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Shared decision-making in older patients with colorectal or pancreatic cancer: Determinants of patients' and observers' perceptions

Noralie H. Geessink[a], Eirik H. Ofstad[c], Marcel G.M. Olde Rikkert[a], Harry van Goor[d], Jürgen Kasper[e,f], Yvonne Schoon[a,b,*]

[a] Department of Geriatric Medicine, Radboud university medical center, Nijmegen, the Netherlands
[b] Radboud Institute for Health Sciences, Radboud university medical center, Nijmegen, the Netherlands
[c] Department of Internal Medicine, Nordland Hospital Trust, Bodø, Norway
[d] Department of Surgery, Radboud university medical center, Nijmegen, the Netherlands
[e] Faculty of Health Sciences, Department Health and Caring Sciences, The Arctic University of Norway, Tromsø, Norway
[f] Medical Clinics, University Medical Center, Tromsø, Norway

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ABSTRACT

Objective: To identify determinants of older patients' perceptions of involvement in decision-making on colorectal (CRC) or pancreatic cancer (PC) treatment, and to compare these with determinants of observers' perceptions.
Methods: Patients' perceptions of involvement were constructed by the 9-item SDM questionnaire (SDM-Q-9) and a Visual Analogue Scale for Involvement (VAS-I). Observers' perceptions were constructed by the OPTION5, OPTION12, and MAPPIN'SDM. Convergent validities were calculated between the patient-sided and observer instruments using Spearman's correlation coefficient. Linear regression was used to identify determinants per criterion.
Results: 58 CRC and 22 PC patients were included (mean age: 71.8 ± 5.2 years, 45.0% female). No significant correlations were found between the patient-sided and observer instruments. Patients' impression of involvement was influenced by patient characteristics such as quality of life and satisfaction, while observers' perceptions mainly referred to encounter characteristics such as the mean duration of consultations and general communication skills.
Conclusion: Due to evident differences in determinants, older CRC/PC patients' and observers' perceptions of involvement should both be collected in evaluating the quality of medical decision-making.
Practice Implications: General communication skills should be integrated in SDM training interventions. New SDM measurement tools for patients are needed to sufficiently discriminate between the constructs of involvement and satisfaction.

1. Introduction

The number of older patients qualifying for oncologic treatment is rising. Due to concomitant co-morbidity and frailty among many of these patients, physicians are faced with increasingly complex treatment decision-making processes [1–3]. Major surgery, chemotherapy, and radiotherapy in (frail) older cancer patients result in significant risks of complications that may jeopardize patients' quality of life (QOL) and functioning. Colorectal (CRC) and pancreatic cancer (PC) resections in older patients are illustrative examples of high-risk procedures where treatment decision-making should be balanced on individual preferences regarding quality or quantity of life [4–6].

To deliver patient-preferred care, shared decision-making (SDM) and shared goal-setting are widely recommended. SDM has been defined as a collaborative process that allows patients or their surrogates, and clinicians to make healthcare decisions together, taking into account the best scientific evidence and patients' values, goals, and preferences [7]. SDM is particularly appropriate to guide older CRC/PC patients and their caregivers in the complex decision-making process [8–10] since alternatives for a major operation are available (e.g. (chemo)radiotherapy, 'doing nothing').

Although there has been a move towards SDM in recent years, the measurement of the construct is still challenging [11]. Further

* Corresponding author at: Department of Geriatric Medicine, Radboud university medical center, PO 9101 (HP 925), 6500 HB, Nijmegen, the Netherlands.
E-mail address: Yvonne.Schoon@radboudumc.nl (Y. Schoon).

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psychometric testing of existing scales is needed [12] and there is an evident need for patient-reported measures of SDM [13]. Though patient experiences should be the key ingredient in evaluating patient-centred care, such experiences are not sufficiently studied in SDM. In addition, patients' perceptions of involvement in decision-making generally do not correlate with observers' perceptions [11,14], possibly because most observer instruments only focus on clinicians' behaviour [15]. In the past few years, however, several new observer instruments covering different parts and perspectives on the SDM concept have been developed [16,17]. It has been suggested that SDM should be seen in the context of broader communication skills [18,19] and investigated by taking into account the entire clinical encounter [20] or even centred on the person rather than the clinical encounter [21]. Also older CRC/PC patients considered general communication skills and obtaining an overall picture of the patient as key elements in optimal treatment decision-making [22].

With this as a backdrop, we aimed to identify determinants of perceptions of involvement in decision-making among older CRC/PC patients in current surgical care, and to compare these with determinants of observers' perceptions (Fig. 1). In addition, we aimed to explore the relation between patients' perceptions of involvement and the overall satisfaction about the decision-making process.

2. Methods

2.1. Study design, setting and participants

This study was a cross-sectional observational study, nested within the EASY-GO study that evaluated the effectiveness of a training and working method regarding SDM and geriatric assessment implemented in the regular care processes for older CRC/PC patients [23]. In total, we included 94 consecutive patients aged ≥65 years within the study's time frame (January 2015–January 016) at the surgical outpatient clinic of the Radboud university medical center, Nijmegen, the Netherlands. All patients were registered as new CRC/PC patient and were initially considered for surgery based on referral information. Consultations focused on treatment decisions including (depending on cancer stage) surgery, (neo)adjuvant chemotherapy and/or radiotherapy, and no treatment. One day before the consultation with their surgeon, patients were asked by phone to have their consultations audio-recorded, and whether one of the researchers could attend the consultation. Just before the consultation, patients were asked if they still consented. After the consultation, a nurse specialist had an additional conversation with the patient to arrange logistics and handover an information folder. During these conversations, patients were asked to fill in the SDM questionnaire at home. To collect data concerning physiological, psychological and social health and wellbeing, patients also filled in the Older Persons and Informal Caregivers Survey Minimum Dataset (TOPICS-MDS) questionnaire [24].

2.2. Measurement

Patient involvement was administered by seven different perceptions: two by patients within the self-reported SDM questionnaire and five by objective observers based on the audio-recordings. Potential determinants were operationalized using the TOPICS questionnaire and patients' medical records, and by characteristics of the physicians and (communication within the) encounters. Patient satisfaction about the decision-making process was additionally administered by patients within the SDM questionnaire to explore its relation with patient-perceived involvement.

2.2.1. Patient involvement

Patient-perceived involvement

SDM-Q-9

Patients' perceptions of involvement in decision-making were constructed by the 9-item Shared Decision Making Questionnaire (SDM-Q-9, scale 0–100, where 0 indicated the lowest level of SDM and 100 indicated the highest extent of SDM) [25,26]. Since the SDM-Q-9 consists of nine statements rated on a six-point scale, raw total scores (0–45) were multiplied by 20/9 to rescale the total range from 0 to 100.

Visual Analogue Scale for Involvement (VAS-I)

Patients' perceptions of involvement in the decision-making process were also assessed by a self-developed Visual Analogue Scale (VAS-I, scale 0–10, where 10 indicated the highest extent of involvement).

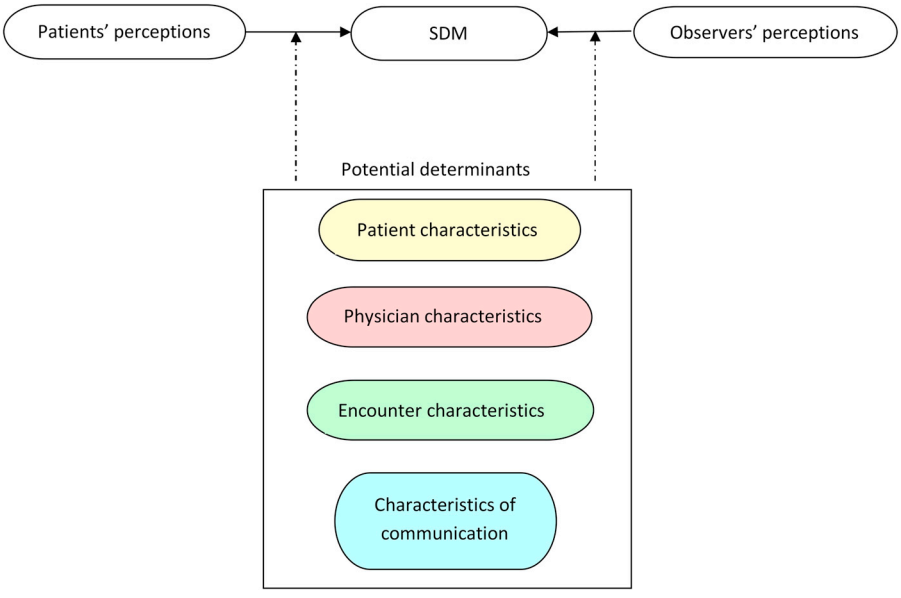

Fig. 1. Interrelations between patients' and observers' perceptions of involvement including potential determinants.

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