

The Role of Nursing in Shared Decision-Making:
A Relational Approach to Implantable Cardioverter-Defibrillator Battery Replacement

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Abstract

Implantable cardioverter defibrillator (ICD) implantation rates are rapidly increasing as advances in heart failure and arrhythmia management progress. The number of patients who will eventually require an ICD battery replacement will thus rise in consequence. It has been suggested that ICD battery replacement is an opportune time for shared decision-making (SDM) regarding continued ICD therapy to carefully review patients' health status, their lived experience with the ICD, and health care goals. My purpose in this project is to critically explore how a relational ethics lens can inform nurses to assist patients in a SDM process at ICD battery replacement. A comprehensive review and critical analysis of 17 articles was conducted to determine the role of nurses in SDM. My analysis revealed four themes: knowledge as a basis for SDM, sharing power in relationships, utilization of decisional support strategies, and communication. I then considered this evidence in the context of relational ethics. Nurses are indeed well positioned and able to participate in decision-making processes but should adopt certain roles and responsibilities in order to ensure their success. Implications for nursing practice, education, and research are offered.

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Introduction

Implantable cardioverter-defibrillator (ICD) deactivation is often left to the days, hours, and minutes prior to one's death. Appropriate and inappropriate ICD shocks are not uncommon nearing end of life and can cause protracted dying experiences for people who may otherwise not want to be resuscitated (Berger, 2005; Dubois, 2005). In 2004, it was estimated that 25% of patients were still receiving painful ICD shocks in the last weeks of life despite efforts to heighten clinicians' education and awareness (Goldstein, Lampert, Bradley, Lynn, & Krumholtz, 2004). The ethical considerations regarding this issue are related to giving people relevant and meaningful information to act autonomously and be in control of their end-of-life experiences. Nurses must begin to look at ways of preventing these decisions from being made at overwhelming and calamitous times. A question to consider is: what are appropriate times to discuss the options regarding the termination of ICD therapies?

Kramer, Buxton, and Zimetbaum (2012) suggest that ICD battery replacement is an opportune time when practitioner and patient can discuss health care goals in accordance with the patient's current clinical state, reassess the risk for sudden death, reflect on the lived experience with the device, and explore personal values and preferences regarding device therapy. This renewed approach to relationship building with patients facing elective ICD battery replacement calls upon a conversational process. Using such a process, the practitioner offers the best available evidence regarding continuing versus abandoning device therapies for tachyarrhythmias, and the patients can ponder and subsequently offer their preferences and values in accordance with the options. An approach such as this parallels the tenets of shared decision-making (SDM).

With care delivery increasingly moving towards an interdisciplinary approach, the involvement of professionals other than physicians should be considered and recognized in the context of SDM. To successfully reach the depth of discussion required to achieve true SDM, I propose that nurses should be involved and have a distinct role.

My purpose in this project is to critically explore how a relational ethics lens can inform nurses to assist patients in a SDM process. In order to contextualize this proposition, I will explore the decision making process that occurs when an ICD battery is in need of elective replacement. Specific objectives for this project include:

1. To review, critically analyze and appraise existing evidence regarding the nursing role in SDM;
2. To consider this evidence using a relational ethics perspective;
3. To recommend ways in which nurses can be involved in SDM when an ICD is in need of elective replacement.

To begin, I will explore the concept of SDM as described in the literature. The Interprofessional Shared Decision-Making (IP-SDM) model (Légaré et al., 2011) will provide a theoretical basis for this project as it supports the presence of disciplines other than medicine in SDM. Barriers and facilitators of SDM will be described in detail. I will then delve into relational ethics, and apply this perspective to SDM to localize and create a space for nurses in this process. To provide context, this pursuit will be applied to the clinical scenario of ICD battery replacement. A comprehensive review and critical analysis of 17 articles seeking the role of nurses in SDM has formed the basis of my findings, and the discussion that follows. Finally, implications for nursing practice, education and research are offered.

Background

Shared Decision-Making

Charles, Gafni, and Whelan (1997) offer an accepted definition of SDM. According to these authors, four main characteristics of SDM exist: "(1) that at least two participants be involved; (2) that both parties share information; (3) that both parties take steps to build consensus about the preferred treatment; and (4) that an agreement is reached about which treatment to implement" (p. 681). SDM is comfortably positioned between paternalism, where the practitioner makes the decision for his/her subordinates, and consumerism, where patient autonomy is the prevailing judge of all health decisions (Clayman & Makoul, 2009; Emanuel & Emanuel, 1992). Paternalism has been identified as the most common mode of interaction between patients and physicians, but is losing ground as it has been recognized that it violates the patient's right to autonomy (Tuckett, 2006). If individuals are denied the right to participate in decision-making, health care professionals consequentially deny them the opportunity to engage in and determine the direction of their lives. This is particularly true in the case of ICD therapy, as it could affect their mode of death.

An interactional, equal-weighted practitioner and patient relationship, as described by Charles et al. (1997) should be considered the gold standard in clinical care. Many would agree, that in principle, it is considered the "pinnacle of patient centered care," as titled in Barry & Edgman-Levitan's (2012) recent piece in the *New England Journal of Medicine*. But, by observing the current state of clinical consultations between patient and practitioner, one can conclude that SDM has not yet reached mainstream practice. Despite an enthusiastic movement to integrate SDM as an axiomatic piece in patient-practitioner relationships, concern for patients' needs, values and preferences is often lost in the choppy waters of increasingly complex care,

time constraints, variations in practitioners' attitudes and skills, and growing enthusiasm for advances in life preserving technology (Barry & Edgman-Levitan, 2012; Bryant, 2012; Edwards & Elwyn, 2009; Gravel, Légaré, & Graham, 2006; Légaré, Ratté, Gravel, & Graham, 2008). Ironically, such barriers are interfering with one of the distinct goals of evidence-based health care: to optimize decision-making by uniting clinical expertise and patients' values (Sackett, Straus, Richardson, & Rosenberg, 2000, as cited in Stacey, Légaré, & Kryworuchko, 2009). When attempts to reduce these barriers are successfully achieved, SDM has been shown to improve decision quality that favourably impacts patient outcomes (Gravel et al., 2006; O'Connor et al., 1998).

Shared decision-making since its inception.

SDM is a contemporary term, but the concept of mutuality in the patient-practitioner dyad has been in the literature since the 1980s. Multiple terms have been coined, including patient-centered care (Stewart et al., 1995), participation and partnership (Coulter, 1997), evidence-informed patient choice (Entwistle, Sheldon, Sowden, & Watt, 1998), informed decision making (Towle & Godolphin, 1999), user involvement (Tilley, Pollock, & Tait, 1999 as cited in Stringer, Van Meijel, de Vree, & Van der Bijl, 2008) and expert patient (Kennedy & Rogers, 2001). While all these terms share the predominant notion of mutuality in the patient-practitioner relationship, among other differences, the weight that each party holds in the decision-making processes varies (Edwards & Elwyn, 2009). Agreement on the multiple nuances of the term is still pending as variations in definition and how to measure its outcomes exist, making it somewhat challenging to compare findings across studies. Clayman and Makoul (2009) proposed an explanation for these inherent variations. The authors believed that concordance has not yet been achieved because SDM was generated free of theory. The term

originated from the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in 1982. This report was primarily focused on recognizing the principle of autonomy, just as interest in "patient-centeredness" mounted. The conversation thus continued to focus on the adherence to ethical principles, and it was not until a decade later that a theoretical foundation was offered.

Another point of contention is when SDM should be used in practice. Some contest that it is better fit for some situations, as compared to others. Debated is whether it should only be used in the presence of true clinical equipoise (a situation in which there is genuine uncertainty regarding the best course of treatment - including status quo) (Elwyn, Edwards, Kinnersley, & Grol, 2000), or whether patient values and preferences should be acknowledged in any decision, regardless of its nature (Makoul & Clayman, 2006). Légaré, Politi, Drolet, Desroches, and Stacey (2012) further contend that SDM includes the option of taking no action. In essence, patients' participation and involvement in their health-related decisions is the crux of patient-centered care (Kitson, Marshall, Bassett, & Zeitz, 2013; Registered Nurses Association of Ontario [RNAO], 2006), thereby supporting the latter argument. Throughout my paper, I support the assumption that there is opportunity for SDM in all health care decisions based on the concept's ontology¹ and epistemology². The philosophical and theoretical underpinnings of SDM are described in the next section.

Philosophical underpinnings.

SDM is heavily rooted in a constructivist philosophical paradigm (Stacey, D., May 2012, personal communication). SDM rests on the assumptions that we live in a society where

¹ Ontology is defined as "a theory about the nature of being or the kinds of things that have existence" (Merriam-Webster, n.d.).

² Epistemology is defined as "the study of the origin, nature, and limits of human knowledge, especially with reference to its limits and validity" (Merriam-Webster, n.d.).

uniqueness is appreciated, personal values and beliefs are recognized, and personal circumstances should always be considered. In other words, people's epistemologies are shaped by their unique life circumstances. Furthermore, a constructivist's lens affirms that a human's desire for purpose and meaning in life lies in subjective experiences, rather than the prefabricated conceptions of the outside world (Stevenson & Haberman, 2009). An effective way to enter a patient's world to grasp personalized meaning and interpretations of health and illness is to adopt a dialogical approach (Doane & Varcoe, 2005a). Dialogue, for the purpose of seeking information, is thus very important between invested parties in SDM to avoid the impulsive, often automatic, generation of presumptuous assumptions and their resultant bias. Deep and thoughtful conversation with the patient permits the practitioner to learn the intricacies of a person's situation, to further understand the origins of their values and preferences and how those values influence their health-related choices. Thus, a nurse's enquiry is meant to purposively seek the ideology of a patient's value-laden world. A thorough exploration and accurate understanding of a person's contextual circumstances enhances a nurse's ability to exercise true patient advocacy when onerous decisions arise.

Theoretical underpinnings.

SDM's theoretical void has since been filled. In recent years, SDM has been grounded in many conceptual frameworks such as the Ottawa Decision Support Framework (O'Connor et al., 1998), the Integrative Model of SDM in Medical Encounters (Makoul & Clayman, 2006), and the IP-SDM model (Légaré et al., 2011) as introduced earlier. These models, and numerous others not mentioned here, vary in the way practitioners and patients are positioned, the sequences of events that follow, and how much weight each party's beliefs should hold when

making a choice. For my purposes in this project, the IP-SDM model (Légaré et al., 2011) will be used as the theoretical lens to localize nurses in the process of SDM.

Interprofessional shared decision-making model.

In recent years, increased interest has surged regarding interprofessional involvement in care delivery, and decision-making is no exception. Légaré and colleagues (2011) created the IP-SDM model following a detailed theory analysis of existing SDM models, key interprofessional concepts, and a stepwise consensus-building and validation exercise with key stakeholders in primary care.

In addition to the presence of an interprofessional team, the IP-SDM model is structured according to the micro, meso and macro levels of the healthcare system. Within the model's micro level, the patient presents with a health problem requiring decision-making. Together with a team of health care professionals, the patient is guided through a structured process to couple their value-based perspective with the practitioners' evidence-based treatment options. At the meso level, the roles health care professionals adopt are considered within their institutional structures. At the macro level, the impact of system level factors (eg: health policies, professional organisations, and social context) on care delivery are acknowledged (Légaré et al., 2011).

According to the conceptual model, the patient is at the centre of the encounter located within the patient-family team. They stand alongside the interprofessional team where roles such as decision coach are specified, but particular disciplines are not. Macro and meso level considerations are located at the top, acting as an umbrella for the many shared decisions that are made under them. The process begins at the micro level when someone from either team initiates a SDM process. A structured sequence of events then follows: the decision to be made is

identified; an exchange of information occurs; and values, preferences, feasibility, and preferred choice are discussed. Once the actual choice has been made, implementation is required and outcome measurements are considered (Légaré et al., 2011).

Doane & Varcoe (2013) claim that therapeutic relationships, much like the ones integrated in the IP-SDM model, and the obligations that accompany them, can be understood relationally. Given the fundamental requirement of patient-practitioner relationships in the process of SDM, the role of nurses in SDM will be articulated by using a relational ethics perspective. Prior to discussing the role of nursing in SDM based on a review and critique of the literature, I will identify the disciplinary identities of nurses and physicians - two of the key disciplinary groups in the health care sector. It is increasingly recognized that a collaborative approach to care delivery provides safe, efficient, and high-quality care (Hanson & Spross, 2009). In the following section, I will focus on the disciplinary identities of nurses and doctors as understood historically, and discuss how recent reform in the structure of the health care team has, and will continue to benefit a patient-centered care approach. As members of each discipline acquire a greater understanding of the others' roles and responsibilities, and as they further recognize the benefits of a collaborative approach, inner-team inequalities could ideally become a phenomenon of the past.

Disciplinary Essences Revealed

The authors of a systematic review on health care professionals' perceptions of SDM noted that little has been published on the role of nurses in SDM (Gravel et al., 2006). To date, the majority of SDM literature has focused on the physician-patient dyad. Reasons for this may include the historical role of physicians leading and controlling the consultation by presenting, negotiating and evaluating treatments options. According to a biomedical perspective, physicians

are mainly concerned with solving a person's health problem by gathering evidence to diagnosis a disease process, and subsequently treating, managing, and evaluating that disease's response to treatment (Christensen & Hewitt-Taylor, 2006). Their hierarchical position within the interdisciplinary team, a position historically at the top of this hierarchy, has also influenced their role in decision-making with patients. As reflected in the IP-SDM model, physicians are most often considered the "initiator" of the SDM process as they are usually the first to identify the health problem and the subsequent decision to be made.

As for nurses, they are concerned with a person's response to the disease, and the act of "caring in the human health experience" (Newman, Sime, & Corcoran-Perry, 1991, as cited in Newman, Smith, Pharris, & Jones, 2008). Nurses are trusted and privileged to care for persons, families and communities, often during vulnerable phases of their lives. Nurses can adopt a wide array of approaches to respond to patients' vulnerabilities within the continuum of their health and illness. These approaches can be classified as theories, which have been described as "central to every nursing moment" (Doane and Varcoe 2005b, p. 82). The knowledge generated by nursing theories guide and support nursing action, attitude, and behaviour.

Nursing as art and science encompasses the essence of the discipline. From a scientific perspective, nurses must understand the ongoing pathological processes in order to heighten their senses during assessments and evaluation of treatment delivery. The art of the discipline is best described relationally. Together, a great deal of skill and knowledge are required to properly assess and balance every dimension of concern, deliver safe and competent care, provide accurate information adjusted to the patient's health literacy level, offer support, and evaluate nursing interventions.

Nursing has progressed a great deal from its not-so-distant historical dependence on physicians' commands. In recent years, nurses have acquired greater professional autonomy. Yet, despite this progress, power imbalances continue to characterize nurse-physician interactions, especially as nurses continue to follow physicians' "orders" as part of their daily routine (Pijl-Zieber, 2013).

It is important for nurses and physicians to co-exist in the same space; equal importance must be given to a medically driven paradigm and a nursing-oriented one. Nurses should no longer be considered as subordinates to physicians, but rather, as equals. By dissolving the historical, and in many ways stereotypical boundaries of a nurse and doctor's work, the adoption of an enhanced collaborative approach and respect for what the other discipline can contribute to practice could transpire. Voyer (2013) believes that this has already occurred. He states that "the emergence of multidisciplinary teams has...changed the traditional hierarchies" (p. 17). If this is true, we can then begin to appreciate how disciplinary identities can synergistically enhance patient care.

The rising discourse of a patient-centered approach to care has been widely adopted by the nursing and medical communities (Barry & Edgman-Levitan, 2012; RNAO, 2005). This discourse is particularly applicable to SDM as all members of the interprofessional team are urged to collaborate, understand, and respect what is happening from the patient's perspective, so they can subsequently provide meaningful care. The patient is therefore considered a member of the team. The importance of acknowledging the patient as "central to the decision-making process" (Légaré et al., 2011, p. 557) is made evident by the patient's central location within the IP-SDM model. This means that enlisting patients and their families in the design, implementation, and evaluation of their care plans, and subsequently being responsive to their

expressed needs and preferences, are indispensable to the delivery of high-quality care (Barry & Edgman-Levitan, 2012).

Conflicting yet complimentary essences.

Based on the principles of bioethics, physicians and nurses have the same moral obligations - to promote good, and prevent harm and suffering (Frank, 2009). However, the way in which these obligations are interpreted and practiced, may result in incongruous priorities. Rather than consider such disagreements as sinister, making peace with them can yield rich opportunities for reflection, open communication, and moral progress within the team. As a result, better team functioning, increased understanding of disciplinary dispositions, and transparency in decision-making can ensue. Adhering to this type of approach, teams could potentially resolve the lack of communication and collaboration often reported in the literature (Silén, Svantesson, & Ahlström, 2008). Collaboration amongst professions is possible through the willingness of team members to act and engage with one another with integrity, trust and shared values. Rushton (2007) considers respect as a foundational ethical principle in practice. She offers sound advice for the unity of nursing and medicine in practice:

Professionalism demands that we demonstrate respect for human dignity and diversity through the roles we play, the relationships we form, and the knowledge and skills we acquire. It is not enough to work alongside with other healthcare professionals to achieve our individual goals in an interdisciplinary setting. We need to integrate our expertise with theirs and play complementary roles in pursuit of a common goal - to work together in an interdisciplinary manner. (p. 153).

This advice is particularly meaningful in the setting of SDM. Members of an interdisciplinary team must recognize nurses as a competent force in the SDM process. This is one of many answers required to overcome SDM's barriers. Widespread adoption of SDM has not occurred, in part due to the many reported obstacles to implementation. Awareness of the common barriers

and facilitators to SDM offers insight as to why its adoption in practice has been unhurried. In the following section of this paper, I will build upon the comprehensive delineation of SDM offered until this point. This information will be particularly useful for those working towards the implementation of SDM processes in their institution to avoid the hurdles that have, to date, prevented its realization.

Barriers and Facilitators to SDM

Despite well-conducted research demonstrating the positive effects of SDM on the quality of decision-making processes, health care professionals have yet to adopt it in their routine settings (Elwyn et al., 2013). Why is it, despite rigorous trials demonstrating SDM's effectiveness, and the development of many SDM policies, that it is used so sparingly and hesitantly in practice? In the following section, I will attempt to answer this question by describing the main barriers to SDM. Facilitators to SDM will also be identified.

Gravel et al. (2006) conducted a systematic review on health care practitioners' perceptions on this very topic. The results primarily reflected physicians' perspectives as they comprised 89% of the respondents. The three most frequently cited barriers to SDM were time constraints, lack of applicability due to patient characteristics and clinical situation. In addition, some health care professionals simply did not agree with asking patients their preferences regarding participation. This suggests that health care professionals are making assumptions regarding participation preferences, and are failing to consider the individual at the center of the decision. Mulley, Trimble and Elwyn (2012) have identified this as a widespread problem in the medical community, and have labelled it the "silent misdiagnosis."

The National Academy for State Health Policy (Shafir & Rosenthal, 2012) published an implementation plan for SDM at the state and federal levels of the United States. From their

perspective, difficulties in implementation stem from a lack of consensus about a clear definition for SDM, a lack of standardization and certification of decision aids, provider resistance, and uncertainty on how to measure its progress in practice.

Standardization of health care through clinical guidelines has also been considered a barrier to the integration of patient preferences into treatment. The perceived need amongst clinicians to adhere to guidelines when a clinically appropriate patient is identified hinders the exploration of values and preferences in fear of repercussions (Matlock et al., 2011). Researchers have shown that many patients who meet clinical guidelines for certain interventions choose not to pursue them once they are fully informed of their treatment choices. Stacey and colleagues (2011) published a systematic review of decision coaching in trials of patient decision aids. The authors demonstrated a 20 per cent decline in major elective surgeries after patients became well informed. In the provision of good information, patients made different decisions and felt more confident with their choices. For this reason, careful exploration of values and preferences can improve patient-centered care by respecting preference-sensitive decisions. While disease may present itself similarly in a pathophysiological manner among those affected, perception and coping is often where uniqueness prevails. Respecting patient preferences increases patient satisfaction, and improves quality care. As a secondary effect, decreasing service consumption reduces health care expenditures (Mulley et al., 2012; Shafir & Rosenthal, 2012). This is certainly not the main reason we are seeking to instill SDM in practice, but is a favourable secondary outcome in this time of limited resources.

In the context of ICD implantation, Goldstein et al. (2004) suggested that a conversation about advanced directives and ICD deactivation may seem out of context given that those undergoing implantation are seeking to lengthen their lives. Other physicians admit that they do

not have the time to engage in these often prolonged, sensitive conversations, while others admit they are ill-prepared to discuss devices they knew little about (Kelley, Reid, Miller, Fins, & Lachs, 2008). Practitioners who were actually willing to discuss ICD deactivation had prior experience with such discussions (Kelley et al., 2008). Finally, Crane, Wittnik, and Doukas (2005) found that end-of-life decisions made when an individual is healthy are often subject to change when the person is actually ill.

The three most cited facilitators of SDM were health care professionals' motivation, the perception that SDM favourably impacts clinical processes, and its positive impact on patient outcomes (Gravel et al., 2006). Attitudes towards SDM such as the ones mentioned above are encouraging, as the very people who are called upon to consider and utilize SDM in clinical practice have acknowledged its benefits. Other positive factors have included the provision of training and skills development for SDM and the identification of a clinical champion in SDM.

Barriers specific to nursing.

Given the limited number of non-physicians represented in the review mentioned above, we must be cautious to accept these barriers as representative for nurses. Stacey, Graham, O'Connor, and Pomey (2005) identified barriers influencing call center nurses' decisional support for callers facing value-sensitive decisions. Cited barriers included a lack of a structured process to guide the nurses through SDM, their limited knowledge, skill and confidence base in providing value-sensitive decision support, pressure to meet organizational measures, and low public awareness. Christensen and Hewitt-Taylor (2006) described another factor limiting nurses' participation in SDM. The authors believed that if nurses' themselves do not feel empowered or autonomous within the interdisciplinary team, they may have a difficult time empowering their patients to do the same. Facilitators influencing call center nurses included access to decisional

support resources, the ability to recognize when callers were faced with decisional difficulty, and working for an organization with supportive infrastructure.

The use of patient decision aids (PDA) has also been found to facilitate SDM. PDAs are tools supplementary to the patient-practitioner consultation and guide patients through the decision making process (Stacey et al., 2010). They are meant to be used by patients to help identify values and preferences in the context of the evidence-based health care options, and attempt to match them with the appropriate course of action. Increasingly, studies around the world are demonstrating that nurses are needed for the successful implementation of decision aids (Stacey, D., March 2013, personal communication). However, the lack of certification for PDAs, and the high costs associated with keeping them timely and accurate, have also been identified as major barriers to implementation (Shafir & Rosenthal, 2012).

Elwyn et al. (2013), in a recent systematic review, concluded that to overcome these major implementation challenges, we must go beyond the barriers and facilitators approach, and quest to understand the driving forces behind professional and organisational resistance to these support interventions. Nevertheless, awareness and understanding of these barriers and facilitators offer clinicians, executives, and policy makers insight into efficient SDM implementation processes.

The engagement of nurses in SDM is an undeniable solution to overcome some of the barriers mentioned above. Nurses are able to navigate the complex, multifaceted, and contextually dependent situations required of SDM - particularly when using relational ethics as a guide. The very nature of nurses' work is relational; whether with others or within one's own self. In the next section of this paper, I will describe relational ethics, and delineate how it applies to nursing practice.

Relational Ethics

Bergum (2013) dubs relational ethics as an "action ethic" (p. 127). Its primary action is founded in morality, which is said to be embedded in all relationships. Morality, perceived through a relational lens, is executed through dialogue - the "space" where relational ethics occurs (Bergum, 2013). Every person, patient, family, community and society has a story to tell - and each of their narratives is exposed through dialogue. The particularities of the information patients share with their clinicians is dependent on the way it is sought: What questions are asked, how they are asked, why they are asked, and who is asking. Non-verbal characteristics of the situation in which the dialogue occurs can also influence the direction of the interaction. True presence, genuine engagement and active listening - sustained throughout the duration of treatment - are essential components to purposeful inquiry to reveal discourses, structures, experiences and people that have shaped the patient.

Doane & Varcoe (2013) have defined relational inquiry as "a reflexive process where one is always assuming and looking for the ways in which people, situations, contexts, environments and processes are integrally connecting and shaping each other" (p. 150). The sociopolitical, cultural and historical locations are essential parts of relational practice. These elements, and the forces between them, shape and support the patient. A practitioner's genuine engagement can empower patients to purposively think about their guiding ontologies and epistemologies, and how they have shaped who they have become. Doane and Varcoe (2013) explain that "relationships...are viewed as sites, opportunities, and/or vehicles for meaningful experience and response" (p. 150). And all those layers are integral to the understanding of the experience of health and healing.

Relational "knowing."

"Knowing", when interacting with patients, is considered a relational process. To learn from a patient, in an effort to truly know them, a nurse and/or the person must create a relationship founded on respect, trust and mutuality. Within this formed relational space, both parties must enact responsiveness and responsibility to ensure a successful relationship (Doane & Varcoe, 2013). A committed nurse can only provide individualized care for the patient who has willingly shared their story.

Carper (1978), notable to many for heightening the ways of knowing in nursing, referred to relational practice as an engagement that "cannot be described or even experienced - it can only be actualized" (p. 16), a statement which further supports Bergum's (2013) claim that it is an ethic of action. Doane and Varcoe (2005a) considered personal and sociopolitical knowledge to be of key importance to relational nursing practice. I would further argue that the moral component of knowing is also central to a relational practice. An innate sense of responsibility to do "right" by the patient, is dependent on a nurse's self-agency. Self-agency is enacted when a person, or group of persons, genuinely engages in deliberate action for the good of another (Gafni & Charles, 2009). This sense of moral responsibility towards others prompts action to resolve ethical unease and reinstate balance. Yet, it should be clarified that simply *being* a nurse does not guarantee self-agency, nor does it guarantee a relational way of being. It is a voluntary and conscious choice, further reinforcing the action component of "action ethic." "It is the individual person who acts, not the role" distinguished Lindh, Severinsson, and Berg (2007, p. 129). Self-agency is thus dependent on a person's inner moral compass, and their ability to perceive, respect, and respond to their patients' needs.

Through consciousness and presence in the nurse-patient relationship, a nurse can seek to identify how a patient perceives their illness, and how those beliefs influence his/her health

behaviours. Illness is a vulnerable time for patients and their families and it is through the careful and attentive art of interview and conversation that nurses can identify a person's specific needs. Doane and Varcoe (2005a) state that "there is relational flow happening in every human encounter" (p. 179). If this is the case, then we must ponder *how* we engage in-relation with patients, rather than *do we* engage in-relation with them. A relational approach does not necessarily require more time - a fear that many practitioners and organizations have reported in SDM studies - but rather requires thoughtfulness and intentionality in the way that time is spent with patients and families.

The goal of nursing is not an end - it is a way of being - calling for consciousness, intentionality and responsiveness when engaged with patients faced with a health related decision. The end result is ultimately for the patient: humanizing the experience of health and illness by relationally considering the particularities of their unique circumstances. In the following section, I will unite relational ethics to SDM, and draw numerous parallels between the two. Following this, I will move onwards to the integrative review of the role of nurses in SDM.

Relational Decision Making in Clinical Practice

Shared decision-making and relational ethics are naturally in concordance as they are both primarily concerned with relationship building and partnering with patients through the use of dialogue. Both require that practitioners listen, identify, and exchange patterns of communication and behaviours as patients and families are telling their stories. A common discourse adopted by individuals when dealing with health practitioners is one of being "patients" (Doane & Varcoe, 2005a). This discourse assumes that patients present to the health care team as unknowing, ill individuals, who expect the all-knowing practitioner to treat them, which reinforces the age old adage of the "doctor knows best." The goal of SDM is concerned

with moving away from this practice. SDM fittingly intersects with relational ethics, and delves into purposeful inquiry acknowledging patients' beliefs, values, and preferences regarding treatment options. Austin (2007) supports the notion that ethical action takes place in societies that are “grounded in relationships and involves perpetual responsiveness to others” (p. 86).

Bergum (2013) acknowledges that many health care professionals already integrate a relational approach to care, but cautions that current practice is not sufficient. She calls for a better developed perspective of ethical relationships and how to best enact them. Developing a prescriptive model for the enactment and articulation of ethical relationships in nursing is beyond the scope of this project, but what I do hope to achieve is to explain how a relational ethics perspective can support nurses' presence in SDM processes. To contextualize this, I will apply this marriage of concepts to the clinical scenario of ICD battery replacement.

ICD battery replacement in practice.

It has been suggested that the current widespread practice at ICD battery change is often a relatively automated process with little exploration of patients' values and preferences (Kramer et al., 2012). In our institution, nurses play an important role in patients' assessment and care management during their routine device interrogation visits. Nurses are the first health care professionals to detect a depleting battery, and are, therefore, the first to be able to enter a relational space with the patient regarding the implications of a depleting battery. As the battery approaches depletion, the frequency of visits to the device clinic increases, meaning that patients are aware of an impending battery replacement. Patients may direct questions regarding replacement towards the nursing staff, prompting a discussion. Thus, nurses in this area are perfectly positioned to be active and effective members in SDM processes.

When a depleting battery is revealed during a routine device appointment, a registry form for battery replacement is filled out and the patient is referred for the replacement procedure. The referral process is so ingrained in the clinic routine, that one could argue that it is primarily focused on efficiency rather than personalization. This possible absence of discussion is arguably a result of practicing in an environment guided by the forces of a biomedical discourse, where the focus is on the treatment of a disease process, rather than a person, with a further assumption that everyone wants to do everything possible to live.

As suggested earlier, a thorough review of health care goals can and should be considered when an ICD battery reaches elective replacement for the following reasons; since the initial implant, the patient could have been diagnosed with a life limiting illness, his or her cardiac status may have deteriorated, and the psychological sequelae caused by life with an ICD may have significantly impacted their quality of life. These are grounds that could support a patient's preference for letting the battery lapse. Paradoxically, a sudden death may now seem ideal. For others, especially the frail elderly, the risk of replacement may outweigh the benefits - particularly if therapies such as anti-tachycardiac pacing or shocks have not been required since implant. Adopting a SDM approach at ICD battery replacement is an ideal time to encourage patients in thinking about and clarifying how the ICD fits within their revised health care goals. Nurses can and should take an active role in discussions of this nature given their well established presence within the device clinic, and their well developed therapeutic relationships with patients. As the role of nurses in SDM has not been extensively studied in the literature, I have chosen to conduct a comprehensive review and critical analysis on this topic. A description of my adopted methodology, summary of the included articles, and presentation of the findings are delineated below. Recommendations for nursing practice, education and research will follow.

Methodological Approach

A comprehensive review and critical analysis of the literature on the topic of the nursing role in SDM was conducted using Whitemore and Knafl's (2005) five step process. This type of review allows for the inclusion of various methodologies in order to achieve a comprehensive understanding of a concept, phenomenon, or nursing issue. The authors built upon Cooper's (1998, as cited in Whitemore & Knafl, 2005) framework, and modified it to incorporate diverse data sources. This framework offers a "more systematic and rigorous approach to the process, particularly to data analysis" phase (Whitemore & Knafl, 2005, p. 552). The five steps include a) problem identification stage, b) literature search stage, c) data evaluation, d) data analysis, and e) presentation.

Problem Identification Stage

The first stage requires elucidating a purpose to set focus and boundaries for the review process. The specific question I sought to answer was: *How can a relational ethics perspective help inform a nurse's role in SDM with patients?* To achieve this, I identified *nurses* as the population of interest, *decision-making, shared decision-making, patient participation and autonomy* as the concepts and *relational ethics* as the perspective. In my area of clinical practice, a lack of patient participation in value-sensitive decision-making regarding continued ICD therapy at battery replacement indicator has been identified.

Literature Search Stage

The literature search stage was conducted using three strategies; electronic database search, ancestry searching, and networking. The following electronic databases were searched; the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature On-line (MEDLINE), PsycINFO, and the Cochrane Database of Systematic Reviews. I contacted

Dr. Dawn Stacey, an associate professor at the University of Ottawa and subject expert in this field, for access to unpublished or grey literature on the topic of nursing in SDM. She provided me with two organizational publications. The first was published by the National Academy for State Health Policy (Shafir & Rosenthal, 2012) in the United States and was focused on the state and federal implementation of SDM in clinical practice. The second, a British article endorsed by The King's Fund (Mulley et al., 2012), was concerned with the importance of considering patient preferences in treatment decisions to avoid what the authors referred to as the "silent misdiagnosis," or "preference misdiagnosis." Finally, Dr. Stacey referred me to a systematic review ahead of publication authored by Elwyn et al. (2013) regarding the implementation of patient decision support interventions into routine clinic settings and workflows. Following my careful assay, none of these publications fit within the inclusion criteria set for this review. But, they provided rich information regarding the current state of SDM in practice and enhanced the background and discussion sections of this paper.

Inclusion criteria for the selection of database retrieved articles included those written in the English language, peer-reviewed, and published from 1982 to the present. I opted to consider articles written from 1982 onwards as this was when the concept of patient participation in health care decisions was first introduced. The authors of chosen articles had to specifically address the nursing profession in the context of decision-making when adult patients with deemed decision-making capacity were faced with a choice related to clinical care. Some authors referred to nursing alone, while others considered nurses who participated in SDM as part of an interdisciplinary team. Diverse data sources were considered including philosophical and theoretical articles, empirical research, reviews and analyses. Interviews, case reports, and perspective articles were not included in an effort to obtain the most rigorous and evidence based

data possible. Articles were excluded if they made reference to nurses' roles in decision-making within the interprofessional team (without patient involvement) or within organizational decision-making. Also excluded were articles describing decision-making made in settings other than healthcare, if nurse practitioners or midwives were the primary sample identified in the article, or if professions other than nursing were investigated. Articles focused on SDM in the paediatric, elderly with dementia, and other populations unable to make informed health care-related decisions were also excluded as additional clinical considerations are required when working with these vulnerable populations. Key words used in the search included *nurse*, *nurse role*, *nursing*, *patient*, *nurse patient relations*, *patient participation*, *decision making*, *ethics*, *nursing ethics* and *relational ethics*.

A total of 322 abstracts were generated searching the databases mentioned above. Thirty-six duplicates were removed. Titles and abstracts were screened for relevance to the research topic and 67 articles were reviewed for consideration. They were all read in their entirety to confirm their eligibility. In order to maintain feasibility, an additional exclusion criteria was applied as many of these 67 retrieved articles were concerned with patients' preferences for decision-making, rather than the role of the nurse in decision-making. In the context of these articles, the nurse's role was primarily addressed in terms of practice recommendations. Since the evaluation of these proposed nursing recommendations was not the purpose of the research, these articles were excluded. With this new exclusion criteria in mind, 21 articles fit inclusion criteria. Ancestry searching revealed three appropriate articles for review, bringing the final tally to 24 articles. Of note, no retrieved article specifically addressed the nursing role in decision-making with patients facing decisions regarding ICDs.

Data Evaluation Stage

The third step, data evaluation, involves the critical appraisal of the literature in order to evaluate study quality, determine reliability and consider exclusion (Whittemore & Knafl, 2005). This was accomplished using Johns Hopkins' Evidence Based Nursing Research and Non-Research Evidence Appraisal tools (Newhouse, Dearholt, Poe, Pugh, & White, 2007) (See Appendix A). These two instruments were used to critique each selected article for its strength and quality. The authors of the John Hopkins Evidence Based Nursing model and guidelines offer clear instructions for tool selection (research vs. non-research) and scoring according to the type of article being critiqued.

While I had originally selected a timeline of 1982-present, my review of older articles revealed that nursing's disciplinary scope, perspective, and role in decision-making has progressed in recent years. Included articles were therefore read, critiqued, and analyzed in reverse chronological order. If data saturation was to be achieved, older articles would be excluded. And this was exactly the case. No new themes transpired following the review of 13 articles. Four more articles were reviewed to ensure saturation. In total, 17 articles were included in this comprehensive review and analysis.

Of the 17 manuscripts, the majority were published in the United Kingdom (5; 29.4%) and Canada (4; 23.5%). The remainder were authored in Sweden (3; 17.6%), and one in each of the United States, Australia, New Zealand, Denmark and the Netherlands. Two selected studies used quantitative methods (11.8%); one being a randomized controlled trial and the other a mixed method study. The remainder were either qualitative in nature (8; 41.1%) or non-research (8; 47.1%) in the form of literature reviews, concept analyses, and clinical practice guidelines.

In terms of clinical setting, three articles were concerned with oncology patients, two were within the confines of a nursing call centre, two others in palliative care, and one in each of

nursing home, critical care, primary asthma care, diabetes chronic care, and mental health. The five remaining articles were unspecified and simply referred to SDM in nursing practice.

Data Analysis Stage

The data analysis stage involved ordering, coding, and categorizing data to formulate a synthesis and conclusion about the original problem (Cooper, 1998). The selected articles were read in full text to obtain a preliminary understanding of the main concepts. A classification table was created to categorize important information from all data sources (eg: research problem, design, ethics, sample size, intervention, results, and strengths and limitations). This table helped me organize the information in preparation for writing a summary of each article. The summaries are included in the next section of my paper. Tentative themes were identified and I marked these with transparent markers following subsequent critical readings and reflections. A constant comparative method was used to interpret the content of text data through the systematic classification process of identifying themes, patterns, and relationships. While some themes were clearly discernable, others were more challenging to assign due to a degree of overlap.

One matrix per emerging theme was created to amalgamate significant and similar findings across sources. This strategy offered focus and structured organization for congruent findings. I further narrowed the similar "raw data" (pulled from the studies) into themes and subthemes. I can best describe this process as an inductive approach to data analysis, where I moved from particular study specific findings to generalizations. Throughout this process, a reflective journal was kept which was extremely useful with the categorization, recurrences, and critical analyses of themes. Data matrices and mind maps provided organized visual accounts of thematic development and patterning. Findings are described in the context of these themes and they will offer basis for my recommendations.

Forming the basis for this analysis stage was the amalgamation of pertinent information from each study, and the writing of a summary for each. An annotation of each selected study follows. I have chosen to include these summaries in my paper to offer readers the opportunity to understand the essence, strengths and limitations of each study included in this review. These summaries are meant to assist readers to further understand the analysis by catching a glimpse of the recurrent themes across studies.

Summary of Chosen References

Ballinger, R., Ford, E., Pennery, E., Jenkins, V., Ring, A., & Fallowfield, L. (2012). Specialist breast care and research nurses' attitudes to adjuvant chemotherapy in older women with breast cancer. *European Journal of Oncology Nursing*, 16(1), 78-86.

Ballinger et al. (2012) conducted a survey-based qualitative study. A descriptive survey was distributed to 259 breast care nurses and research nurses to find out more about their roles, attitudes and involvement in decision making regarding the offering of adjuvant chemotherapy when older women were faced with breast cancer. The authors' results supported the notion that nurses have specific skills to develop rapport and engage in discussions with patients throughout their illness trajectory. The authors found that 34.8% of breast care nurses wanted more involvement in clinical decision-making and 26.6% in patient decision-making. Only one research nurse reported wanting less involvement in both types of decision-making. Some nurses sought greater involvement as they believed to have the expertise, the time, and the willingness to support and be present for patients. In this setting, nurses offered patients explanations and clarifications of physician provided information, enhancing their comprehension and advocacy. Nurses were recognized as able

to readily and effectively convey their patients' needs to the multidisciplinary team.

Communication was identified as the major component of a successful consultation.

Despite their current involvement, 69% of nurses believed they had not received specific training to discuss chemotherapy with older patients and all believed that evidence-based training to further develop their effectiveness in decision-making would be beneficial.

Limitations of this study included a low response rate despite a mixed approach to recruitment, calling into question the representativeness of the sample. Upwards of 19% of questionnaire data fields were returned unanswered. Also, the survey was study specific and had not been tested for reliability or validity - nor had it even been reviewed by others familiar with this patient population. Ethical considerations were not addressed. While nurses' perception of older women's interest in information and involvement in SDM was addressed, the authors did not confirm whether their perceptions were accurate. The study's results may therefore be based on nurses' inherent assumptions of what older women want. The authors determined that nurses are indeed present in the process of decision-making with patients, with some nurses seeking greater involvement. The authors recommended more education to optimize nurses' contribution to decision making processes.

Barthow, C., Moss, C., McKinlay, E., McCullough, L., & Wise, D. (2009). To be involved or not: Factors that influence nurses' involvement in providing treatment decisional support in advanced cancer. *European Journal of Oncology Nursing*, 13(1), 22-28.

The authors conducted a secondary analysis of a primary qualitative study designed to understand how doctors and nurses, together with patients with advanced cancer, were involved in decision making processes. In the initial data set of semi-structured interviews

of 13 nurses, there was a great degree of variability in nursing engagement in decision-making. Nurses also reported varied responses regarding the importance, meaning, and the way in which they exercised treatment related decisional support. Following a thorough secondary analysis of nurse transcript data, the authors identified the factors that influenced nurses' attitudes when providing patients with decisional support. No framework guided the study, yet one was created based on the following factors limiting nursing involvement: degree of knowledge, level of experience, nurses' beliefs and understandings of their roles, and structural interfaces in the work setting. While the authors supported nurses' participation in decision making, the factors mentioned above hindered nurses' involvement in the provision of decisional support. The authors stated that being aware of and understanding these factors is important because it can promote the need for effective decisional support strategies in this area of practice. Of concern was a statement made by the authors in their findings: "We expected that knowledge would be an important aspect in facilitating decisional support" (p. 21). As the authors did not address bracketing or reflexivity in this article, this statement raised some questions about the influence of their preconceived notions on their analysis. Also, member checking following the analysis was not mentioned, however, it is possible that both were addressed in the primary study report. A final limitation of this study was that it was a secondary analysis. However, the authors explicitly justified the design and the small sample size given the paucity of literature on this topic.

Beaver, K., Craven, O., Witham, G., Tomlinson, M., Susnerwala, S., Jones, D., & Luker, K. A. (2007). Patient participation in decision making: Views of health professionals caring for people with colorectal cancer. *Journal of Clinical Nursing, 16*(4), 725-733.

Beaver et al. conducted a qualitative, exploratory study with in-depth interviews of 35 nurses, physicians, and allied health professionals. The authors explored the health care professionals' views of patient participation in decision making when caring for people with colorectal cancer. Policy guidelines formed the framework for the study. Ethical issues were addressed. Three distinct themes emerged from these interviews: availability of choice for these patients regarding all aspects of their care including physical and psychological care; partnerships with patients, including the assessment of who holds/wants decision-making power; and the barriers and facilitators to patient participation in decision-making.

Numerous interview quotations were included in the findings section of the article offering a degree of confirmability to the identified themes. Patients perceived choice within treatment as limited. Because treatment was viewed as the priority, choice concerning the physical and psychological dimensions of the person was never offered. I interpret this as an invitation for nurses to ensure that both these dimensions are addressed in the context of the care plan. While the majority of the participants were nurses (21/35; 60%), responses were not segregated by profession. Therefore, is it unconfirmed whether the themes are representative of one disciplinary perspective over another. Data saturation, member checking, and bracketing were not addressed. According to the authors, the participants in this study thought that policy guidelines promoting the use of SDM in practice were tempered by the reality of the environments in which they work.

Christensen, M., & Hewitt-Taylor, J. (2006). Modern nursing. Empowerment in nursing:

Paternalism or maternalism? *British Journal of Nursing*, 15(13), 695-699.

Christensen & Hewitt-Taylor's (2006) objective was to determine whether patient empowerment was taking place as health care reform in the United Kingdom was underway, or if nursing and medicine's quest for power continues to precede patients' best interests. In this article, the authors agreed with the Royal College of Nursing that empowerment is one of the nursing discipline's central tenets, but caution that "any differences of opinion between team members over patient empowerment may interfere with this function" (p. 696). The review of the literature revealed that nurses must genuinely want to relinquish control and shift the balance of power to their patients. Empowerment also required staff valuing and accepting patients' rights to make decisions regarding their care. But amongst the interdisciplinary team, the authors called upon nurses to increase their own level of power. While empowerment is often viewed as occurring between professional and patient, the authors argued that if true empowerment is going to occur, issues regarding power and control must also be addressed within the interdisciplinary team, and at meso and macro levels of health care as well. Limitations included the lack of an identified framework, a tool for appraisal, and a defined search strategy.

Florin, J., Ehrenberg, A., & Ehnfors, M. (2006). Patient participation in clinical decision-making in nursing: A comparative study of nurses' and patients' perceptions. *Journal of Clinical Nursing, 15*(12), 1498-1508.

Florin et al. (2006) conducted a qualitative, comparative design study to compare the degree of concordance between patients and nurses' perceptions of patients' preferences in clinical decision-making. They also sought to compare patients' actual level of participation in clinical decision-making in nursing with their preferred participatory role. The authors

sent out a study specific survey to 80 nurse-patient dyads examining the following dimensions of decision-making: needs of nursing care, physiological needs, psychological needs, and spiritual needs. The survey included a modified version of the Control Preference Scale (CPS) to elicit patients' preferences in decision-making. What was found was that nurses overestimated patients' preferences in assuming an active role in decision making, when in reality, patients preferred a more passive one. In addition, nurses seemed to adopt the rhetoric of patient participation but were not successful in its implementation - even if they perceived the patient wanted a more active role. Based on the findings, the authors suggested that nurses make assumptions regarding their patients' preferences for participation, and that these assumptions were often inaccurate. The authors called upon nurses to better assess their patient's preferences, which would in turn help them design and deliver individualized care. The median age, years of work experience and time of employment on the ward of the nurses in this study were all low, suggesting that they may not have had much experience in this area and would benefit from more training. The sample size originated from one unit and was small, therefore unit culture and personal characteristics could have influenced the results. The CPS scale used in the survey was manipulated, possibly hindering the validity of the scale and its findings.

Frank, R. K. (2009). Shared decision making and its role in end of life care. *British Journal of Nursing*, 18(10), 612-618.

Frank (2009) conducted a literature review of 17 qualitative articles, dating from 1998-2006, which sought to identify the extent to which SDM occurs during end-of-life care in the acute care/hospice setting. Particular attention was paid to the nurse's role in end-of-life decision-

making and factors that influence the interprofessional relationships between doctors and nurses. Overall, Frank wondered whether current processes permit or inhibit SDM during end-of-life care. Identification of these factors was important because SDM was associated with a "good death" (p. 618). Communication, accepting prognosis, information sharing, and a sense of well-being were all related to greater patient participation. In order for SDM to work, the authors found that nurses must willingly engage in the process, initiate discussions, and share power and control in the relationship. The authors cautioned against the adoption of assumptions regarding patients' decisional capacity, especially when one's condition was rapidly deteriorating. Doctors were found to be barriers to SDM, as they reportedly failed to listen to nurses who had accrued a holistic account of the patient's wishes. The authors did not mention how the studies were appraised, nor was an analysis framework offered. However, a detailed summary of the search strategy was provided enhancing reproducibility.

Registered Nurses' Association of Ontario (2006). *Client centred care*. (rev. suppl.) Toronto, Canada: Registered Nurses' Association of Ontario.

Funded by the Ontario Ministry of Health and Long Term Care, this supplement is a revision of the best practice guideline *Client Centred Care* that was originally published in 2002. In this revision, the authors included new evidence on the topic, appraised the quality of selected articles, and devised new recommendations based on the evidence. Additional information was included regarding the role of the nurse in providing decision support (eg: decision coaching, use of patient decision aids) and the importance of adequate resources and support at the meso and macro levels. Implementation strategies, such as skill-building

interventions and barriers-management strategies, were offered within this guideline.

Recommendations could be further combined with the RNAO Toolkit: Implementation of Clinical Practice Guidelines (RNAO, 2005). Experts in the field served on the revision panel, adding further credibility to the findings. This is a high quality, rigorous publication that has relevance in all areas of nursing concerned with serving the public. This is an important document for nurses wishing to heighten their understanding and practice of involving patients' in their journey of illness and health.

Rushton, C. H. (2007). Respect in critical care: A foundational ethical principle. *AACN Advanced Critical Care*, 18(2), 149-156.

Based on the literature, this article is a quasi concept analysis of *respect* in nursing practice in the critically ill population. Rushton explained that respect can be demonstrated when sharing decision-making processes, engaging in family centered care, cultural humility, and bearing witness. The author highlighted a key process named the "Council Process" which "shifts dialogue from telling to discovering, from judging to inquiring, it neutralizes conjecture, fosters the acceptance of moral conflict and protects the integrity of healthcare professionals and their organizations" (p. 153). Unfortunately, the author did not describe how this process was developed and how to implement it in practice. Despite this important omission, this is an informative article reminding practitioners of the importance of demonstrating respect towards patients and one another. The author further offered an encouraging reminder that its use is a required step towards shaping a relationally rich healthcare environment capable of offering SDM. From a methodological standpoint, the author offered very little information, making it difficult to reproduce.

Sahlsten, M. J., Larsson, I. E., Sjoström, B., & Plos, K. A. (2008). An analysis of the concept of patient participation. *Nursing Forum*, 43(1), 2-11.

Sahlsten et al. (2008) conducted a concept analysis of *patient participation* within the context of nursing practice. Rigorously following Walker and Avant's model, they explored the attributes of the concept of patient participation, and highlighted the skills, knowledge, and experience required of nurses to enable the successful implementation of patient participation in practice. The analysis was based on literature obtained from 1996-2005. Four defining attributes of patient participation were identified: established relationship, a requirement for nurses to surrender power or control, the sharing of information and knowledge, and active mutual engagement. These themes mirrored findings from a concept analysis (Cahill, 1996) conducted on the same topic 12 years earlier, enhancing reliability. Limitations to this article are inherent to Walker and Avant's concept analysis model. Limitations included the lack of clear guidelines for the literature review, and the absence of a validation phase to verify the accuracy of the identified attributes of patient participation. The article is useful to know how nurses can facilitate and activate patient participation in patient decision-making.

Silén, M., Svantesson, M., & Ahlström, G. (2008). Nurses' conceptions of decision making concerning life-sustaining treatment. *Nursing Ethics*, 15(2), 160-173.

The authors of this study used a qualitative, descriptive and inductive design to describe nurses' perceptions of decision making regarding life-sustaining treatment for dialysis patients. Following ethical approval, thirteen dialysis and nephrology nurses with 1-18 years of nursing experience in this particular area were recruited using purposeful

sampling. Semi-structured interviews were used to elicit their conceptions regarding life-sustaining treatment, communication, patient participation, and their roles in the decision-making processes in their area of practice. Results revealed that nurses were mostly dissatisfied with the decision-making process. They believed the process was characterized by uncertainty, and lacked a framework for physician and patient collaboration. They also reported that patients were not included in decision-making. Five themes emerged from the interviews: various ways of handling decision-making, lack of physician-nurse collaboration, lack of confidence in physicians, hindrance of patient participation, and ambivalence in regards to the role of the next of kin. The quality and rigour of this study were noteworthy. Adherence to a rigorous data analysis process was described in detail. Segments of raw data were included to provide a source for the researchers' synthesis. The results paralleled findings from previous studies, confirming transferability to other areas concerned with life sustaining treatments. In terms of limitations, no member checking was done, yet analysis was performed and agreed upon by three authors. The purposive recruitment strategy raised concern. There was no mention of data saturation, which raised questions about the appropriateness of the sample size. The authors did not acknowledge their assumptions. The authors suggested that future research should be concerned with defining the role of nurses in decision-making and testing models for interdisciplinary collaboration and communication.

Stacey, D., Graham, I. D., O'Connor, A. M., & Pomey, M. P. (2005). Barriers and facilitators influencing call center nurses' decision support for callers facing values-sensitive decisions: A mixed methods study. *Worldviews on Evidence-Based Nursing*, 2(4), 184-195.

The authors of this study identified barriers and facilitators that influence the provision of decision support by call-center nurses in a Canadian facility. Using a mixed method approach, the authors interviewed key informants (n=4), conducted focus groups (n=7), sent out a survey (n=54), and analyzed simulated patient calls (n=38) using the Decision Support Analysis Tool. The study was supported by the Ottawa Decision Support Framework and the Ottawa Model of Research Use, and received ethics approval from the University of Ottawa Research Ethics Board. Triangulation of data sources was completed using a conceptual content analysis method, and interview interpretation was validated by the participants themselves increasing the validity of the findings. Nurses had positive attitudes regarding their role in supporting patients facing values-sensitive health decisions. Ninety eight percent of nurses believed that nurses supporting patients stimulated them to ask more questions, which increased their involvement in decision making. Ninety three percent of nurses believed that they needed greater knowledge about supporting callers making health decisions. Facilitators of SDM included access to decisional support resources, training to recognize when callers were having difficulty and supportive organizational infrastructure. The most frequently identified barriers were difficulty using patient decision aids via telephone, lack of a structured process to guide nurses through decisional support, nurses' limited knowledge, skills and confidence in providing values-sensitive decision support, unclear program direction, organizational pressure to minimize call length, and low public awareness of the offered services. Despite nurses' positive attitudes, many changes are required at the practice and organizational policy levels to address these barriers. Limitations included nonresponse bias (survey response rate of 52.8%) and reporting bias as nurses' perception of their practice (via survey) and their

actual practice (via analyzed simulated calls) differed significantly. Call center work is very specific, and so generalizability of findings beyond this setting is questionable.

Stacey, D., O'Connor, A. M., Graham, I. D., & Pomey, M. P. (2006). Randomized controlled trial of the effectiveness of an intervention to implement evidence-based patient decision support in a nursing call centre. *Journal of Telemedicine and Telecare*, 12, 410-415.

Stacey et al. conducted a well-designed randomized controlled trial to evaluate the effect of a structured coaching protocol intervention on call centre nurses' knowledge of decision support and skills in coaching callers. Outcome measures included: the quality of nurses' coaching skills evaluated by a knowledge test, analysis of their coaching skills with simulated callers as evaluated by the decision analysis support tool, and call length. The University of Ottawa's Research Ethics Board granted ethical approval for the study. Forty one nurses in total were randomized. Twenty-one nurses were randomized to the intervention group and 20 to the control group. The intervention was comprised of a three-hour self-directed online tutorial and a 3-hour interactive skills-building workshop. Both groups completed the knowledge test at a similar time. One-month following the intervention, both groups received a simulated patient call that was independently evaluated by two blinded evaluators. Compared to controls, the intervention group nurses had more knowledge ($p=0.007$) and their coaching quality was significantly better than the control group ($p<0.001$). They were also more likely to have assessed the callers' decisional needs and were able to tailor their coaching appropriately. There was no significant difference in call duration. The majority of the group randomized to the

intervention arm agreed that the protocol was compatible with their practice. Identified barriers included: a lack of integration with their electronic charting system, the need for greater experience with decision support, and the fear of lengthening phone calls due to organizational pressures. Only 50% of recruits had been working in the call centre for more than one year, which may explain their reported need for more exposure to decision support educational opportunities. Twelve of the twenty-one (57%) nurses randomized to the intervention reported that the intervention was time consuming and labour intensive. Finally, the Hawthorne effect may have influenced the results as nurses were not blinded to the simulated calls and were aware that their approach to decision support was being evaluated. Therefore, they may have adopted a more systematic approach to the assessment of decisional conflict and provision of decisional support than if they were not observed. However, the fact that the intervention group scores were far superior to the control group suggested that even a less comprehensive and time consuming intervention can be beneficial. The authors concluded that the provision of education and knowledge exchange can positively impact nurses' ability to provide quality decisional support.

Stacey, D., Murray, M. A., Légaré, F., Dunn, S., Menard, P., & O'Connor, A. (2008). Decision coaching to support shared decision making: A framework, evidence, and implications for nursing practice, education, and policy. *Worldviews on Evidence-Based Nursing*, 5(1), 25-35.

The framework for decision coach-mediated SDM was built upon a combination of high quality publications, theory and expert clinicians' experience with decision coaching in various clinical areas. The framework is designed to demonstrate that decision coaching can

facilitate patient engagement and empowerment in SDM, and improve decision quality. The authors also discussed the development of pre and post licensure competencies for the nursing profession to enhance training and education in relation to decision coaching skills. Barriers and facilitators to decision coaching were explored. The model had already been tested for relevance in practice, and the authors have confirmed that it is transferable to various patient populations, settings, and countries. The authors concluded that nurses are well positioned to provide decisional support using decision coaching strategies, but many lack the awareness, skills, and knowledge to do so effectively. Practice environments, regulatory bodies, and educational systems can all play a part in the integration of decision coaching in clinical practice. Of great value are the concrete and feasible recommendations offered by the authors to integrate decision coaching competencies in pre and post licensure nursing education curriculums.

Stringer, B., Van Meijel, B., De Vree, W., & Van der Bijl, J. (2008). User involvement in mental health care: The role of nurses. A literature review. *Journal of Psychiatric & Mental Health Nursing, 15*(8), 678-683.

Stringer et al. (2008) conducted a literature review to examine the effects of *user involvement* in SDM processes and the methods and tools available to psychiatric nurses to measure and encourage user involvement. They aimed to answer the following questions: (a) How can user involvement be defined?; (b) What are its reported effects?; and (c) What tools/methods exist to help nurses shape user involvement? Reported effects included better care, better compliance, improved health outcomes and higher patient satisfaction. Many tools and methods exist to measure patients' decisional capacity, preferred level of

involvement, and evaluation of outcomes. While the review revealed that all key players are in agreement with the ideology of user involvement, nurses are not yet sufficiently prepared or skilled to do it. Nurses are deemed well-positioned to assess a patients' decisional capacity, and efforts to involve patients in their treatment and coaching in "any way possible and at all stages of the treatment process" (p. 682) should be taken. The authors suggested that nurses need more training in order to do this effectively. This is a well described literature review despite a few limitations. The search is replicable given the detailed account of the authors' search strategy, but a number of articles dated beyond the 10 year recommended time frame. Neither an appraisal tool, nor a framework was identified to guide the review.

Tuckett, A. G. (2006). On paternalism, autonomy and best interests: Telling the (competent) aged-care resident what they want to know. *International Journal of Nursing Practice*, 12(3), 166-173.

The author of this article called upon nurses to consider their roles and abilities to really know another person's best interest. Do nurses really know what is in their patients' best interests, and are nurses best suited to make decisions for them? This literature review was completed to determine what is needed to identify and manage residents' informational disclosure and treatment preferences. The article began with an extensive background section where the author critically analyzed paternalism and autonomy. The author proposed a very simple recommendation when treatment decisions are required: ask the patient. The author included questions to prompt practitioners when they are engaged in conversations regarding advanced directives. Similarly to other articles critiqued in the context of this

review, this recommendation endorsed the importance of communication in the patient-provider dyad to grant patients' the autonomy they have a right to hold. While the theoretical framework and methodology were not described in this paper, the author did provide a reference to a related article for this information.

Upton, J., Fletcher, M., Madoc-Sutton, H., Sheikh, A., Caress, A., & Walker, S. (2011). Shared decision making or paternalism in nursing consultations? A qualitative study of primary care asthma nurses' views on sharing decisions with patients regarding inhaler device selection. *Health Expectations, 14*(4), 374-382.

Upton et al. (2011) investigated the nature of consultations between patients and primary care asthma nurses. Semi-structured interviews with primary care asthma nurses were conducted to answer the following questions: (a) How do the nurses define SDM and what is its purpose?; (b) What do they perceive to be the barriers and facilitators of SDM?; and (c) Is there a balance of power between nurses and patients when making decisions regarding asthma devices? The topic book for the interviews was well developed (based on evidence) and the guidebook was revised as the initial interviews were conducted. The data analysis phase was thoroughly described and methodologically sound. The authors revealed that while nurses agreed with the rhetoric of SDM, its practice was not often reported. Rather, nurses viewed SDM as a tool to improve patient outcomes by increasing their adherence to prescribed treatments. Assumptions made by nurses regarding patients' treatment and involvement preferences were inherent to their consultations. Nurses also reported persuading patients to agree with their recommendation, often by giving patients the "illusion of power" (p. 379). Therefore, nurses held more power in the consultation by

virtue of their clinical knowledge. Barriers to SDM were reported as cost, time constraints, and greater importance placed on improving the patient's symptoms rather than sharing power. Facilitators to SDM included nursing education and training, visual aids, and patient information booklets. While nurses all agreed that, in principle, a SDM process should be utilized in practice, the nurses' current practice did not correlate with their beliefs. This was a well-conducted study that provided insight into a "key barrier to an equal partnership between nurses and their patients" (p. 379). The authors determined that this key barrier was nurses who assumed that symptom control was more important than shared power in consultations. Generalizability of the findings are somewhat limited given the specificity of the sample. Only the first nine interviewees were given the opportunity to verify the interpretation of their responses, but none responded. Finally, bias may have resulted from the recruitment strategy as the first nurses to volunteer were selected to participate. By way of their enthusiasm, these recruits may have had more assertive personalities, and thus may utilize a different approach in consultations with patients. Two main recommendations came from this study. The first was that a fundamental shift in the culture of the health professional and patient consultation was required and the second was that improvements in knowledge and understanding of SDM were also needed.

Zoffmann, V., Harder, I., & Kirkevold, M. (2008). A person-centered communication and reflection model: Sharing decision-making in chronic care. *Qualitative Health Research*, *18*(5), 670-685.

Using a grounded theory approach based on Glaser & Straus' (1967) reputable tradition, the authors developed a person-centered communication and reflection model based on

interactions with patients with poorly controlled diabetes. Conversations between patient-nurse and nurse-interdisciplinary team member dyads were audiotaped, transcribed, and analyzed. The sample size included a total of 11 patients and eight nurses and nurse-interdisciplinary team members. The study was approved by the ethics committee of Århus County. Methodological rigour was described in detail and validity considered at several levels through the inclusion of multiple data sources, and recording of conversations at strategic times. Measures were also taken to avoid response bias. The model demonstrated that reflection is "necessary to reach decisions" (p. 677), and the type of reflection that a practitioner engaged in affected the quality of the evidence used to make that decision. Types of reflection were identified and included situational vs non-situational, and disease-oriented vs life-oriented. They were both characterized by a "dialogic accomplishment" (p. 683). Various patterns of communication and reflection are included within the model. The authors explained how the adoption of a particular communication and/or reflection approach can either enhance or hinder meaningful and effective decision-making and problem solving. Of interest, SDM is achieved when person-specific (and contextual) knowledge is co-created and used. The role of nurses is therefore concerned with "gaining evidence" (p. 682), engaging in the right form of reflection (situational) within the right dimension (life-oriented), to empower patients and strengthen their relationship. That evidence should be based on patients' perspectives of life with illness. The authors also cautioned against the use assumptions in practice. Limitations of the study included the lack of mention of data saturation. This model has already been tested for fit, practice and relevance with diabetes practitioners, and has been used to form the basis for practice

recommendations. The authors' conclusions offered strategies in how best to shape and frame communication efforts to achieve SDM in chronic care.

According to the authors included in this review, the role of nurses has been studied in regard to key features and factors of SDM such as patient participation and autonomy. Nurses are involved in varying degrees in SDM. They are motivated to engage in SDM given the multiple reports of nurses' seeking greater involvement, perhaps because they acknowledged the good it brings to patients. "True" SDM, as described within the confines of this paper, is a contemporary movement. Given its youth in the literary realm, it is no surprise there is a paucity of high level quality research and evidence regarding the role of nursing in true SDM. The findings presented in the following section depict what roles and responsibilities nurses should adopt when sharing decisions with patients, their families and the interdisciplinary team.

Findings

Four themes regarding the role of nurses in SDM emerged from the review: (1) knowledge as basis for SDM; (2) sharing power in relationships; (3) utilization of decisional support strategies; and (4) communication. These four themes were found not to be mutually exclusive as relationships between each were apparent, and all seemed to play an integral part in the achievement of successful SDM.

Knowledge as Basis for SDM

Nurses are strong supporters of SDM (Ballinger et al., 2012; Barthow et al., 2012; Florin et al., 2006; Silén et al., 2008; Stringer et al., 2008; Stacey et al., 2008; Upton et al., 2011).

Despite nurses' adoption of SDM as rhetoric, major gaps have been identified between their intentions to involve patients and their actual ability to do so (Florin et al., 2006; Stacey et al., 2008; Stringer et al., 2008; Upton et al., 2011; Zoffman et al., 2008). It appears that a main

reason for this disparity stems from a lack of knowledge. The transfer and exchange of knowledge is a key feature of SDM. In order to support patients using a SDM approach, nurses must acquire two forms of knowledge; knowledge about SDM and patient-specific knowledge.

Knowledge about SDM.

Upton et al. (2011) suggest there is a "fundamental misalignment" between what nurses believe SDM is, and how it is enacted (or not enacted) in practice. These authors, along with several others, suggest that for nurses to develop a better understanding of SDM they need exposure to educational opportunities (Stacey et al., 2008; Stringer et al., 2008). This is in accordance with Stacey et al.'s (2005) findings that nurses' limited knowledge, skills, and confidence in SDM hindered the delivery of quality decision support. In their mixed method study of call centre nurses, 92.9% of nurses believed they needed to enhance their knowledge of decisional support to assist patrons in health decisions. In Stacey et al.'s (2006) randomized controlled trial, the effect of a structured coaching protocol intervention on call centre nurses' knowledge of decision support and skill in coaching callers was evaluated. The intervention group's nurses' coaching quality was significantly better than the control group ($p < 0.001$) as they were more likely to have assessed the callers' decisional needs, and were able to tailor their coaching appropriately according to patients' needs. And yet, 9/21 (42.9%) did not even complete the intervention. This suggests that mere exposure to education or training increases the quality of decisional support. Florin et al. (2006) found that nurses did not know how to involve their patients, even if they had expressed a desire to do so. Even previous experience, confidence, and skills in decision-making with patients were shown to influence nurses' level of involvement in decisional support. Barthow et al. (2009) reported that "experientially-gained knowledge appeared to both play a role in fostering a greater level of involvement and shape the

decisional support offered" (p. 25). Baseline information of treatment intent and regimes within the specialty area in which one works is also important to facilitate decisional involvement. Ballinger et al. (2012) identified 69% of nurses who believed education would be beneficial to improve discussions regarding adjuvant chemotherapy with older patients. As nurses become increasingly recognized as an influential force in SDM, the provision of further education and opportunities to develop their skills will be required to optimize their potential contribution in SDM.

Patient-specific knowledge.

Considering all dimensions of a person is necessary to contextualize decision support and construct meaningful decisions (Barthow et al., 2011). Zoffman et al. (2008) coined the phrase "co-creating person-specific knowledge" (p. 673) which required that nurses verify information obtained from the patient with the patient. Sahlsten et al. (2008) agreed that an exchange between patient and caregiver is required to obtain patient opinions, expectations, and experiences. To do so, the authors urged nurses to move beyond a disease-oriented perspective to a life-oriented one, as the latter focuses on the patient's response to daily life and relationships within their illness. Similarly, Beaver et al. (2007) found that treatment related decisions were prioritized, often at the cost of offering choice in physical and psychological aspects of care. Two distinct strategies to co-construct person-specific knowledge were identified in this review; through assessment and through reflection.

Accruing knowledge through assessment.

Numerous foci for assessment were identified in this review. According to Frank (2009), decision-making assessment in patients nearing end of life included their understanding and acceptance of prognosis, their wishes and expectations of treatment, and their level of decisional

capacity. Florin et al. (2006) found three dimensions of decision-making assessment: needs of nursing care, physiological needs, psychological needs, and spiritual needs. Assessing patients' informational needs was another dimension identified to provide meaningful information (Stacey et al., 2005). Stringer et al. (2008) sought tools and methods to assist and enhance decisional capacity. Their review confirmed that many tools and methods exist for nurses to simplify and objectify assessments. Tuckett (2006), on the other hand, challenged nurses' capacity to truly know another person's best interests. His literature review revealed that significant differences exist between patient and nurse perceptions of symptoms, distress and preference in decision-making. He suggested that the best way for nurses to learn their patients' informational needs, avoid paternalism, and promote best interests was to simply ask them about their preferences.

A critical barrier to objectivity in assessment was the adoption of assumptions (Beaver et al., 2007; Florin et al., 2006; Frank, 2009; Rushton, 2007; Stringer et al., 2008; Tuckett, 2006; Upton et al., 2011; Zoffman et al., 2008). Nurses often made assumptions based on patient demographic characteristics to determine patient preferences for type of treatment and for level of involvement in decision making (Beaver et al., 2007; Florin et al., 2006; Upton et al., 2011). Tuckett (2006) cautioned care providers to, "not fall prey to cultural stereotypes by assuming that all persons of a particular group ascribe to a culturally derived position" (p. 167). Perhaps the most influential foundational assumption carried by some nurses was that symptom control and disease management were more important than sharing power in consultations (Beaver et al., 2007; Stringer et al., 2008; Upton et al., 2011). The real danger in ascribing to assumptions is that nurses may oversee the opportunity to seek their patients' underlying values associated with the care plan options, missing the very essence of SDM (Upton et al., 2011).

Heightening understanding through reflection.

Reflection, the second strategy to construct person-specific knowledge, was identified by Zoffman et al. (2008). The authors discerned between situational reflection, which referred to contextual knowledge specific to a patient's situation, and non-situational reflection, referring to generalized knowledge accrued from experience and research evidence. While difficult to achieve and rarely seen in practice, Zoffman and colleagues (2008) urged both nurses and patients to move into the realm of situational reflection. If nurses remain free of assumptions, they can help patients achieve self-insight and self-awareness into their illness.

Nurses need to seek and learn these types of knowledge to become effective and genuine when sharing decisions with patients. Importantly, nurses need to consciously make the change from assuming to knowing to construct accurate patient-specific knowledge.

Sharing Power in Relationships

Respect, as an ethical principle, is foundational to the development of meaningful and productive relationships (Rushton, 2007). Established relationships are essential to patient participation (Frank, 2009; Sahlsten et al., 2008). The RNAO (2006) stated that "creating a respectful relationship that supports the client's ability to identify his/her personal needs is essential to ensuring that information is given at the appropriate time and is relevant to the client's own decision making" (p. 16). However, synthesis of the literature suggests that a fundamental flaw exists in the nurse-patient relationship, inhibiting nurses from engaging in SDM processes: nurses hold too much power (Frank, 2009; Sahlsten et al., 2008; Silén et al., 2008; Upton et al., 2011). It also appears that some nurses continue to display signs of unwillingness to relinquish power despite their ideological endorsement of patient-practitioner equality (Stringer et al., 2008). A concept analysis of patient participation conducted by Sahlsten et al. (2008) identified the surrendering of power and control as a key component to patient

participation. Therefore, another role of the nurse is to recognize their potential for dominance and establish relationships in ways to minimize this imbalance.

Powerful nurses inhibit equal partnerships.

Power imbalances were shown to be an inhibitor to patient-nurse partnerships. Frank (2009) and Silén et al. (2008) found that at the end-of-life, many patients are simply ignored and not even offered the right to decide for themselves. A nurse interviewed by Beaver et al. (2007) believed that "most patients are usually just led along the path, which has already been decided [for them]" (p. 729). Silén et al. (2008) found that some patients did not know they had the right to refuse treatment due to perceived authority in the relationship. Reason for this power imbalance was suggested by a nurse in Upton et al. 's (2011) qualitative study. She claimed that, "the nurse held the power by virtue of her clinical knowledge" (p. 378). In the same study, SDM was considered but a skill employed by experienced nurses to persuade patients and give them the "illusion of power" (p. 379). The use of persuasion was also reported by Stringer et al. (2008) at the cost of patient priorities: "Care providers are sometimes inclined to try and convince patients that they are right, sweeping aside patient priorities" (p. 680). Rushton (2007) offered a solution to solve this problem of persuasion. She stated that "clarity about the boundaries of...persuasion, manipulation and coercion is essential to respectful professional relationships" (p. 150).

According to Sahlsten et al. (2008) an established, mutual, trusting, respectful, meaningful, and connected relationship is a defining attribute of patient participation. When engaged in relationships with patients, nurses must first get to know the patient, attend to the whole person, and create opportunities for choice (Frank, 2009; Rushton, 2007). Patients cannot express their preferences if they have not been presented with options. Beaver et al. (2007)

observed that patients who ask about options are more likely to be offered them. Yet, those who do not ask may be patiently waiting for the invitation. Finally, providing patients with knowledge about their health, illness and treatment options affected their level of empowerment. Christensen & Hewitt (2006) stated that "knowledge is a tool of power" (p.696), but its true influence on empowerment lied in the information's quality and in the context in which it was given.

Nurses must be committed, willing, and confident to share power, authority, and knowledge with patients (Frank, 2009; Sahlsten et al., 2008; Upton et al., 2011). Surrendering control was found to be necessary to enable patient participation. When patients are granted control, they are more willing to act and think independently (Stringer et al., 2008).

Benefits of patient empowerment.

Nurses' recognition of the benefits of patient empowerment and participation can motivate this shift in power. Upton et al. (2011) found that nurses appreciated the value of SDM as they believed it gave patients ownership of the decision. For patients, a sense of personal control increased self-esteem, improved well-being, and decreased stress (Ballinger et al., 2012). Sahlsten et al. (2008) further recognized that a sense of control resulted in patients taking greater responsibility for their health and demonstrated better adherence to their prescribed treatment plans. Within the confines of established relationships, nurses must assess to which degree patients want to participate. Beaver et al. (2007) made an important distinction and suggested that even though patients want to feel involved and be guided in the right direction, the majority of them do not want to bear the responsibility of making the decision. Florin et al. (2006) found that no patient (out of 80) chose self-determination as their first choice of decision making preference. The majority of their sample (36%) preferred a collaborative role with the health care team.

Equalizing power within the interdisciplinary team.

A power imbalance also exists within the interdisciplinary team. In this case, however, nurses believed they were subordinated by physicians. A nurse in Barthow et al. (2009) reported "if it was simply a nurse's opinion versus a medical opinion...the medical opinion would be held as weightier" (p. 25). Frank (2009) concurred that nurses have little input in decisions: "Doctors make the decisions and nurses have to act upon them" (p. 617). Such beliefs hindered and prevented patient and nurse participation in SDM (Frank, 2009). Christensen & Hewitt-Taylor (2006) believed that nurses' subsidiary position to physicians prevents them from empowering others because they are "less powerful than those working against it [empowerment]" (p.696). The RNAO (2006) recommended that organizations shift their focus to remove these power barriers and include structures that allow for the sharing of power.

Role of nurse in achieving balance.

If patients, nurses and the remainder of the interdisciplinary team are to work as partners, nurses must make every effort to equalize the power imbalance by establishing relationships founded on respect (Rushton, 2007). However, Sahlsten et al. (2008) warned that "a desire to relinquish a degree of power seems to be no longer sufficient" (p. 9). Beyond that, sharing decision making power is not only a mandate to share information and take patient values and preferences into consideration. Perhaps even more challenging, is acquiescing to the informed choices patients make even if we do not agree with them (Rushton, 2007). Christensen and Hewitt-Taylor (2006) further enforced this notion by stating that the most important skill required in empowerment is to enable patients to make informed choice that accord with what they, not what healthcare staff, want and see as important.

Utilization of Decisional Support Strategies

It is within the scope of nursing practice to support patients in decisions regarding their health. When patients are considering their options, many can experience a sense of uncertainty with the decision they are facing (Stacey et al., 2006). If decisional conflict persists, it can eventually lead to decision regret and poor outcomes. Many strategies exist to offer patients in this uncertain state the opportunity to deliberate and explore options with a neutral facilitator. Two of the most reported and effective strategies are decision coaching and PDAs, which are both described here.

Decision coaching.

Patients facing value-sensitive decisions often need support as decisions of that nature can lead to decisional conflict (Stacey et al., 2008). Decision coaching offers one-to-one guidance by a trained facilitator, using a stepwise process. The facilitator must be supportive, but non-directive with respect to the decision (Stacey et al., 2005). Rushton (2007) concurs: "Under conditions of uncertainty, neutrality must guide our interactions" (p. 151). Decision coaches clarify values with the evidence-based outcomes of the presented treatment options and guide patients through the process of decision making (Stacey et al., 2008).

The IP-SDM model devised by Légaré and colleagues (2011) included the role of decision coach to help support patients facing value-sensitive decisions. Many researchers have concurred that nurses are well positioned to identify decisional conflict and provide decisional support using decision coaching strategies (Barthow et al., 2011; Frank, 2009; RNAO, 2006; Stacey et al., 2005; Stacey et al., 2008). Strategies include clarifying decisions and monitoring needs, facilitating access to evidence-based information, verifying understanding, clarifying values, building skills in deliberation, communication, and monitoring progress with decision-making. Stacey and colleagues' (2008) tested their model of decision coaching mediated SDM.

They demonstrated that decision coaching facilitated patient engagement and empowerment increased patient satisfaction, and improved decision quality.

Using a mixed methods approach, Stacey and colleagues' (2005) investigated barriers and facilitators to the provision of decision support by call-center nurses. More than 98% of nurses agreed that if patients received decisional support, they were more likely to ask questions and be actively involved in making the decision. The same authors also revealed that organizational structures and support are key components in the provision of decisional support. Nurses' degree of knowledge and level of experience influenced their provision of decisional support (Barthow et al., 2009).

Patient decision aids.

Decisional support can be enhanced using PDAs as adjuncts to the consultation (RNAO, 2006). They are tools that help people become involved in decision making by making explicit the decision that needs to be made, providing evidence-based information about the options and outcomes, and by clarifying personal values (RNAO, 2006). Assisting and supporting patients in the navigation of these aids is well within the scope of nursing practice. The RNAO (2006) encouraged nurses to use PDAs to provide structured decision support. Nurses can coach patients to review these aids in preparation for the clinical encounter with their physician. This cost-effective measure has shown to permit maximization of time when patients meet with their physicians. The utilization of PDAs in practice does not, however, equate with SDM as the latter is a process. PDAs are simply an adjunct to SDM-guided consultations.

Communication

None of the roles described above could be carried out without the use of communication. An exchange of information is necessary for nurses to be privy to patients'

values, preferences and beliefs. Engaging in dialogue, asking non-leading questions with openness can reveal individuals' thoughts towards the decisions they face. Respectful communication is indispensable with both the patient and the remainder of the interdisciplinary team. Creating respectful dialogue is best described by Rushton (2007). She stated that it requires "shifting from telling to discovering, from judging to inquiring, and from blaming to uncovering" (p. 153). Respectful and focused dialogue is a bridge to greater mutual understanding and moral action.

With the patient.

Patients' interests cannot be truly served unless efforts are made to determine what they value, what they hope to achieve, and how they wish to get there (Tuckett, 2006). Clarifying these terms is best sought through respectful dialogue (Rushton, 2007). Nurses surveyed by Ballinger et al. (2012) believed that the manner in which the message is delivered influenced the success of the conversations that ensued.

Nurses have long been considered mediators, or translators, of information previously provided by the medical team. In SDM, the nurse can provide explanations and clarifications as they have the skills to explain treatment options, assist with information processing thereby increasing comprehension (Ballinger et al., 2012). Frank (2009) conducted a literature review on SDM and how it is used in end-of-life care. He found a key link between a patient's participation in decisions and the communication and information sharing skills of the practitioner. Non-verbal communication was equally as important. If tone and body language suggested disinterest or time constraints, patients chose a more passive role in decision-making. Zoffman et al. (2008) had similar findings in that difficulties with decision-making were central to communication. Nurses' lack of clarity or direction for intended conversation resulted in unfocused conversation,

and thus wasted time. Focused communication was integral to the achievement of mutual situational reflection. Another key component of dialogue was that it must be ongoing as SDM is considered a process (Ballinger et al., 2012; Florin et al., 2006; Rushton, 2007; Sahlsten et al., 2008; Stringer et al., 2008). Preferences in accordance with treatment options and outcomes are context dependent and it was agreed amongst these authors that they can shift over time.

Within the interdisciplinary team.

For an interdisciplinary team to function successfully, effective communication between nurses, physicians, and other health professionals is indispensable (Silén et al., 2008). Within the context of life-sustaining treatment, Silén et al. (2008) ascribed nurses' perception of lack of communication to "the paucity of discussion between the two groups regarding decision-making" (p. 164). If exchanges do not occur, information cannot be transferred. Inadequate communication can lead to insufficient physician-nurse collaboration, and misunderstanding of each other's roles and responsibilities (Silén et al., 2008). Educating nurses to be competent interdisciplinary team members is held to be foundational to fostering quality care (IOM, 2003). Nurses were perceived as an important force in the communication of patient needs to the multidisciplinary team (Ballinger et al., 2012). Frank (2009) found that nurses can impact the ultimate decision when they advocated their patients' wishes to the physicians.

Barthow et al. (2009) found that a "lack of clarity about treatment goals caused nurses to feel reticent to provide information or discuss treatment decisions" (p. 24). If nurses are not made aware of the treatment plan, then their ability to successfully engage in SDM is limited. However, "when the goals were clear, it was easier for the nurses to accept the decisions, even if they did not agree with them" (Silén et al., 2008, p. 167). The lack of consensus between professions can be sensed by patients, and can possibly hinder trust and quality care. The

growing importance of interprofessionalism in SDM requires strategies and commitment from all those involved to enhance and maximize communication between all team members.

Discussion

Relational ethics and SDM complement each other well, as they both require entering into relation and being in collaboration with others. All relationships carry a degree of ethical responsibility. A relational approach to decision-making pushes the boundaries of traditional decision-making. SDM, through a relational lens, requires nurses to let go of certainty, acknowledge variability in perspective and desires, and seek to understand the patient's moral experience by asking fundamental questions. "Through genuine engagement with the other's experience, the moral decision-making process is rendered ethical, not by virtue of the outcome, but by virtue of the relational process through which the decision came to be made" (Wright and Brajtman, 2011, p. 24). This relational process occurs through open dialogue, and can be achieved using relational ethics' fundamental themes of environment, embodiment, mutual respect, and engagement as a guide (Bergum, 2013).

Many patients facing ICD replacement may enter this relational space adopting a patient discourse, never challenging or questioning recommendations. For others, the increase in democratic thinking has people more cognizant of their rights, demanding information and expecting choice. When establishing the relationship, the nurse should extend an invitation and lead patients into the space to exchange knowledge, assess for decisional conflict and offer support - all within a relationship founded on equality. Strategies such as decision coaching and PDAs exist to support patients in their decision-making processes, both falling within nurses' scope of practice (Légaré & Stacey, 2009; O'Connor, Stacey, & Légaré, 2008; RNAO, 2006; Shafir & Rosenthal, 2012). Using these strategies could inform patients of the evidence behind

continued ICD therapy and alternatively, its discontinuation. They can also reduce clinician variability in the type and quality of information that is presented to patients. Some patients have reported only truly understanding the risks and side effects of ICD therapy following initial implantation, leading to possible changes in values and preferences about the treatment when replacement looms (Matlock et al., 2011). Psychological factors can also affect ICD acceptance and influence a patient's decision to have it replaced. SDM is considered a process, and nurses must be prepared to support patients as they vacillate between choices as contextual circumstances vary.

In accordance with the findings from this review, the Heart Rhythm Society's expert consensus statement on the management of ICDs in patients nearing end-of-life, or requesting withdrawal of therapy, call upon those involved in the care of ICD patients to improve their communication techniques, commit themselves to ongoing education and, despite its complexities, be prepared to accept refusals or deactivation requests (Lampert et al., 2010). Similarly to Zoffman et al.'s (2008) result of needing to move from a disease-oriented perspective to a life-oriented one, the Heart Rhythm Society also addressed the need to move from treatment-directed conversations to goal-directed ones (Lampert et al., 2010). "Without a better understanding of their current state of health and the role that the CIED [cardiovascular implantable electronic device] plays within it, patients cannot make fully informed decisions" (Lampert et al., 2010, p. 1015).

As practitioners, we must ask ourselves, have we offered patients all the information they needed, and have we helped them explore the meaning of it in terms of their own lives? Did we listen to their responses? And finally, did we respect their preference? Assumptions can often prevent this from happening. Readily generated and disguised as knowledge, assumptions can

deprive a patient of the relational experience necessary to explore their honest preferences and beliefs in accordance with the options. Patients' narratives may be offered but not heard, hindering the design and delivery of meaningful interventions. Zellner, Aulisio, and Lewis (2009, as cited in Lampert et al., 2010) remind us that "patients' decisions have priority over practitioners' decisions" (p. 1012). Mulley et al. (2012) called upon practitioners to aspire to the same standards as diagnosing disease when diagnosing what patients want. They have named it "preference misdiagnosis," or "silent misdiagnosis" and this occurs when practitioners assume they know what patients want in treatment.

In their qualitative, descriptive survey-based study, Lewis and Birnie (2013) suggested that preference misdiagnosis occurs at ICD battery replacement. Of 106 respondents who underwent ICD battery replacement in the previous three years, the majority (55/106, 51.9%) of patients were unaware that ICD replacement was non-obligatory. If given the option, 15/55 (27.2%) of them stated they would have considered not replacing the ICD at battery change. Furthermore, 88/106 (83.0%) respondents stated it was "important" or "very important" to discuss all pros and cons of continued device therapy before making a decision about future replacement. Nurses and physicians were also surveyed, and reported discussing the non-compulsory nature of ICD battery replacement with less than 20% of patients presenting with depleting batteries. Nurses engaged in these conversations less than 5% of the time, and physicians 26% of the time. Sixteen (17/18, 94.4%) health care providers acknowledged the need for more discussion. Given the number of patients who place importance on the receipt of meaningful information regarding continued device therapy, and the 15.4% (15/106) of patients who would not have considered replacing their ICD if they had known, suggests that current practices must improve. Conducting surgery on a patient who would not want an operation is "as

ethically dubious as anything that happens in medicine" (Mulley et al., 2012, p. 7). This statement should be kept in mind when in consultation with patients facing ICD battery replacement surgery.

What is difficult to appreciate given the current status of the literature on this topic, is which of the nursing roles and responsibilities identified in this paper is most influential to successful SDM. Future researchers in this area can aim to answer this important question.

A primary goal of SDM is to offer patients a high quality decision, characterized by information, reflecting personal values, acted upon with satisfaction and free of coercion. "Decisions are never certain, but through careful moral reasoning they are nonetheless probably, reasonable, wise, prudent, and balanced" (Hermesen & Ten Have, 2005, as cited in Wright & Brajtman, 2011, p. 26).

Limitations

It is important to note some limitations inherent to the studies included in this review. First, authors of seven studies did not identify a philosophical or theoretical framework (Ballinger et al., 2012; Barthow et al., 2009; Christensen & Hewitt, 2006; Florin et al., 2006; Frank, 2009; Rushton, 2007; Stringer et al., 2008). Ethical considerations were addressed in all but one qualitative survey study (Ballinger et al., 2012). This omission could be explained by either the authors considering the return of a completed survey as implied consent, or due to publication spatial constraints.

The sample sizes were small in many of the qualitative studies, and this was especially concerning when the authors did not confirm achievement of data saturation (Beaver et al., 2007; Silén et al., 2008; Zoffman et al., 2008). In other studies, participants had limited experience in the field being studied. In Florin et al.'s (2006) study, nurses had worked in the nursing

profession for a median of 1.5 years. In Stacey et al.'s (2006) randomized controlled trial, just under 50% of recruits had been working at the call centre for less than one year. A lack of experience rather than external factors may have influenced their results. None of the authors of the five literature reviews identified an appraisal tool to evaluate selected articles. A description of their search strategies was also omitted in three of them, hindering reproducibility (Christensen & Hewitt-Taylor, 2006; Stacey et al., 2008; Tuckett; 2006).

Reporting bias was identified as another limitation in some studies, particularly in the survey and interview based ones, as participants may have been more likely to provide socially desirable responses (Ballinger et al., 2012; Beaver et al., 2009; Florin et al., 2006; Stacey et al., 2005; Upton et al., 2011). This was specifically noted by Stacey et al. (2005) as their patients' survey responses significantly differed from the objective measures obtained from performance audits.

There may be a degree of researcher bias that influenced the findings as reflexivity and bracketing were not addressed by authors of two of the descriptive qualitative studies (Barthow et al., 2009; Silén et al., 2008). Many authors focused on the factors limiting nurses' involvement in SDM. What is less clear is which of the many factors explored most directly and most strongly influences nurses' involvement.

Many of the authors quoted limited generalizability and transferability of their findings due to the specificity of their studied settings and populations. But, given the identification of similar themes across populations, this review's results hints at the possibility of nurses holding similar roles in decision-making regardless of the setting and patient population for whom care is being provided. Stacey et al. (2008) are the only authors to have confirmed transferability of

their decision coaching support model across clinical environments, patient populations, and countries.

The credibility of the findings are for the most part rigorous, but in the qualitative interview studies conducted by Barthow et al. (2009), Beaver et al. (2007), Silén et al. (2008), and Stacey et al. (2005), member checking did not occur to validate the interpretation of the findings. Arguably, in Stacey et al.'s (2005) mixed methods study triangulation could have provided confirmation of the findings. Upton et al. (2011) were the only authors who reported sending a synopsis of the emerging themes to some, but not all, of their participants (9/20; 45%). They invited recruits to comment on their interpretations but none did.

I believe the findings of these studies to be sufficiently rigorous to be included in this review. They were all are peer reviewed, and those which involved human subjects maintained ethical integrity, except for one study (Ballinger et al., 2012) in which authors did not address ethical considerations. Researchers had similar findings, thereby contributing to an increased understanding of the role of nurses in SDM.

Implications for Practice, Education and Research

Following this comprehensive review and analysis, and based on my experience working with patients with ICDs, I have formulated recommendations for nurses who work with patients with ICDs. This is especially applicable for those who are involved in the identification of depleting ICD batteries, and those who assist in this patient population's care management.

1. Incorporate the values and beliefs of patient-centered care when establishing and developing therapeutic relationships with patients.

2. Develop partnerships with patients based on equality. Offer choice, and engage them in focused conversation to clarify values, beliefs, and preferences in accordance with their preferred level of involvement in decision-making.
3. When patients are nearing ICD battery depletion (as early as one year prior to depletion), revisit or initiate advanced care planning. Inform patients about the option of not replacing their device. Ideally, conversations of this nature should not be rushed, permitting enough time for reflection (or decisional support if required) prior to coming to a decision.
4. Assess for signs of uncertainty and/or decisional conflict. If identified, offer decisional support by adopting a decision coaching role.
5. Self-identify gaps in knowledge of SDM and of ICD therapy, and seek literature and resources to enhance knowledge base. Examples of skill-building decision support interventions include:
 - i) Self-directed Ottawa Decision Support Tutorial that can be retrieved from www.ohri.ca/decisionaid (Ottawa Hospital Research Institute, 2013)
6. Develop competencies for nurses to integrate SDM into the clinical setting. Begin by exposing nurses to the main concepts of decision support, decisional conflict, and its modifiable factors. Then, immerse nurses in SDM by providing education and skill development opportunities such as the online tutorial mentioned above, or skills building workshops. Once SDM is integrated into the clinical setting, assess nurses' competence in the provision of quality decision support and offer enhanced learning opportunities as required.
7. Create and maintain a practice environment that fosters and supports interprofessional SDM. Identify and train a SDM nurse champion who can be readily accessible to all nurses to help promote SDM in clinical practice.

8. Develop a protocol and implementation checklist for patients presenting or nearing ICD battery replacement. These guidelines should address clinical, ethical, and logistical aspects of ICD replacement including key players, their roles and responsibilities, items to be discussed, expectations for documentation, and involvement of other disciplines (eg: psychologist, neuropsychologist, palliative care team, institutional ethics committee) in the event of unresolved decisional conflict.
9. Review current organizational policies to reduce barriers in the practice environment and facilitate opportunities for the provision of nursing-based decisional support.
10. Integrate SDM and decisional support learning opportunities within the nursing orientation for incoming device clinic nurses.
11. Provide learning opportunities and access to educational resources on SDM for current employees.
12. Create, evaluate and implement a PDA in collaboration with the interprofessional team and field experts in SDM for patients facing a decision regarding ICD replacement.
13. Develop a SDM clinic specifically for patients in decisional conflict regarding continued ICD therapy. Identified patients would be referred to the SDM clinic from the device clinic. The SDM clinic would be run by a nurse and physician. In this setting, a greater amount of time could be spent with these patients without feeling pressured to meet organizational expectations.

Dissemination of Findings

The findings from this review are presented in the form of this written report and will be presented orally as partial fulfillment for the degree of Master in Nursing. Ideally, I would like to work towards the publication of a manuscript. The review was conducted to seek and highlight

the role of nurses in SDM processes. Practice, education, and research recommendations are offered specifically for nurses, yet are meant to be considered by the entire device clinic team to encourage a collaborative interdisciplinary approach for the management of patients facing decisions regarding ICD replacement. Hopefully, integration of the recommendations into practice will be considered in our institution.

Conclusion

My goal for this review was to localize the role of the nurse in SDM processes using a relational ethics lens, specifically at ICD replacement. SDM, in and of itself, is a contemporary movement and defining the role of the nurse in its implementation in practice has been understudied. The inclusion of relational ethics in the advancement of our understanding of SDM is an important contribution to our continued study of philosophies, theories and concepts that help clarify and advance SDM's applicability to nursing practice. This may promote a shift in practice and make relational decision-making a reality for patients. My comprehensive review and critical analysis has confirmed that indeed, nurses have, and are willing to endorse, the ideology of SDM. They are well positioned to engage in it, and with the adoption of certain roles and responsibilities, are able to successfully provide it.

Towle, Godolphin, Grams, and LaMarre (2006) acknowledged that genuine SDM in practice is often difficult to achieve. It appears more as an ideal, far from reality, in the everyday practice of clinicians, nurses and experiences of patients. Nurses are generous beings; they have always been willing to share their time, expertise, and selves. It is no surprise that they are willing to share the decision-making process as well.

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Appendix A

Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal

Evidence Level: _____

ARTICLE TITLE:				NUMBER:	
AUTHOR(S):				DATE:	
JOURNAL:					
SETTING:			SAMPLE (COMPOSITION/SIZE)		
<input type="checkbox"/> Experimental	<input type="checkbox"/> Meta-analysis	<input type="checkbox"/> Quasi-experimental	<input type="checkbox"/> Non-experimental	<input type="checkbox"/> Qualitative	<input type="checkbox"/> Meta-synthesis
Does this study apply to the population targeted by my practice question?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If the answer is No, STOP here (unless there are similar characteristics).					
Strength of Study Design					
<ul style="list-style-type: none"> • Was sample size adequate and appropriate? • Were study participants randomized? • Was there an intervention? • Was there a control group? • If there was more than one group, were groups equally treated, except for the intervention? • Was there adequate description of the data collection methods? 				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Study Results					
<ul style="list-style-type: none"> • Were results clearly presented? • Was an interpretation/analysis provided? 				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Study Conclusions					
<ul style="list-style-type: none"> • Were conclusions based on clearly presented results? • Were study limitations identified and discussed? 				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
PERTINENT STUDY FINDINGS AND RECOMMENDATIONS					
Will the results help in caring for my patients?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

Evidence Rating (scales on back)

Strength of Evidence			
Quality of Evidence (check one)	<input type="checkbox"/> High (A)	<input type="checkbox"/> Good (B)	<input type="checkbox"/> Low/Major flaw (C)

Johns Hopkins Nursing Evidence-Based Practice Non-Research Evidence Appraisal

Evidence Level: _____

ARTICLE TITLE:		NUMBER:	
AUTHOR(S):		DATE:	
JOURNAL:			
<input type="checkbox"/> Systematic Review	<input type="checkbox"/> Clinical Practice Guidelines	<input type="checkbox"/> Organizational (QI, financial data)	<input type="checkbox"/> Expert opinion, case study, literature review
Does evidence apply to the population targeted by my practice question?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If the answer is No, STOP here (unless there are similar characteristics).			
Systematic Review			
• Is the question clear?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Was a rigorous peer-reviewed process used?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are search strategies specified, and reproducible?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are search strategies appropriate to include all pertinent studies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are criteria for inclusion and exclusion of studies specified?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are details of included studies (design, methods, analysis) presented?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are methodological limitations disclosed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are the variables in the studies reviewed similar, so that studies can be combined?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clinical Practice Guidelines			
• Were appropriate stakeholders involved in the development of this guideline?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are groups to which guidelines apply and do not apply clearly stated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Have potential biases been eliminated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Were guidelines valid (reproducible search, expert consensus, independent review, current, and level of supporting evidence identified for each recommendation)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are recommendations clear?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organizational Experience			
• Was the aim of the project clearly stated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Is the setting similar to setting of interest?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Was the method adequately described?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Were measures identified?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Were results adequately described?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Was interpretation clear and appropriate?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Individual expert opinion, case study, literature review			
• Was evidence based on the opinion of an individual?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Is the individual an expert on the topic?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Is author's opinion based on scientific evidence?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Is the author's opinion clearly stated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Are potential biases acknowledged?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
PERTINENT CONCLUSIONS AND RECOMMENDATIONS			
Were conclusions based on the evidence presented?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Will the results help me in caring for my patients?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Quality of Evidence (scale on back):

Basic quality rating of the study under review (check one)	<input type="checkbox"/> High (A)	<input type="checkbox"/> Good (B)	<input type="checkbox"/> Low/Major flaw (C)
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