

## EDITORIALS

## Moving Towards Shared Decision Making in Prostate Cancer Screening

Richard M. Hoffman, MD, MPH<sup>1,2</sup> and Deborah L. Helitzer, ScD<sup>2,3</sup>

<sup>1</sup>Department of Medicine, New Mexico VA Health Care Center, 1501 San Pedro Drive SE, 111GIM, Albuquerque, NM 87108, USA; <sup>2</sup>University of New Mexico Cancer Research and Treatment Center, Albuquerque, NM, USA; <sup>3</sup>Department of Family and Community Medicine, University of New Mexico School of Medicine, Albuquerque, NM, USA.

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The United States Preventive Services Task Force concluded in 2002 that there is insufficient evidence to recommend for or against routine prostate cancer screening.<sup>1</sup> However, the Task Force did recommend that providers discuss the risks and benefits of screening with eligible patients to help them reach an informed decision. The content of such a discussion, comprehensively addressed in focus-group work by Chan and Sulmasy, would encompass the domains of epidemiology, pathophysiology, screening, treatment options, and treatment complications.<sup>2</sup> These authors identified over 20 specific relevant items for inclusion in screening discussions.

Unfortunately, despite the abundance of information to address, PSA testing often occurs in the absence of any discussion. Patient surveys have reported that approximately a third of men being seen in outpatient clinics<sup>3–5</sup> were unaware when a PSA test was ordered, and a physician survey found 20% acknowledging ordering PSA tests without telling their patients.<sup>6</sup> The paper by Guerra and colleagues, published in this issue of the *Journal of General Internal Medicine*, confirms that these discussions do not routinely occur.<sup>7</sup> These authors make an important contribution to the literature by qualitatively evaluating why these screening discussions do not occur. The barriers they found include patient comorbidity, assumed limited education/health literacy, previous patient refusal, physician forgetfulness, and lack of time.

Although the identified barriers certainly have face validity, the generalizability of the study results is limited because the sample size was small and the physician participants practiced in a single urban practice. Nonetheless, combining in-depth interviews with chart-stimulated recall is an appropriate strategy for evaluating barriers to delivering preventive services.

Interestingly, even this select group of physicians was somewhat confused about the guidelines. As an example, participants cited that screening was inappropriate in old age, which they defined as between 75 and 80 years, and in the setting of reduced life expectancy, defined as less than 5 to 10 years. In fact, the guidelines consistently support the notion that screening should not be performed when life expectancy is less than 10 years—which implies an upper age limit of 75 years for a man in average health. These guidelines are based on the observations that the prevalence of microscopic cancer is quite high in older men and that many of the cancers are indolent.

These are relatively minor misconceptions, but they bring out a very important issue in considering screening discussions. Even when the discussion happens, there is no quality control—no way of ensuring that accurate, comprehensive, understandable, and objective information is being consistently conveyed to patients. Rather than working just for the general goal of increasing health care discussions, we would argue that efforts should also be directed at increasing the use of health decision aids. These aids can provide both the patient and the provider with accurate information about prostate cancer and screening.

A barrier noted by the authors was the presumed low health literacy of the patient. Health literacy is not equivalent to educational attainment, although there are documented correlations between the two. The accepted definition of health literacy is the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”<sup>8,9</sup> Physicians should not presume a low level of health literacy but rather make some attempt to identify whether the patient can understand the information provided and make decisions using that information. Health decision aids that are written in plain, comprehensible language will go a long way to reducing the health literacy gap.

Another important issue in discussing screening is the desirability of moving beyond “informed” decision making to “shared” decision making. Rimer and colleagues have defined an informed decision as one in which a patient understands the clinical condition or disease, comprehends the implications of undergoing the clinical service, makes decisions based on his or her personal preferences, and believes that he or she has appropriately participated in the decision-making process.<sup>10</sup> Shared decision making is a process where physicians and patients collaborate in making decisions. The idea of “finding common ground” is the most important factor in predicting

positive patient outcomes.<sup>11</sup> This implies that the burden of decision making is not on the patient alone but is shared with the provider—whose responsibility is helping the patient to understand the information. Ideally, providers who are invested in shared decision making would not order a PSA test without first informing the patient.

Health decision aids, which can be written, oral, video, or interactive computer programs, are designed to promote informed and shared decision making.<sup>12</sup> They can facilitate shared decision making by providing an unbiased and accurate presentation of the risks and benefits for each intervention option being considered. Health decision aids are very appropriate for complex decisions, such as prostate cancer screening, where evidence is uncertain and decisions highly reflect patient preferences.<sup>10</sup> Numerous health decision aids have been developed for prostate cancer, and controlled trials have shown that they increase cancer knowledge and change attitudes about screening—making subjects less inclined to undergo testing.<sup>12</sup> An effective use of decision aids is providing them to patients before visits to address screening and encouraging them to share the decision aid with family members or friends. In this way, the clinic discussion can be focused on just the questions that the patient has after reviewing the information. This is an important efficiency, given the estimated seven plus hours a day that a primary care provider would need just to address prevention issues.<sup>13</sup>

There is still much to be learned about health decision aids and other tailored health promotion materials. We need to better modify decision aids for non-English-speaking patients and those with low health literacy, and to ensure culture appropriateness. Ongoing research is evaluating the most effective ways of implementing health decision aids in routine practice and whether patients feel that decision aids achieve the goals of increasing participation in decision making, increasing satisfaction with the decision-making process, and reducing decisional conflict.<sup>10</sup> In the meantime, providers should be aware that health decision aids are available to supplement patient discussions on prostate cancer screening.

**Corresponding Author:** Richard M. Hoffman, MD, MPH; Department of Medicine, New Mexico VA Health Care Center, 1501 San Pedro Drive SE, 111GIM, Albuquerque, NM 87108, USA (e-mail: rhoffman@unm.edu).

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