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Rethinking Decision Quality – Measures, Meaning, and Bioethics. *Peter H. Schwartz and Greg A. Sachs. 2022¹*

Short summary

In this article Schwartz and Sachs examine different ways to measure decision quality in medicine and discuss the extent to which these approaches can be said to improve decision-making and informed consent. Three types of measures are analyzed with a view to demonstrating their strengths and weaknesses with regards to determining decision quality. While all the measures capture important aspects of decision-making in medicine, they fall short in terms of consistently assessing the quality of decisions in medicine.

Introduction

Schwartz and Sachs examine three types of measures designed to assess decision-making quality: a) Subjective measures, including the Decisional Conflict Scale (DCS) and the Decisional Regret Scale; b) Observational Measures, including the Informed-Decision-Making Scale and the Observing Patient Involvement in Decision Making scale (OPTION); and c) Informed Concordance Measures, including the value concordance approach. The advantages and disadvantages of each approach are analyzed to determine its implications for decision quality.

- a) ***The Decision Conflict Scale*** measures the individual patient's satisfaction with their medical care by asking them to rate their approval on sixteen Likert-scale questions. A lower score appears to be associated with higher satisfaction with care and lower decisional anxiety. However, the downside of this measure is that the score is subjective and entirely based on the individual patients' feelings and opinions. As such, this measure does not indicate what the patient actually knows, but only what the patient feels they know about the treatment when making a decision. Although patient satisfaction is relevant for decision quality, it is not in and of itself a measure of decision quality. For example, a patient might have a high level of knowledge about a decision, but still feel uninformed, and this will impact the score on the DCS. Another subjective measure is the Decision Regret scale, where the patient is asked to indicate whether they feel they made the right decision or if they regret the decision they've made around medical treatment. The problem with this type

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of measure is that it does not consider risks and/or unforeseen complications, which may impact the patient's score on the Decision Regret Scale.

- b) **Observational measures** such as the Observing Patient Involvement in Decision Making scale (OPTION) measure informed decision on basis of observation of recorded patient-provider conversations. Two observers review the recordings and score the provider's efforts in provision of information about alternative treatments and management options as well as their ability to support the patient in their deliberation around the available treatment options and the associated risks and benefits. Extensive discussion of all issues tends to provide a better score for decision-making. However, the measure fails to consider recurrent patient-provider interactions where the patient is already familiar with risks of, for example, mammogram screening. In such cases the patient might make a well-informed decision, but the measure would automatically score the interaction as poor because the provider does not go over all the details. Furthermore, some patients may prefer to limit their information gathering, which would lead to a low score on the decision-making scale. An extended and explicit discussion between the patient and the provider is therefore not necessarily reflective of the quality of the decision-making process.

- c) Informed concordance measures what a patient actually knows about a given medical treatment or intervention versus what they feel they know. The purpose of informed concordance measures is to determine or measure whether the patient received the intervention that is aligned with their preferences and/or values. If a person chose a treatment or medical intervention that is in line with their values they have received value concordant care. The downfall of this approach to measuring decision quality is that it requires an evaluation of the patient's values to measure if a patient has adequate knowledge to make an informed decision. Moreover, it is necessary to know the patient's values in depth to evaluate if a given medical treatment or intervention is value concordant.

Conclusion

The three types of measures reviewed in this paper capture important aspects of decision-making. The Decision Conflict Scale provides insight into the patient's feeling and experiences; the Observational measures provide insight with regards to the quality of communication between patients and providers; and the Informed Concordant measure reflects about the alignment between the patient's understanding of facts and their personal values. However, each measure has its limitations with regards to evaluating decision quality. Therefore the authors conclude: 1) No single measure is able to fully capture the idea of decision quality; 2) decision quality can only be referred to in broad categories as either "poor", 'satisfactory', or 'good'; 3) research efforts to improve patient autonomy and decision-quality should focus on identifying and addressing cases of 'poor' decision quality rather than seeking to improve the average score for decision quality.