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Patient-Centered Discussions about Prostate Cancer Screening: A Real-World Approach

Barak Gaster, MD¹, Kelly Edwards, PhD², Susan Brown Trinidad, MA², Thomas H. Gallagher, MD^{1,2}, and Clarence H Braddock III, MD, MPH³

Barak Gaster: barakg@uw.edu

¹Division of General Internal Medicine, University of Washington, School of Medicine, Box 354760, 4245 Roosevelt Way NE, Seattle, WA 98105, (206) 598-3575, fax (206) 598-5952

²Department of Bioethics and Humanities, University of Washington, School of Medicine

³Department of Medicine, Stanford University School of Medicine

Abstract

National guidelines recommend that primary care providers discuss the risks and benefits of prostate cancer screening with their patients, but give little guidance about how to fit such a complex discussion into a busy clinic encounter. We propose a process-oriented approach (Ask-Tell-Ask) that promotes tailored conversations and value-based recommendations. The Ask-Tell-Ask approach includes assessing a patient's informational needs, providing targeted education based on those needs, and making a shared decision regarding testing. This time-efficient model emphasizes the provider's role as an interactive guide rather than a one-way supplier of information. While there is no way to make these discussions simple, this streamlined strategy can help patients and providers efficiently negotiate the complex and important decision about prostate cancer screening.

Keywords

prostate cancer screening; medical decision making; patient communication

INTRODUCTION

Current guidelines recommend that primary care providers discuss prostate cancer screening with their patients and obtain a prostate-specific antigen (PSA) test in those who want one. (1–3) Clinicians have been urged to employ various communication strategies to achieve this goal, including informed decision making, shared decision making, and patient-centered communication.(4–6) Some have suggested specific content to be delivered to patients,(7–9) while others have emphasized the use of decision aids.(10–12) Yet little specific guidance has been offered for how these complex discussions should occur.

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Despite these recommendations, recent data suggest that few providers are discussing prostate cancer screening with their patients.(13–15) Time pressure and fear of litigation may make it difficult for clinicians to implement an individualized approach.(14–17) The confusion over mammography guidelines further illustrates the difficulties clinicians face in implementing recommendations to discuss cancer screening when the evidence is incomplete.(18)

To bridge this gap between recommendations and current practice, we propose an approach that is based on both theory and evidence to help providers have interactive, time-efficient discussions about prostate cancer screening.

Framing the Discussion in the Context of Primary Care

Primary care providers face multiple barriers to effective prostate cancer screening discussions. Time pressure is foremost, leading them to avoid opening what they fear will be a lengthy conversation when they already feel they do not have enough time to spend with patients.(14–16,19–20) The complex and conflicting evidence around prostate cancer screening can leave clinicians uncertain about what information to share and in how much detail.(15) Patients who have poor health literacy present yet another challenge, particularly when conveying complex statistical information.(21)

As a result of these challenges, many clinicians simply order PSA tests without discussing the uncertainties, or they never order PSA tests unless patients specifically ask for them.(13–15) Others give all their patients a fixed, one-size-fits-all set of facts about PSA testing, repeating the same content for every patient. These approaches all miss the goal of being patient-centered. The one-size-fits-all strategy may also waste time by offering more detail than many patients want or need.

The Ask-Tell-Ask Approach

The Ask-Tell-Ask model for prostate cancer screening discussions (Figure) is an adaptation of similar approaches in the patient communication literature.(22–26) In particular, it draws from motivational interviewing (e.g. “elicit – provide – elicit” and reflective listening)(27) and the readiness staging component of the transtheoretical model of behavior change.(28) Whereas these strategies were designed to support behavior change, we have adapted them to facilitate communication when the patient faces a decision for which there is no right answer. Our approach differs from previous approaches to cancer screening discussions in that it: (1) focuses on the process, rather than the body of information to be shared with patients, (2) emphasizes the ethical, patient-centered goal of tailoring the conversation to the individual patient’s desired level of involvement, and (3) introduces “communication triage” by recommending that the discussion begin with an assessment of the patient’s stage in the decision making process, thereby facilitating a discussion that is time efficient while still meeting his informational needs.

“Ask”—The Ask-Tell-Ask approach begins with a quick assessment of the patient’s need and desire for information about screening, with the clinician asking what the patient already knows or is concerned about. In this initial step, the clinician assesses the patient’s information needs up front with exploratory questions (see Figure for suggested questions).

Beginning the discussion by finding out what the patient already knows and may be thinking has several important benefits. First, it invites the patient to take a participatory role in the decision, highlighting the importance of his current perspective in the decision-making process. Further, the open-ended question signals to the patient that there is no single, evidence-based “right answer” for everyone.

This approach encourages efficiency, allowing the clinician to ascertain the patient's need for information early in the conversation and omit information that the patient may already know. If the patient already has made up his mind for or against screening, then a short, focused discussion to confirm that he is making an informed choice may be all that is needed. If a patient wants the clinician to decide for him, the clinician can offer a recommendation based on an understanding of the patient's values, explaining the thinking behind the recommendation, and finishing with an invitation for the patient to ask questions. (29) Despite many clinicians' fears that starting with such an open-ended question might "open Pandora's box," (30) this approach may actually save time by allowing targeted teaching, avoiding having to cover the same lengthy presentation with all patients regardless of their needs. (31)

To gain a sense of how much information the patient wants and what he values in the decision, the clinician can offer "anchor points" that allow the patient to situate himself relative to sample patients. For example, the clinician could say, "Some patients like to hear every detail before making a decision. Others just want the highlights. What would help you make this decision?" (Figure) Using "anchor points" in this way gives patients permission to have a range of views on the issue of prostate cancer screening and further emphasizes that there is "no right answer" to the decision.

"Tell"—Based on the patient's response to these initial questions, the clinician can fill in missing information, answer the patient's specific questions, and correct any misconceptions. A patient whose best friend recently died of prostate cancer likely has very different needs for information about screening compared with a patient who says he "would rather let sleeping dogs lie." Arguably, neither of these patients needs a lengthy discussion about the decision. However, a patient who has not thought much about prostate cancer screening, but would like to learn more, may require more information from the provider.

Most patients do not need or want a comprehensive review of the evidence. (32) A simple statement that the benefit of prostate cancer screening is uncertain will be sufficient much of the time. For patients who want more information, clinicians should be prepared to offer a full range of details about prostate cancer screening including such factors as the role of digital rectal exams and the risk of false positive PSA tests. (see Figure for additional details)

The patient's educational level should especially play a role in tailoring the "Tell" portion of the discussion. Specific patient education handouts and other decision aids, such as video interventions and interactive computer-based modules, can assist men with low literacy. (33–35) Innovative work is also ongoing to help clinicians provide culturally competent prostate cancer screening discussions to high-risk African-American men, including outreach in settings such as barbershops and churches. (36–38)

This "Tell" portion of the discussion is another opportunity to invite the patient's participation in the decision. Asking "What about this information feels most important to you?" can help the clinician determine which aspects of the decision to explore more fully.

Several studies have shown that some patients do not desire an active role in decision making (39–40) or the responsibility of deciding whether to be screened for a potentially life-threatening cancer. (41) Once again, it can be helpful to emphasize that there is no "wrong answer" by suggesting ways that other men have dealt with this decision. The clinician might say something like, "This is an individual decision. Some men strongly prefer screening, even without good evidence that it significantly extends men's lives. Others would rather prefer to wait and see." The clinician can also offer reassurance by conveying

his or her unconditional support: “I will support any decision that you make about prostate cancer screening.”

“Ask”—With the final “Ask,” the provider confirms that the patient’s needs have been met and inquires whether the patient is ready to make a decision. The clinician might ask, “So does screening for prostate cancer sound like something you’d be interested in?” If the patient asks, “What do you think I should do?” the clinician can make a patient-centered recommendation based on concerns or opinions the patient has shared during the discussion. (42) For example, the clinician can say: “Based on what you have told me, it sounds like we should [test / not test]. Does that sound right to you?”

Some clinicians resist offering a recommendation of what to do when the best course of action is uncertain.(16) Here we propose providing value-based advice tailored to the concerns of the individual patient. Rather than making a generic recommendation, providers would offer different recommendations based on patients’ needs and concerns, taking into account patient-specific factors such as the patient’s race or a specific concern a patient may have about his family history.

DISCUSSION

Shared decision making about prostate cancer screening is crucial given the continued uncertainty regarding its risks and benefits.(43–44) The Ask-Tell-Ask approach elicits the patient’s values to focus the discussion on what is most important to the patient. The final decision about whether to screen for prostate cancer may come from the patient directly or from the clinician making a recommendation based on the patient’s values.

We have based this approach on emerging theory and evidence in the field of patient communication with the goal of engaging patients and addressing their concerns.(22–28) Studies suggest that approaches like this are well received by patients(45) and when used alone or in combination with previsit decision aids may be time efficient.(31,46–47) By starting with an open-ended “communication triage” question rather than always covering the same fixed set of facts, the provider can find out what the patient already knows and then tailor information to fill in gaps or correct misconceptions. By serving as a guide, the provider can help the patient arrive at a decision based on what is important to him and avoid leaving the patient adrift in what can feel like a difficult decision.

While no approach will make prostate cancer screening discussions easy, the Ask-Tell-Ask approach is designed to be time efficient, patient centered, and process oriented, with the goal of improving the quality of care by encouraging more informed decisions about prostate cancer screening.

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Figure.
Ask-Tell-Ask Model