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Decision Making in Oncology: A Review of Patient Decision Aids to Support Patient Participation

Dawn Stacey, RN, MScN, PhD; Rajiv Samant, MD; Carol Bennett, MSc

ABSTRACT Although cancer management is becoming more structured with disease-specific guidelines and clinical pathways, many decisions remain complex. Contributing to this complexity is the need to make value tradeoffs between benefits and harms across cancer treatment and/or screening options. Since there is no “best” option for everyone, decisions are defined as being of higher quality when informed with the latest scientific evidence and based on patients’ informed values associated with outcomes of options. However, clinicians are not good judges of patients’ values, and patients often have inadequate knowledge, unrealistic expectations, and decisional conflict that interfere with their involvement in decision making. Effective approaches to support patient involvement into clinical decisions include clinicians trained in shared decision making, question prompt sheets, patient decision aids, and decision coaching by nurses and other allied health professionals. Based on systematic review of 23 randomized trials of cancer patient decision aids, patients exposed to decision aids are more likely to participate in decision making and achieve higher-quality decisions. This review highlights key historical changes leading to patient involvement in decision making, summarizes evidence on effective interventions to support shared decision making, explores strategies to implement these interventions in oncology practices, and identifies future directions. (*CA Cancer J Clin* 2008;58:293–304.) © American Cancer Society, Inc., 2008.

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INTRODUCTION

Over the last 3 decades, cancer treatments have become increasingly more sophisticated as a result of research and technological advances. Some clinical decisions are straightforward, with clear evidence to support one best approach, while other decisions are more difficult because of their preference-sensitive nature. Preference-sensitive decisions require weighing of patients’ values for benefits and harms across options, including the option of doing nothing (see Table 1).¹ At the same time, there has been a rapid expansion in medical information, improved access to health information for patients, and an evolution in the patient’s role in decision making. A growing percentage of patients has shifted from being passive bystanders to active participants in the clinical decision-making process. Yet many patients feel uncertain about the best course of action and require support to participate in the decision-making process.²

The goal for preference-sensitive decisions where there is no “best” choice for everyone is to achieve a higher-quality decision. Decision quality is defined as the degree to which decisions are based on current scientific evidence and consistent with patients’ informed values and preferences.^{3–5} However, emerging evidence suggests that decision quality resulting from standard counseling in clinical practice is inadequate.^{6–9} In these studies of standard counseling, physicians focus on information-giving only without consideration of patients’ expectations or values associated with outcomes of options. As a result, patients exposed to current practice do not necessarily receive cancer treatment or screening tests that they value.¹⁰ Patient involvement in the decision-making process can help to improve

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TABLE 1 Examples of Preference-sensitive Cancer Decisions

Tamoxifen for chemoprevention
Genetic testing
Prostate-specific antigen screening
Early-stage breast or prostate cancer treatment
When to stop active treatment
Location of care at end of life

satisfaction, understanding, and confidence in the decisions that are made.¹¹ Furthermore, supporting patients to be involved in decision making is recognized as an important facet of patient-centered care.^{12,13}

The purpose of this review is to highlight key historical changes leading to patient involvement in decision making, summarize evidence on approaches and effective interventions to support shared decision making, explore strategies to implement these interventions in oncology practices, and identify future directions.

HISTORICAL PERSPECTIVES

There has been a major shift in the approaches to clinical decision making within the last generation of practicing physicians. For much of the 20th century, physicians and their designates were considered the keepers of medical information and the sole decision makers. This is referred to as the so-called “paternalistic model.”¹⁴ For this approach to decision making, physicians and other health care professionals were expected to make decisions on behalf of their patients, often with little or no input from the patients themselves or their families. The physicians’ perspective took precedence, and they had the burden of responsibility for making vital decisions for patients.

Since the 1970s, there has been increasing recognition that patients need to be better informed about their medical care, and informed consent was introduced. Currently, cancer patients routinely provide written consent for surgery, radiotherapy, chemotherapy, and genetic testing. Although informed consent as described in legislation generally implies that patients are informed of a particular treatment in light of alternative options, consent forms primarily focus on the potential benefits and side effects of the chosen

treatment.^{15–18} Furthermore, the process of obtaining informed consent does not necessarily indicate that patients are involved in making their cancer decision; rather, the signature indicates that they agreed to the treatment, which may have been a recommendation by their physician.

Surveys of patients across different health conditions consistently indicate that the majority want and expect to be involved in making health decisions.^{19–22} These patients see themselves as being responsible for their health and well-being, which includes wanting to be fully involved in decision making when they become ill. Perhaps more importantly, evidence is beginning to emerge to indicate that women with breast cancer who have been actively involved in deciding about their treatment tend to be more satisfied with the care they receive, as well as having higher overall quality of life, higher physical and social functioning, and fewer reported side effects.^{23,24} Concurrently, within health professionals’ organizations, there is increased emphasis on client-centered care that includes expectations that patients are involved in making health decisions.^{12,13}

An important milestone for the promotion of active patient participation as a routine part of health care occurred in 2007; Washington state passed the first informed-consent legislation to indicate the need to acknowledge that shared decision making occurred as evidence to support informed consent to treatment.²⁵ The description of shared decision making within this legislation includes patient engagement in decision making, use of patient decision aids, and the need to ensure patients’ understanding of the seriousness of the disease and available treatment alternatives (eg, risks, benefits, and uncertainties). State legislators and advocates of patient involvement in shared decision making are monitoring the implementation of this innovative legislation.

APPROACHES TO PATIENT INVOLVEMENT IN DECISION MAKING

Given the shortcomings of the paternalistic approach to patient decision making, some patient advocacy groups strongly promote a “consumer model” in which the health care team diagnoses the problem, provides the options,

and subsequently allows the patient to make the decision in a fairly autonomous manner.¹⁴ This consumer approach also has limitations. Allowing patients and their families to deliberate on and make decisions independently can lead to significant patient uncertainty about the best course of action, and clinicians may not be comfortable following through with the patient's chosen option (eg, use of unproven herbal therapies).

Although a small proportion of patients prefers either a completely passive or completely active decision-making role, within the last decade, the prevailing approach for patient involvement in decision making among the majority has been "shared decision making."^{22,23,25-29} Shared decision making is a process whereby patients together with their clinician discuss the current evidence on options and arrive at a mutually agreed-on choice.^{14,30,31} Elwyn and colleagues expanded the definition to include practitioners making explicit the uncertainty or equipoise surrounding the decision.³¹ Therefore, shared decision making facilitates an individualized patient-centered approach in which patients actively participate in achieving quality decisions that are based on their informed values. Through this process, patients' views are clearly acknowledged and valued by the health care team (see Table 2).

At present, shared decision making is not widely prevalent in clinical practice, and many clinicians have yet to fully embrace this approach.³² Specifically with regard to cancer care, recently published studies suggest that oncologists often do not involve patients in the decision-making process to the extent that is desired.³³⁻³⁵ Furthermore, clinicians often underestimate their patients' preferences to be involved in clinical decisions.^{7,8} Therefore, it is essential to explicitly discuss with patients the role they prefer in the decision-making process. Patient preferences are difficult to predict and are not correlated with age, gender, educational status, or income, so an individualized approach is required.^{26,27} For example, a study in which a hypothetical case scenario of early-stage prostate cancer was presented to clinicians found that urologists usually recommend removing the cancer surgically, while radiation oncologists tend to recommend radiotherapy.³⁶ These early-stage

TABLE 2 Reasons for a Shared Decision-making Approach

Provide patient-centered care
Comply with legal and ethical patient rights
Be responsive to patients' desire to be involved
Remain accountable for screening and treatments used
Improve patient satisfaction with the decision-making process
Potentially improve patient health outcomes

prostate cancer patients rarely receive guidance from these specialists in making the best decision for their individual circumstances.

There are several known barriers to using shared decision making in clinical practice. In a review of 28 studies, the most common barriers were health care professionals' concerns about not having enough time, perception that patient characteristics or clinical situations were not conducive to shared decision making, view that some patients prefer a paternalistic approach without asking patients about their preferred role in decision making, and limited familiarity with shared decision making.³² Alternatively, some clinicians were very motivated to engage patients in shared decision making and believed that it would lead to a positive impact on the clinician-patient encounter and clinical outcomes. These clinicians also agreed that shared decision making was useful and that most patients want to participate in making decisions together with their clinicians. Interventions such as educational training workshops on shared decision making and tools to screen for decisional conflict in routine clinical practice may overcome some of the known barriers.³²

THE PROBLEM-DECISIONAL CONFLICT

Patients faced with different options for cancer screening and/or treatment are likely to experience decisional conflict. Decisional conflict occurs when individuals experience "uncertainty about which course of action to take when choice among competing options involves risk, loss, regret, or challenge to personal life values."³⁷ Unfortunately, those experiencing decisional conflict are more likely to change their minds, delay making a decision, regret the decision(s) they have made, fail a knowledge test, and blame their doctors for bad outcomes.³⁸⁻⁴⁰ An obvious

indication of decisional conflict is verbalized uncertainty, but other, more subtle signs include being preoccupied with the decision, being concerned about potential “bad” outcomes, and feeling distressed or tense.

A substantial proportion of individuals making preference-sensitive cancer-related decisions experience decisional conflict. For example, 66% of women with early-stage breast cancer reported feeling uncertain about whether to choose mastectomy or lumpectomy with radiation therapy.⁴¹ Another study indicated that 43% of patients with advanced cancer were uncertain about whether to receive end-of-life care at home or in a health care institution.⁴² In a third study of cancer patients with advanced non-small-cell lung cancer, only 30% felt sure about choosing chemotherapy or best supportive therapy.⁴³ Key factors contributing to patients’ decisional conflict across these studies included feeling uninformed, unclear about their values, and unsupported in decision making.

INTERVENTIONS TO FACILITATE PATIENTS’ PARTICIPATION

Patients require targeted approaches to prepare them for participating in the medical consultation, sharing in the decision-making process, and overcoming factors contributing to decisional conflict. Ideally, interventions should help patients recognize that a decision needs to be made, understand the current scientific evidence, clarify their values associated with outcomes of options, and achieve a quality decision.³ While usual patient education materials are not adequate, question prompt sheets and consultation planning are effective interventions to facilitate cancer patient involvement in the medical consultation,⁴⁴ and both patient decision aids and decision coaching facilitate patients’ roles in shared decision making and help them achieve higher-quality decisions.¹⁰

Question prompt sheets are standardized sets of questions used by patients to acquire information during the consultation.⁴⁵ Studies indicate that patients who used question prompt sheets asked more questions, and their information needs were more likely to be met, but they had no difference in anxiety or satisfaction when

compared with patients in the control group.^{44–46} Consultation planning is a process whereby patients are coached by trained facilitators (typically nurses, patient navigators, or resource center staff) to make their own lists of questions to ask within the medical visit.⁴⁷ Breast cancer patients who participated in consultation planning were more satisfied and reported fewer barriers to communicating with their oncologist.^{48,49} However, further research is required to address what effect these interventions have on improving discussion of patients’ informed values associated with their options, an important element of decision quality.

Patient decision aids are tools that translate evidence into a patient-friendly form by providing, at a minimum, information on the options, benefits and risks, and implicit methods to clarify personal values.⁵⁰ In addition, many decision aids also include information on the condition, probabilities of the outcomes of options (benefits/harms), exercises to help patients explicitly clarify their values, and guidance in the steps of decision making (see Table 3). Most patient decision aids are self-administered and are available in a variety of formats (paper-based resources, videos/DVDs, or computer software). However, there are some practitioner-administered decision aids, and these can involve more complex approaches.^{53,60,61} In recent years, the Internet has become the most widely available resource for patient decision aids, given the ease of updating the tools as new evidence emerges and the minimal costs associated with dissemination.

A recent update of the Cochrane review of patient decision aids identified 55 randomized controlled trials. Of these, 23 were focused on cancer-related decisions such as prostate cancer screening (n = 8),^{66–73} colon cancer screening (n = 3),^{61–63} breast cancer genetic testing (n = 6),^{54–59} breast cancer treatment (n = 4),^{51–53,60} and prostate cancer treatment (n = 2)^{64,65} (see Table 3). Patient decision aids, in general, were found to consistently improve knowledge, reduce decisional conflict, and result in choices that were congruent with patients’ values.¹⁰ When cancer-specific decision aids were compared with usual care, people receiving patient decision aids had higher average knowledge scores (weighted mean difference

TABLE 3 Characteristics of Twenty-three Trials of Patient Decision Aids Focused on Cancer Treatment or Screening Decisions

Source, Year, Location	Options Considered	Comparison of Most and Least Intensive Intervention	Elements in Decision Aids				
			Options and Outcomes	Clinical Problem	Outcome Probability	Explicit Values Clarification	Guidance in Steps of Decision Making
Goel V, Sawka CA, Thiel EC, et al, ⁵¹ 2001, Canada	Breast cancer surgery	Audiotape and booklet PtDA (n = 86) Simple PtDA pamphlet (n = 50)	X X	X X	X —	X —	X —
Street RL Jr, Voigt B, Geyer C Jr, et al, ⁵² 1995, United States	Breast cancer surgery	Interactive multimedia PtDA (n = 30) Simple PtDA (n = 30)	X X	X X	— —	— —	X —
Whelan T, Levine M, Willan A, et al, ⁵³ 2004, Canada	Breast cancer surgery	Decision board PtDA (n = 94) Usual care (n = 107)	X —	— —	X —	— —	— —
Green MJ, Biesecker BB, McInerney AM, et al, ⁵⁴ 2001, United States	Breast cancer genetic testing for higher-risk women	CD-Rom PtDA plus counseling (n = 29) Usual care (n = 14)	X —	X —	— —	— —	— —
Green MJ, Peterson SK, Baker MW, et al, ⁵⁵ 2004, United States	Breast cancer genetic testing for higher-risk women	CD-Rom PtDA plus counseling (n = 106) Genetic counseling (n = 105)	X —	X —	— —	— —	— —
Lerman C, Biesecker B, Benkendorf JL, et al, ⁵⁶ 1997, United States	Breast cancer genetic testing	Discussion PtDA and counseling (n = 122) Usual care, wait-list control (n = 164)	X —	X —	X —	X —	X —
Miller SM, Fleisher L, Roussi P, et al, ⁵⁷ 2005, United States	Breast cancer genetic testing (n = 279)	Discussion PtDA and general information pamphlets General information pamphlets	X X	X X	X —	— —	— —
Schwartz MD, Benkendorf J, Lerman C, et al, ⁵⁸ 2001, United States	Breast cancer genetic testing for Ashkenazi Jewish women	Booklet PtDA (n = 191) Usual care (n = 190)	X —	X X	— —	— —	— —
van Roosmalen MS, Stalmeier PF, Verhoef LC, et al, ⁵⁹ 2004, The Netherlands	Prophylactic surgery for women with <i>BRCA1/2</i> mutation	Video and brochure PtDA with decision analysis (n = 44) Same video and brochure PtDA pamphlet (n = 44)	X X	X X	X X	X —	X X
Whelan T, Sawka C, Levine M, et al, ⁶⁰ 2003, Canada	Breast cancer chemotherapy	Decision board PtDA and booklet (n = 82) Usual care with booklet (n = 93)	X —	X X	X —	— —	— —
Dolan JG, Frisina S, ⁶¹ 2002, United States	Colon cancer screening in adults	Computer: analytic hierarchy process and pamphlet PtDA (n = 50) Usual care (n = 47)	X —	X X	X —	X —	X —
Pignone M, Harris R, Kinsinger L, ⁶² 2000, United States	Colon cancer screening in adults	Video PtDA (n = 125) Usual care (n = 124)	X —	X —	— —	— —	— —
Wolf AM, Schorling JB, ⁶³ 2000, United States	Colon cancer screening in seniors	Script PtDA (n = 266) Usual care (n = 133)	X —	X —	X —	— —	— —
Auvinen A, Hakama M, Ala-Opas M, et al, ⁶⁴ 2004, Finland	Prostate cancer treatment	Pamphlet PtDA (n = 103) Standard care clinical guideline (n = 100)	X —	— —	X —	— —	— —
Davison BJ, Degner LF, ⁶⁵ 1997, Canada	Prostate cancer treatment	Written materials PtDA and audiotape of consultation (n = 30) Usual care (n = 30)	X —	X X	X —	— —	— —
Frosch DL, Kaplan RM, Felitti V, ⁶⁶ 2003, United States	PSA testing	Video PtDA (n = 112) Internet presentation mirroring content of video (n = 114)	X X	X X	X X	— —	— —
Gattellari M, Ward JE, ⁶⁷ 2003, Australia	PSA testing	Pamphlet PtDA (n = 126) General information leaflet (n = 122)	X —	X —	X —	X —	— —
Gattellari M, Ward JE, ⁶⁸ 2005, Australia	PSA testing	Pamphlet PtDA (n = 140) General information leaflet (n = 140)	X —	X —	X —	X —	— —
Myers RE, Daskalakis C, Cocroft J, et al, ⁶⁹ 2005, United States	PSA testing	Discussion PtDA and general information pamphlet (n = 121) General information pamphlet (n = 121)	X X	X X	— —	X —	X —

— continued

TABLE 3 (continued)

Source, Year, Location	Options Considered	Comparison of Most and Least Intensive Intervention	Elements in Decision Aids				
			Options and Outcomes	Clinical Problem	Outcome Probability	Explicit Values Clarification	Guidance in Steps of Decision Making
Partin MR, Nelson D, Radosevich D, et al, ⁷⁰ 2004, Canada	PSA testing	Video PtDA (n = 384) Usual care (n = 384)	X	X	X	—	—
Schapira MM, VanRuiswyk J, ⁷¹ 2000, United States	Prostate cancer screening	Booklet PtDA (n = 122) Simple PtDA pamphlet (n = 135)	X	X	X	—	—
Volk RJ, Cass AR, Spann SJ, ⁷² 1999, United States	Prostate cancer screening	Video with pamphlet PtDA (n = 80) Usual care (n = 80)	X	X	X	—	—
Wolf AM, Nasser JF, Wolf AM, Schorling JB, ⁷³ 1996, United States	Prostate cancer screening	Script PtDA (n = 103) Usual care (n = 102)	X	X	X	—	—

Abbreviations: PSA, prostate-specific antigen; PtDA, patient decision aid; X, present; —, absent.

[WMD] 13.7%, 95% confidence interval [CI] 9.0, 18.5); the 3 studies comparing detailed with simpler patient decision aids showed a smaller effect (WMD 4.1%, 95% CI 1.6, 6.5) (Figure 1). People receiving cancer-specific decision aids with descriptions of outcomes and probabilities were more likely to have accurate risk

perceptions than those who did not receive this information; the pooled relative risk (RR) of having accurate risk perceptions was 1.5 (95% CI 1.2, 1.9) (Figure 2). Furthermore, there was a 50% reduction in the proportion of patients who assumed a passive (practitioner-controlled) role in decision making (pooled RR 0.5, 95%

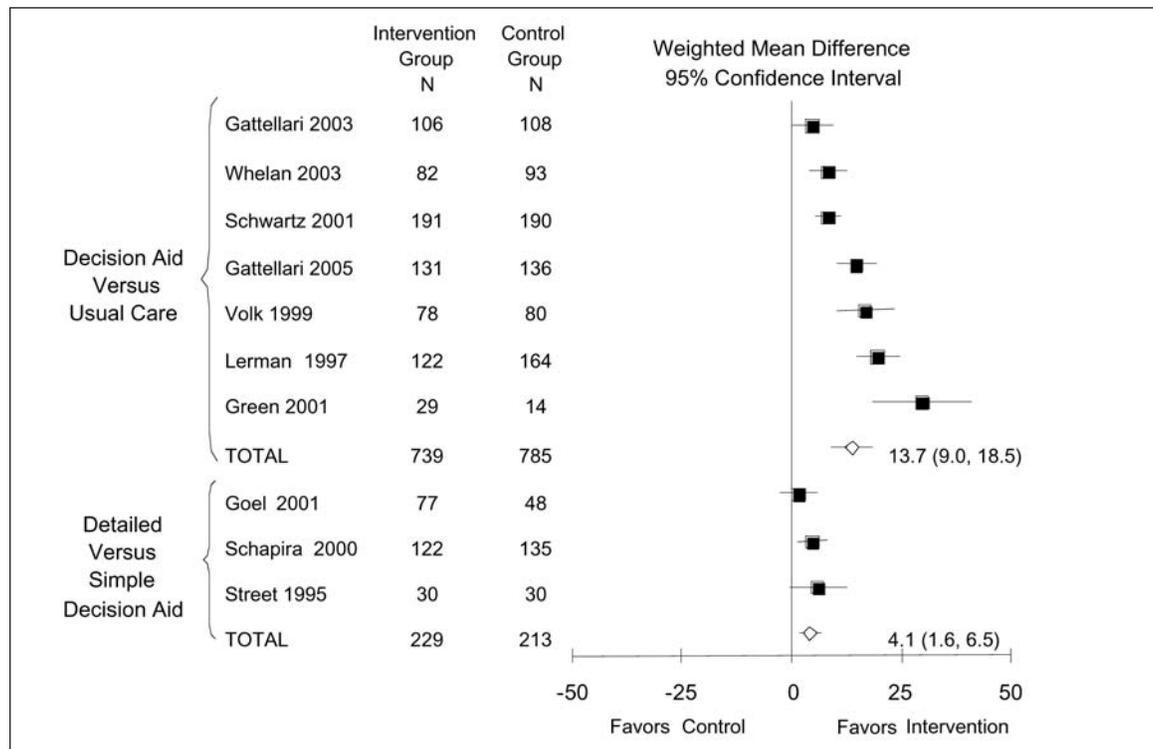


FIGURE 1 Effect of Patient Decision Aids for Cancer-related Decisions on Patients' Mean Scores on Knowledge Tests: Decision Aid Versus Usual Care (n = 7) and Detailed Versus Simple Decision Aid (n = 3).

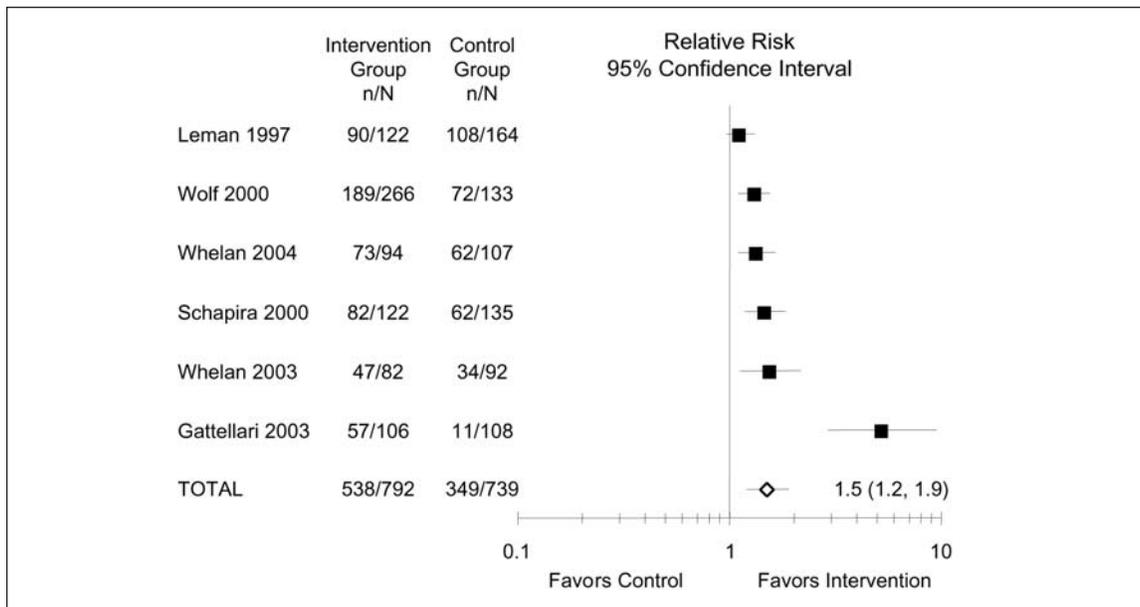


FIGURE 2 Effect of Patient Decision Aids for Cancer-related Decisions on the Proportion of Patients Classified as Having Accurate Risk Perceptions: Decision Aid with Outcome Probabilities Versus No Probability Information.

CI 0.3, 0.8) (Figure 3). Overall, decision aids did not have adverse effects on anxiety, health status, or patient satisfaction.

Patient decision aids can potentially reduce overuse of some aggressive interventions (eg, orchiectomy for prostate cancer) and also reduce underuse of other interventions (eg, colon cancer screening), particularly when base rates are either very high or very low, respectively (see Figure 4). Patient decision aids have also been shown to reduce the use of aggressive interventions when

base rates are already low. For example, women with early-stage breast cancer who utilized a decision aid were less likely to choose mastectomy compared with lumpectomy plus radiation despite seemingly low baseline rates of mastectomy (24% to 40%).^{52,53} For cancer screening, of 8 studies evaluating patient decision aids for prostate-specific antigen testing, 3 found significant reductions of 11% to 42% in men's preference for screening,^{62,66,72} and the other studies found either nonsignificant increases^{67,69} or reductions^{68,70,71}

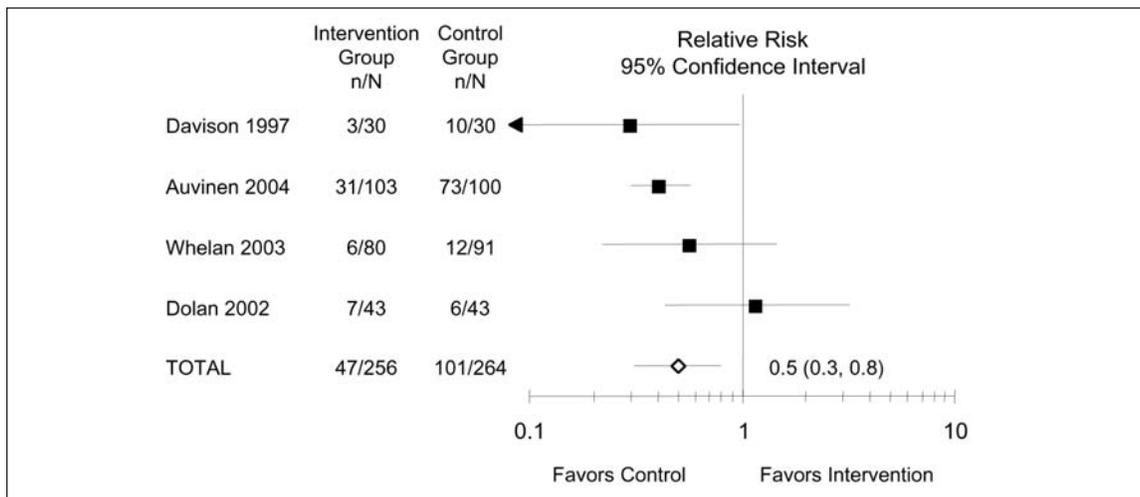


FIGURE 3 Effect of Patient Decision Aids for Cancer-related Decisions on the Proportion of Patients Reporting that Their Doctor Made the Decision.

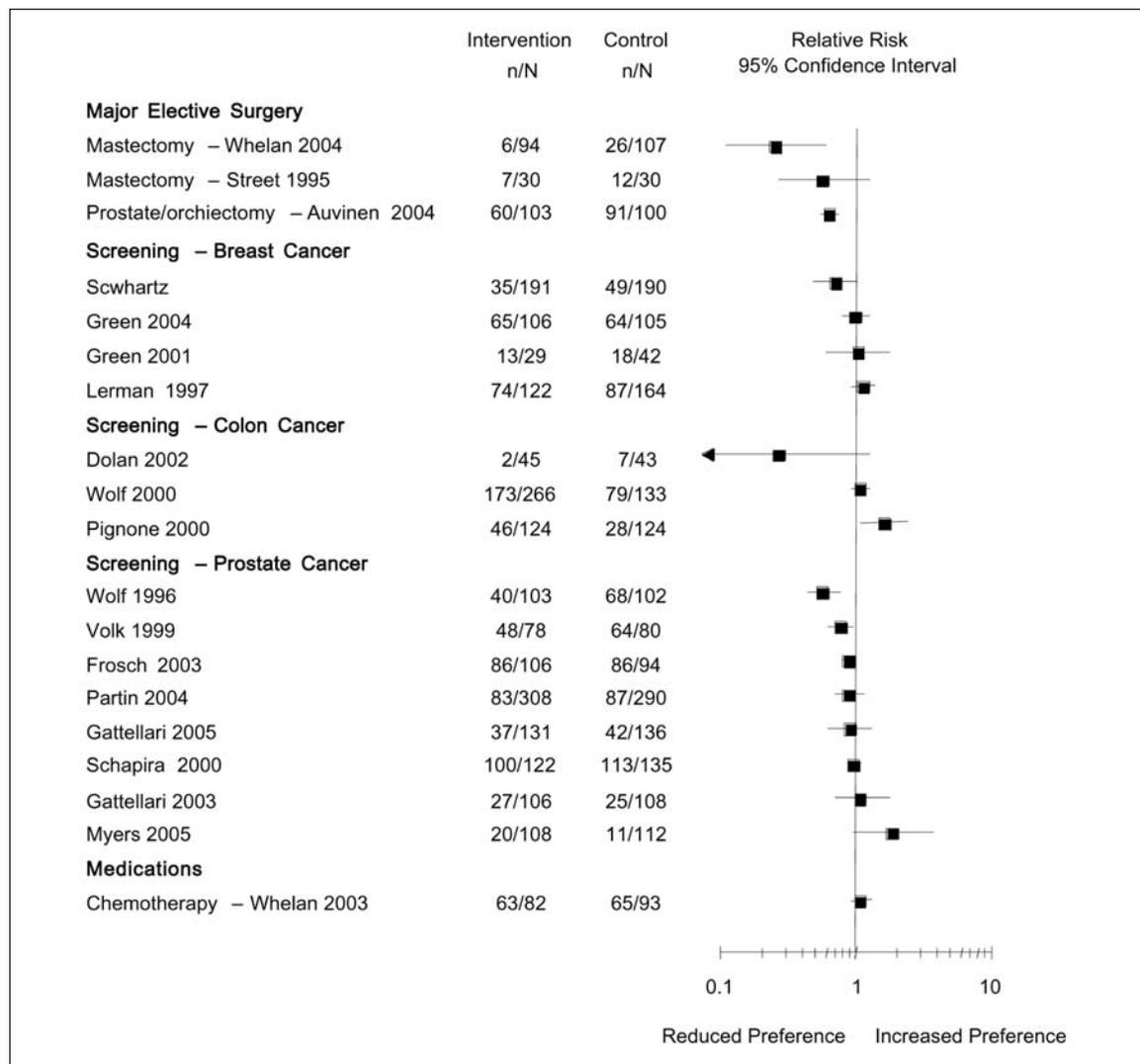


FIGURE 4 Effect of Patient Decision Aids on Specific Cancer-related Treatment and Screening Decisions.

in preference for screening. These results appear to highlight the controversy and uncertainty that currently exist regarding the overall value of prostate-specific antigen screening. Two studies that evaluated the effect of patient decision aids for colon cancer screening found no difference,^{61,73} and another study found a 64% uptake in colon cancer screening.⁶² There were no differences in preferences between groups for breast cancer genetic testing^{54–56,58} or breast cancer adjuvant chemotherapy.⁶⁰

Decision coaching is a process of facilitating patient engagement in shared decision making.⁷⁴ Decision coaches are health professionals who (a) assess patients' decisional conflict and related needs; (b) tailor decision support to

address patients' needs by offering patient decision aids and/or providing evidence-based information, verifying understanding, clarifying values, and building skills in accessing support; (c) guide patients through the decision-making process; and (d) monitor for factors that can influence implementing the decision (eg, motivation, self-efficacy, barriers). Studies of decision coaching indicate that when combined with patient decision aids, it improves decision quality, increases patient satisfaction, and is cost-effective.^{75,76} For example, the study by Wirrman and colleagues on the effect of decision aids plus nurse coaching for men considering prostate cancer treatment found that men in the intervention group had higher knowledge

scores and were more likely to receive treatment congruent with their values.⁷⁶

STRATEGIES TO IMPLEMENT DECISION AIDS IN ONCOLOGY PRACTICE

Successful implementation of interventions such as patient decision aids in clinical practice requires access to the interventions, practitioners aware of and skilled in using them, and environmental structures that support their use.⁷⁷ The Cochrane Inventory of Patient Decision Aids has over 500, with over 200 that are currently available.⁷⁸ Some decision aids are produced by academic teaching institutions, while others are mass produced by health information organizations. For example, mass producers of decision aids including cancer-related topics are the Foundation for Informed Medical Decision Making (www.fimdm.org), Healthwise (www.healthwise.org), the Mayo Clinic (www.mayoclinic.org), and the Ottawa Health Research Institute (www.ohri.ca/decisionaid). The Ottawa Health Research Institute also has a personal decision guide that is an interactive tool useful for exploring any decision.

Given the variable quality of available patient decision aids, a group of experts from 14 countries established consensus on a set of criteria for judging their quality.³ These criteria are categorized into the domains of essential content, development process, and evaluation. The International Patient Decision Aid Standards (IPDAS) Collaboration's criteria is available as a checklist (www.ipdas.ohri.ca) and is currently being used to quality-rate patient decision aids that are publicly accessible. These quality ratings are available at www.ohri.ca/decisionaid (see Decision Aid Library Inventory). The IPDAS checklist was designed to be used by developers, patients, health care professionals, health care insurers, administrators, policy makers, and researchers to critically appraise individual decision aids or to compare across available decision aids on the same topic.

Patients can access most available decision aids directly on the Internet or be given the decision aid or its URL by health care professionals or disease-specific community resource programs.⁷⁹ For example, several cancer programs

have integrated decision aids and decision-quality measures within the process of care for women with breast cancer considering treatment options.^{80,81} In primary care, cancer screening decision aids have also been incorporated into routine medical visits.^{82,83} Factors influencing successful implementation of decision aids in practice were reminders in the scheduling system, patient decision aids integrated with patient flow through the clinic, and physicians recommending them.^{32,80}

IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE

Gaps in knowledge remain. Further research is required to evaluate the influence of patient decision aids on patient-clinician communication; best practices for streamlining the updating process; and downstream effects, such as patient satisfaction and overall health outcomes, once they are more fully utilized.⁷⁹ One study found that practitioners' interactions with women who prepared for the consultation by using patient decision aids were more likely to have included a discussion of patients' values for outcomes of options and support needs.⁶ It is also important to establish effective ways to make them easily accessible to patients, including low-literacy groups. For example, researchers at Baylor College of Medicine are testing the use of a "soap opera" approach for the presentation of information on breast cancer treatment decisions within video-formatted patient decision aids.⁸⁴ Finally, patient decision aids will need to have routine updating built into the development process to ensure that they capture emerging evidence as it becomes available.

Although the value of patient decision aids has been clearly demonstrated in many areas of health care, including oncology, they have not become part of routine practice. Known barriers include limited health care professional skill in shared decision making and decision coaching, lack of awareness of patient decision aids, and limited number of available patient decision aids. Also, a fundamental change from the traditional doctor-patient roles is needed so that the new roles for both clinicians and patients are recognized instead of reliance solely on the clinician's opinion. Clinical practice models to best

support the introduction of shared decision making and patient decision aids within clinical practice are needed. The effect of legally mandating these interventions into the informed-consent process, as occurred in Washington state, is yet to be known. By creating an environment where patients expect to be supported in decision making and making it easy for clinicians to prescribe standardized patient decision aids, we are more likely to incorporate these interventions as part of routine quality health care.

SUMMARY

Patients want to be involved in health decisions. Given the preference-sensitive nature of many oncology treatment or screening decisions,

it is essential to use decision-making approaches that acknowledge patients' informed values. To support their involvement in decision making, patients need access to clinicians skilled in shared decision making and effective interventions such as question prompt sheets, consultation planning, patient decision aids, and decision coaching. Considerable effort is required to ensure that shared decision making and effective interventions to facilitate this process are incorporated into oncology care pathways and informed-consent processes. The goal is to achieve higher-quality decisions by balancing patient autonomy with clinician expertise, encouraging open dialogue between patients and their oncology team, and sharing in the responsibility for these decisions.

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