

# Unintended Influence

## When Our Words Mean More Than We Think

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A **family friend** recently shared the experience of her 83-year-old mother, a relatively healthy woman who lives independently at home. She has 3 daughters who check in on her and support her. The only notable medical history was a stroke about a year and a half prior that resulted in challenges with decision making, but she has made considerable recovery.

At a regular visit to her long-time family physician, the patient's physician ordered an annual mammogram. The result of the screening mammogram showed something abnormal, and follow-up ultrasonography was recommended.

The ultrasonography results revealed an abnormal finding, and her physician recommended she see a surgeon at the cancer center for a biopsy, a cause for some anxiety for this woman and her family. Her daughters were not certain if their mother would want treatment if the results were positive for breast cancer. Her grandson, a fourth-year medical student at the time, asked his mom why his grandmother even had a screening mammogram given her age.

The days until the appointment with the surgeon were filled with worry and questions: "What if mom has cancer?" "Would she tolerate surgery and chemotherapy?" "Would treatment make her unable to live alone and independently?" The surgery appointment came, and the surgeon explained the biopsy procedure and what it involved. Still, neither the patient nor the family recalled any discussion about the possibility of false-positive mammography results or the risks vs benefits of screening mammography.

The biopsy result was negative for cancer and yielded much relief for the patient and her family; they were glad to have this behind them. Her primary care physician recommended a follow-up mammogram in 6 months. Her daughters were hesitant to proceed with any more mammograms. They wondered how additional mammograms would be helpful and if it would just put them through more worry and anxiety.

They talked with their mother and asked if she would have wanted treatment if the biopsy had been positive. Also, they wondered whether the treatment to cure the cancer would allow her to continue to live alone and independently.

One of her daughters recalled that her mother was confused through much of the process. Since her stroke, she had experienced more difficulty making decisions. Nonetheless, her mother realized that with her current good health, she would be better off not looking for cancer. She decided to forgo any more mammograms.

I spoke with the patient's primary care physician, a personal friend who I respect, and we discussed his views on screening mammography in older women.

He said he offers screening mammography to older women as an option, and some patients choose to have one, and others choose less frequent screening or none at all. He reported that while he does not share specifics about the possibility of false-positive test results, he does speak about it in generalities. He acknowledged that the data about screening mammography are not clear.

Published guidelines for screening mammography are many and varied. Some do not clearly state when to stop screening but some give recommendations. The US Preventive Task Force<sup>1</sup> says there is insufficient evidence for screening after age 75 years. The National Cancer Institute<sup>2</sup> states that screening mammography in women older than 65 years may yield cancer diagnosis in about 1% of elderly women, but many of these cancers are low risk and screening often results in additional diagnostic testing that may cause anxiety. They recommend that screening in women in their 80s and 90s be performed on a case-by-case basis. The Centers for Disease Control and Prevention<sup>3</sup> recommends screening mammography every 2 years for women 50 to 74 years old but provides no guidance for women older than 75 years.

As a nurse practitioner, I am reminded by this patient's experience of the power of our words. When we offer a test to a patient, he or she may perceive that we are recommending it, that it should be done. Many patients may believe that we would not offer a test if it isn't needed. Our efforts to "offer" are often perceived by patients as an endorsement of the test or procedure.

In this case, the patient had a long-standing relationship with her physician. The annual screening mammogram had become a routine. When the physician offered it, the patient heard it as if it was time for her annual screening, and there was no choice to be made. The risks did not come to light until the abnormal reading required the patient and family make a decision about the biopsy, and later, whether to have future mammograms.

It's time we get beyond a "cookbook" approach of simply offering mammograms. It may seem like the safe bet, to offer it so we don't "miss" breast cancer. Yet finding breast cancer or having a false-positive test result can be a stressful and traumatic experience. Quality of life and patients' values and preferences must be considered. After age 75 years, or, in this case, 83 years, would detection and treatment of cancer improve quality of life? Is the risk of a false-positive test result worth the benefit a mammogram might offer at this age? This is a decision each patient can make for herself, but only if she understands the tradeoffs.

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As clinicians, we need to give patients information to help them make informed choices that are best for them based on their age, health status, and personal values. We must do more than offer tests and procedures. We owe it to our patients to give them a choice, to

offer options, and to share the potential risks and harms of those options. The conversation can bring to the surface preferences and values to be considered if the test results are positive. That would be a good thing to do before the screening is even started.

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## Invited Commentary

### LESS IS MORE

# Shared Decision-Making Easy to Evoke, Challenging to Implement

Miriam Kuppermann, PhD, MPH; George F. Sawaya, MD

**In this issue** of *JAMA Internal Medicine*, 2 poignant accounts of experiences with breast cancer screening are presented: that of a 40-year-old trying to engage her physician in shared



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decision-making regarding mammography, which she ultimately decides to forgo,<sup>1</sup> and the account of an 83-year-old who has the test, perhaps without realizing it was being offered and not necessarily recommended, and has an abnormal finding.<sup>2</sup> In both, a central component of patient-centered care is missing: elicitation of patient preferences and values as part of a shared decision-making process. While the need for shared decision-making is easy to evoke, it can be challenging to implement. How do clinicians decide which among the myriad clinical decisions they face each day warrant a shared decision-making approach? And how can they integrate shared decision-making into busy practices?

Professional societies and governmental groups have taken the lead on informing clinicians about when shared decision-making is appropriate. The US Preventive Services Task Force, for example, has described the process in one of its source documents<sup>3</sup> and has made recommendations using a rigorous process to determine the magnitude and certainty of net benefit (benefit minus harms) provided by a preventive service; those deemed to confer a small net benefit with at least moderate certainty are given a C grade.<sup>4</sup> The Task Force recommends selectively offering or providing such services, based on “professional judgment and patient preferences.”<sup>5</sup> Grade C recommendations, therefore, are particularly sensitive to patient values and often require an in-depth conversation. The decision to undergo mammography at age 40 years is a grade C recommendation; the decision to screen after age 75 years is an “I statement” indicating insufficient evidence to determine net benefit.

With continually emerging techniques and treatments, however, much uncertainty about benefits and harms will ac-

company many medical decisions, including, but by no means limited to, preventive services that receive “I statements.” What is the clinician’s obligation to discuss these decisions with his or her patients? It is important to note that the absence of high-quality evidence to inform clinical recommendations is not meant to be a cue to acquiesce to patient demands because vital information to inform the choice may well be missing. The content of these discussions should center on the uncertainty about possible benefits and harms and may include clinically relevant examples. Thus, clinicians can assume the role of a patient advocate for high-value services rather than that of an unwitting accomplice in what may end up being a regrettable decision.

As we move toward greater patient involvement in clinical decisions, there is a critical need for criteria to use in selecting which clinical questions require a shared decision-making approach. Asking clinicians to engage their patients in shared decision-making in every instance in which preferences might vary, regardless of the number of decisions to be made, the time required for the shared decision-making encounter, and the economic consequences of opting for the more expensive option, is neither reasonable nor tenable.

How to engage in shared decision-making in the context of screening is a particularly challenging question, given the relatively large numbers of screening tests recommended for symptom-free populations, the complexity of explaining the risks and benefits of screening when the prior probability of disease is quite low, and the lack of attention that has been paid to the less-quantifiable harms that result from overscreening. The patient in her 40s does an excellent job of laying out the information that a clinician should communicate to the patient in an ideal shared decision-making encounter that is not subject to time or economic constraints. In such an encounter, the potential health outcomes of screening vs not screening should be clearly presented by the clinician, the expert in health outcomes, and the probabilities of each should be ex-