



Quality of Shared Decision Making in Lung Cancer Screening: The Right Process, With the Right Partners, at the Right Time and Place

Claudia C. Dobler, MD, PhD; David E. Midthun, MD; and Victor M. Montori, MD, MSc



From the Knowledge and Evaluation Research Unit (C.C.D., V.M.M.) and Division of Pulmonary and Critical Care Medicine (D.E.M.), Mayo Clinic, Rochester, MN.

When lung cancer screening with low-dose computed tomography (LDCT) was added as a Medicare benefit in 2015, a lung cancer screening counseling and shared decision making (SDM) visit before the initial screen was made a condition for reimbursement. It was specified that SDM should involve the use of decision aids and the discussion of benefits and harms of proceeding or not with screening (eg, false-positive findings leading to unnecessary invasive investigations, overdiagnosis, and radiation exposure).¹ To be eligible for reimbursement, a clinician (either a physician or a qualified nonphysician practitioner, eg, a physician assistant, nurse practitioner, or clinical nurse specialist) needs to conduct the consultation.

Shared decision making refers to a process in which a patient and a clinician work together to understand the patient's situation and to determine how best to address it.² This is especially important when making decisions about investigations or treatments that potentially have major adverse effects for which the benefits and risks have to be carefully weighed against each other and in situations in which there is insufficient scientific evidence to inform decisions. Lung cancer screening is associated with potentially important harms to the patient; in particular, there is a substantial risk of false-positive findings on LDCT (lung nodules that are not cancerous), and investigation of these nodules carries a risk of morbidity and even mortality.³ It is, therefore, essential that patients get an opportunity to deliberate the option of lung cancer screening vs no screening with a health professional, so that they can clarify what is most important to them and be guided in their health care decision by their values.

There seem to be several advantages to referring patients to specialized lung cancer

screening programs for these consultations, including access to specialists' experience and expertise.⁴ A potential downside is that patients and clinicians who conduct the SDM consultations may interpret referral to the screening counseling and SDM visit as referral to the screening procedure itself and then consider the SDM discussion as a mere formality, a bureaucratic hurdle. That is, on referral, patients may expect to receive the screening test, LDCT, rather than to participate in a process by which the patient and clinician determine together whether screening is an adequate response to the patient's risk of lung cancer given the potential benefits and harms of screening vs not screening. Specialists may also confuse the purpose of referral by assuming that patient attendance means that the patient, once adequately informed, prefers screening. Specialists may, thus, just ascertain coverage eligibility and proceed with an informed consent procedure. Misunderstandings triggered by the referral to specialized screening services may be compounded by conflicts of interest that may arise when the clinicians who are expected to engage in SDM have a stake, sometimes financial, in one of the options, in this case, lung cancer screening.

The challenges that can emerge from having an SDM consultation at a relatively late point on the patient's clinical pathway, when implicit expectations arising from the referral to a specialist lung cancer screening service have the potential to guide the SDM conversation, are associated with challenges in transitioning care between different health care professionals. Ideally, ensuring coordination and continuity of care when the patient leaves one care setting and moves to another would result in all clinicians who participate in the patient's care having current information about

the patient's treatment goals, values and preferences, and health or clinical status. In reality, there are often gaps in information sharing between referring clinicians and specialists, which can lead to misunderstandings. Also, patient preferences are constructed in the process of evaluating the options of screening or not screening and may evolve as patients receive information and are involved in SDM. Thus, preferences may change as patients move across settings and access new information.

In this context, decision making around lung cancer screening calls for a broader understanding of SDM, one in which SDM acts as an integrative process and the mindset and spirit of SDM spans all encounters with different clinicians. The implementation challenge for such a process would be to ensure that the patient and the health professional take part in SDM with the right information, using the right tools, in the right manner, in the right setting, and at the right time (see [Table](#)). The promotion of SDM has focused more on the development and uptake of tools that facilitate SDM and not as much on the quality of the SDM process. To ensure a high-quality SDM service, however, SDM for lung cancer screening must transcend the use of tools and instead broadly meet the six domains of health care quality put forward by the Institute of Medicine: SDM should be safe, effective, patient centered, timely, efficient, and equitable.⁵

Delegating SDM to clinicians who are not directly involved in lung cancer screening could mitigate conflicts of interest and associated pro-screening biases. Whether the bias reduction of such delegation justifies excluding clinicians directly involved with the intervention, who may have the most expertise with it, is unclear. Exclusion may not be the best or only approach to address potential specialist bias. Tools for SDM may address potential clinician biases by providing balanced evidence-based information on the pros and cons of a health care intervention and may calibrate patient and clinician expectations. In our experience, however, clinicians who believe that a patient will benefit from an intervention can use these same tools to persuade a patient of its value.⁶

Because the magnitude of specialist bias (and of potential anti-screening bias among primary care clinicians) and its effect on the uptake of LDCT for lung cancer screening

remains unknown, improvements in the quality of SDM will need to be based on evidence about the limitations of existing services and of the referral paths used to access them.

A systematic review found that patient navigators are an effective intervention to increase uptake of cancer screening and completion of recommended care events.⁷ Patient navigators could potentially facilitate SDM across the care continuum of lung cancer screening by involving at-risk people in the community at the time when a referral to a lung cancer screening service is considered, after screening, and in the event of recommended further investigation. Models that use these navigators for continuity of SDM across the health system deserve further investigation.

When we consider SDM as an ongoing process ingrained in clinical decision making, it is also clear that SDM should be used by patients and clinicians to guide the evaluation of suspicious nodules found by screening. Most lung cancer screening programs manage lung nodules found on screening by applying algorithms, although there is substantial uncertainty in the evidence about the relative merits of different strategies. Serial CT, nonsurgical biopsy, and surgical resection all have potential benefits and risks.

The implementation of SDM to determine with patients how to address the problem of elevated risk of lung cancer—including methods of smoking cessation and lung cancer screening—would benefit from quality evaluation. Given the potential for misunderstood referrals, potential conflicts of interest, medicalization, and low-quality SDM aimed at ascertaining eligibility or obtaining informed consent, ideal SDM, as described previously herein, should be the benchmark for all lung cancer screening programs. Implementation of SDM—with the right patient, the right clinician, using the right tools, at the right time, in the right setting—would benefit from emphasizing effectiveness (using patient-centered evidence-based communication and well-designed SDM encounter tools), equity (using health literacy universal precautions and designing services and SDM tools for inclusion), timeliness (identifying optimal moments in the continuity of care across practice silos to support SDM), and efficiency (focusing the program on patients most likely to benefit from considering screening

Download English Version:

<https://daneshyari.com/en/article/8673468>

Download Persian Version:

<https://daneshyari.com/article/8673468>

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