review question (Stage 1)

To allow for a broad and inclusive approach to the topic of interest, the Charles et al. [3] TDM framework was also adopted in this study. In this framework, different approaches to TDM (i.e., informed, shared, paternalistic) are described as well as three analytic stages that are common to each of the different approaches (i.e., information exchange, deliberation, deciding on the treatment to implement). To reflect this conceptualization of TDM, the research question was adjusted to: *What is known from the existing literature about the empirical relationship(s) between HL and the three stages of the TDM process?*

2.3. Identification of relevant studies (Stage 2)

To identify relevant studies, a literature search strategy for the four electronic databases listed in Table 1 was developed in consultation with a specialist librarian. Terms relating to health literacy and to treatment decision making (including physician–patient communication) were identified for each database. The search terms and combinations used in each database can be found in Online Appendices A–D.

As shown in Fig. 1, a total of 2772 records were retrieved from the four databases. A search of the reference lists of all review papers ($n = 83$) did not lead to the identification of any new records. After de-duplication, 2023 records remained and were uploaded into Distiller SR © for relevance screening.

2.4. Study selection (Stage 3)

Two levels of relevance screening criteria were developed, agreed upon, and pre-tested on a small sub-set of records by all of the authors. The first level of relevance screening (RS1) criterion was applied to the title and abstracts of all remaining records by LMW and MW. Records remaining after RS1 were read in full by LMW and MW to determine whether or not they met the second level (RS2) of inclusion criterion. Following RS2,

Table 1
Databases searched for the scoping review.

Database type	Database	Temporal period covered (Start date reflects the year in which each database was established. End date is the date in which the search was limited to)
Academic	Medline (Ovid)	1946–31/12/2013
Academic	Embase	1980–31/12/2013
Academic	CINAHL	1982–31/12/2013
Academic	Eric	1966–31/12/2013

Download English Version:

<https://daneshyari.com/en/article/6153656>

Download Persian Version:

<https://daneshyari.com/article/6153656>

[Daneshyari.com](https://daneshyari.com)