

Information about the Critically Appraised Topic (CAT) Series

The objective of the Doctor of Nursing Practice (DNP) program at George Mason University is to prepare graduates for the highest level of nursing practice. Emphasis is placed on evaluating and applying the evidence that supports practice, understanding and creating practice delivery systems based on patient outcomes, and assuming leadership roles in practice settings. Graduates of the program will be able to assume many roles in the health care system, including direct patient care, clinical nursing faculty, practice management, and policy development.

All DNP students take an evidence-based practice course titled Evidence Based Practice in Nursing and Healthcare (NURS 883). This hallmark course for the DNP program builds on knowledge of research methodologies to analyze the selection and evaluation of research underlying evidence based practice. Emphasis is placed on the translation of research in practice, the evaluation of practice and the improvement of the reliability of health care practice and outcomes.

The first assignment students complete is a Critically Appraised Topic (CAT). CATs are mini-systematic reviews and considered a snapshot of the literature on a topic of interest. Students critically appraise literature related to a focused clinical question and summarize the best available research evidence on the topic of interest. CATs conclude with clinical bottom lines for practitioners to quickly take away for consideration in practice.

The CATs published in MARS (Mason Archival Repository Service; mars.gmu.edu) are submitted by students after they have been reviewed, revised, and approved by their instructor. All CATs are current at the time of original publication but will not be updated over time.

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Critically Appraised Topic
NURS 883

PICOT Question: Does family pressure for non-disclosure of a cancer diagnosis interfere with patients' ability to cope?

Name of Reviewer: Christine Althoff

Date of Review Completed: February 22, 2013

Search Strategies and Results: EBSCO HOST search engine was used to search: a) CINAHL, b) PsychINFO databases. Terms used: "cancer, family communication and culture," which yielded nine articles from 2005 to 2012. Three quantitative studies were selected. Six qualitative studies with a lower level of evidence were eliminated.

Evidence Retrieved:

Back, M., & Huak, C. (2005). Family centered decision-making and non-disclosure of diagnosis in a South East Asian oncology practice. *Psycho-Oncology, 14*, 1052–1059. doi: 10.1002/pon.918

Chan, W. (2011). Being aware of the prognosis: How does it relate to palliative care patients' anxiety and communication difficulty with family members in the Hong Kong Chinese context? *Journal of Palliative Medicine 14* (9), 997-1003. doi: 10.1089/jpm.2011.0099

Fujimori, M., Akechi, T., Morita, T., Inagaki, M., Akizuki, N., Sakano, Y. & Uchitomi, Y. (2007). Preferences of cancer patients regarding the disclosure of bad news, *Psycho-Oncology, 16*, 573–581. doi: 10.1002/pon.109

Back and Huak (2005) completed a 12 month prospective audit of 369 new patients to a single Western trained oncologist practicing in Singapore. Data collected included demographics, tumor details, treatment plan and decision making process. At the first visit, staff interviewed family to collect demographic information. Request for non-disclosure of diagnosis (NDD) by family some times occurred at this time. Patient was queried of their understanding of the medical condition and invited to participate in the decision making process. If the patient declined, family did subsequent decision-making. If the patient was non-English speaking, bilingual family members acted as interpreters. Study endpoints were NDD of diagnosis and prognosis. Univariate and multivariate logistic regression analyses were performed on all potential variables. NDD of diagnosis

occurred in 17.6% (n=66) patients. NDD of prognosis occurred in 36.8% (n=166) patients. Univariate analysis of the data in the NDD for prognosis group identified the following characteristics: advanced age ($p < 0.001$, OR = 5.5, 95% CI 3.4–8.6), female, non-English speaking ($p < 0.001$, OR = 6.0, 95% CI 3.4–10.7), palliative treatment aim ($p < 0.001$, OR = 3.6, 95% CI 2.3–5.6), and short-term median survival ($p < 0.001$, OR = 4.3, 95% CI 2.6–7.1). Family initiated NDD in 58 of the cases.

Strengths: The intake process included an assessment of each patient’s knowledge of medical condition and invitation to participate in decision-making encouraged patient autonomy. There was clarification of family members to act as the (DM) decision makers. The data was collected on intake process as opposed to other studies that interviewed or surveyed healthcare professionals. This audit of patient data was able to identify that elderly, non-English speaking patients with shortened prognosis were significantly more likely to be in the family initiated NDD group. The discussion section explained the concept of family centered decision-making being part of the “principle of autonomy exists, but it is interpreted as concepts of the family rather than self-determination” (Back & Huak, 2005).

Limitations: There was no assessment of economic status or education level, which could influence behavior, and the decision to use the traditional family centered approach. The use of a family member as translator creates bias in the information presented to the patient. A patient who prefers to be involved with decision-making may not be provided all information when family serves as the translator.

Chan (2011) performed clinical data mining of medical records from patients who died in a palliative care unit in a public hospital in Hong Kong between 2003-2005 was used in this study to examine the relationship between prognosis and communication. Chan (2011) stated, “this study aimed at exploring the relationships among patients’ awareness of prognosis, family members’ awareness of prognosis, and two psychosocial outcomes of patients: patients’ anxiety and communication with family members”. Demographic data was collected. Independent variables included Palliative Performance Score (PPS), level of financial difficulty, family’s and patients insight into prognosis. Dependent variables or outcomes included patient’s anxiety level and communication between patient and family. Support Team Assessment Schedule (STAS) was used to measure other variables like financial difficulty, patient/family insight into illness, patient anxiety and family communication. The STAS tool reliability and inter-rater reliability was satisfactory. Using SPSS, logistic regression was used to evaluate the relationship between patients’ and families’ insight into prognosis with anxiety level and communication of family members. Patients who were less aware of prognosis were associated significantly with anxiety (OR = 1.44, 95%; CI = 1.14–1.82, $p < 0.002$).

Patients who were less aware of the prognosis were associated significantly with difficulty communicating between patient and family (OR= 2.11, 95% CI = 1.62-2.76, $p < 0.001$).

Strengths: This study was able to show that patients who were not aware of their prognosis experienced more anxiety and difficulty with family communication. This is contrary to the cultural belief in Chinese communities that disclosure of prognosis is harmful to the patient.

Limitations: This study only examined awareness of diagnosis and did not explore the possibility of denial of prognosis. Causal relationships of prognosis, communication difficulties and anxiety were not explored. The reliability of the STAS tool was tested in the United Kingdom palliative care setting and was modified for use in the Chinese inpatient setting. Many of the result ratings were skewed. The STAS may not be the best tool for this population. This limits the generalizability of the study.

This study by Fujimori et al. (2007) is the descriptive analysis of 529 Japanese cancer patients identified by their physician or their medical chart as the recipient of “bad news” e.g. cancer diagnosis, recurrence or disease progression in the previous three months. Patients completed a 70-item questionnaire after their medical appointment and returned the document by mail. The questionnaire included items from the Japanese version of both the Mental Adjustment to Cancer (MAC) and the Hospital Anxiety and Depression Scale (HADS). Results were analyzed using multiple regression analyses to study the relationship of demographic, medical and psychological characteristics as independent variables, and communication styles as dependent variables. The results generated information on communication styles preferred by patients and the interindividual variation of the patients such as degree of fatalism, helplessness/ hopelessness and formal education. The results also identified how patients preferred information to be delivered and how emotional support was provided to the patient and the family. Japanese physicians have historically informed the family before the patient. Patients were not always informed of the diagnosis. This study found that patients want to be informed. Interestingly 84% of the respondents preferred to have a physician give support to the family as well. Japanese differ from their Western counterparts in a preference to have the physician use more euphemisms during the discussion about their cancer prognosis. The conclusion of the study was the patients have a preference for a collaborative role with the physician and inclusion of the family. Communication style should be individualized.

Strengths: This study examined attitudes and preferences from multiple angles to give an in depth understanding of Japanese cancer patients preferences of information sharing at time of diagnosis, disease progression or recurrence.

Limitations: This study was done at single teaching cancer center and may not be reflective of other cancer centers. Secondly this study examined patients' feelings and preferences at a single point in the course of their disease.

Conclusion/ Clinical Bottom Line: Withholding prognosis information was associated with anxiety and difficulty with patient and family communication. Singapore, Chinese and Japanese patients prefer to be informed of cancer diagnosis and disease progression. Physicians from all three Asian cultures frequently delivered prognosis information to the families and expect the family to make a decision about prognosis disclosure. The patient family groups preferred to hear the information together. The family group is more important than the individual patient. The concept of family centered decision-making being part of the “ principle of autonomy exists, but it is interpreted as concepts of the family rather than self- determination.” Patients expected the physician to provide emotional support to the family.