Fall October 1, 2016

Barriers and Promoters to Participation in the Era of Shared Treatment Decision-Making

Sarah P McCarter, MSN

Joseph D Tariman, PhD

Enisa Mehmeti, MSN, *DePaul University*

Nadia Spawn, MSN, *DePaul University*

Jessica Bishop-Royse, PhD, *DePaul University*, et al.

This work is licensed under a [Creative Commons CC BY-NC-ND International License](https://creativecommons.org/licenses/by-nc-nd/4.0/).

Barriers and Promoters to Participation in the Era of Shared Treatment Decision-Making

Western Journal of Nursing Research
2016, Vol. 38(10) 1282–1297
© The Author(s) 2016
Reprints and permissions:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/0193945916650648
wjn.sagepub.com

**Sarah P. McCarter¹, Joseph D. Tariman¹,
Nadia Spawn¹, Enisa Mehmeti¹,
Jessica Bishop-Royse¹, Ima Garcia²,
Lisa Hartle³, and Katharine Szubski⁴**

Abstract

This study aimed to identify the barriers and promoters for participation in cancer treatment decision in the era of shared decision-making (SDM) process. A qualitative design was utilized. Nineteen nurses and 11 nurse practitioners from oncology inpatient and outpatient settings participated in semi-structured interviews. Data were analyzed using directed content analysis. The findings include practice barrier, patient barrier, institutional policy barrier, professional barrier, scope of practice barrier, insurance coverage barrier, and administrative barrier. Multidisciplinary team approach, having a nursing voice during SDM, high level of knowledge of the disease and treatment, and personal valuation of SDM participation were perceived as promoters. Oncology nurses and nurse practitioners face many barriers to their participation during SDM. Organizational support and system-wide culture of SDM are essential to achieve better cancer treatment decisions outcome. Additional studies are needed to determine the factors that can promote more participation among nurses and nurse practitioners.

¹DePaul University, Chicago, IL, USA

²Clinical Trial Educator at Quintiles, Durham, NC, USA

³Oncology Specialists S.C., Park Ridge, IL, USA

⁴Advocate Medical Group, Chicago, IL, USA

Corresponding Author:

Joseph D. Tariman, SON, College of Science and Health, DePaul University, Chicago, 990 W. Fullerton Avenue, Suite 3000, Chicago, IL 60614, USA.

Email: phdinseattle@yahoo.com

Keywords

roles of oncology nurses and nurse practitioners, cancer treatments, patient advocacy, patient care planning, multidisciplinary team approach, shared decision making, barriers to practice, promoters to practice

In contemporary cancer nursing practice, shared decision making (SDM) is now considered the dominant model of health care delivery (Kane, Halpern, Squiers, Treiman, & McCormack, 2014). A systematic review of patient's preferences for participation in decision making showed that a majority of patients with cancer (as high as 80%) preferred to have a role during cancer treatment decision making (Tariman, Berry, Cochrane, Doorenbos, & Schepp, 2010). This shift in health care delivery from paternalistic to shared decision making model has placed the nurse at the front and center of cancer treatment decision making. Oftentimes, nurses are being asked by patients, "if you were me, which treatment would you choose."

The nurses' high rating on patient's trust (Gallup, Inc., 2014) undoubtedly positions nurses to become reliable and fierce advocates for the patients, particularly when patients cannot advocate for themselves. The tenets of SDM charge the nurses with complex roles in cancer treatment decision making, which include patient educator role, informant role during exchange of information between patient and health care team members, and advocacy role to achieve a treatment decision that is mutually agreed among patients, physicians, nurses, and other health care team members.

Barriers and promoters to implementing the SDM process and ensuring patient-centeredness in multidisciplinary cancer teams as observed by health care professionals have been described in literature (Clancy, 2012; Lipkin, 2013; Obeidat, Homish, & Lally, 2013). However, a systematic review on this topic by Legare, Ratte, Gravel, and Graham (2008) involving 38 studies demonstrated an overwhelmingly large number of physician participants ($n = 3,231$; representing 89% of sample). Moreover, despite the greater number of hours spent by nurses and nurse practitioners with the patient providing direct patient cancer care, studies examining the barriers and promoters to participation in the SDM process from the nursing perspective are limited.

When faced with a new cancer diagnosis, there are many factors that can influence an individual patient's treatment decision-making process. Time limitations, lack of ability to make shared decisions due to the patients' characteristics, patients' specific clinical situations, and difficulties in measuring patients' preferences for treatment decision participation were identified as barriers by clinicians (Kane et al., 2014; Kon, 2010, 2012; Legare et al., 2008). On the contrary, the clinician's personal motivation to being involved, perception of positive impact

on the clinical process, and positive patient outcomes, such as higher satisfaction with decisions and decreased uncertainty or decisional conflict, were considered as promoters to SDM (Hamilton, 2014; Kane et al., 2014; Legare et al., 2008).

The purpose of this study is to identify the barriers and promoters for nurse and nurse practitioner participation in cancer treatment decision in the era of SDM process.

SDM and the Role of the Nurse

What Is SDM?

SDM is a model of health care delivery developed by Charles, Gafni, and Whelan (1997), which was later refined in 1999. The model posits four key tenets such as: at least two participants—clinician and patient be involved; both parties share information; both parties take steps to build a consensus about the preferred treatment; and an agreement is reached on the treatment to implement. This model is highly relevant in oncology nursing practice because nurses have been found to be key sources of information, manage side effects of chemotherapy, evaluate outcomes of treatment, and advocate on behalf of the oncology patients (Tariman & Szubski, 2015).

The SDM model that incorporates both the patient and the clinicians, which includes the nurse and nurse practitioner and the various factors that have influences in the SDM process is shown in Figure 1 (Charles et al., 1997, 1999).

Nursing Role Competency in Oncology Practice

Oncology nurses and nurse practitioners with various educational levels from baccalaureate to doctoral degrees are required to provide patient, family, and caregiver education and expected to demonstrate competencies for advocating on behalf of their patients throughout the cancer care continuum, especially during difficult treatment decision-making processes. These expectations have been described by the American Association of Colleges of Nursing (AACN; 1998, 2010a, 2010b, 2012) competencies for nursing as well as the National Organization of Nurse Practitioners Faculties (NONPF; 2012). For patients to become actively involved in treatment decision making, they are dependent on receiving information and comprehending their options for treatment from trusted sources such as nurses and physicians (Tariman, Doorenbos, Schepp, Singhal, & Berry, 2014; Thornton, Parry, Gill, Mead, & Macbeth, 2011). Patient education, information sharing, and advocacy are key tenets of SDM, which nurses are doing in a day-to-day basis.

Figure 1. SDM model in cancer care.

Source. Charles, Gafni, and Whelan (1997, 1999).

Note. SDM = shared decision making; TDM = treatment decision making.

Advocacy as an Important Competency for Clinical Practice

Advocacy on behalf of the patient in nursing is defined as “an intervention to help patients obtain services and rights and benefits that would (likely) not otherwise be received by them and that would advance their well-being” (Jansson et al., 2015, p. 163). Masters (2014) explained, “The professional nurse speaks for the client as if the client’s interests were the nurse’s own” (p. 204). In a recent literature review on the roles of the nurse in SDM during cancer treatment decisions, authors described six nursing roles, which include informant to multidisciplinary team, patient educator, patient advocate, management of side effects, psychological support provider, and outcomes evaluator (Tariman & Szubski, 2015). In two studies of patients newly diagnosed with localized prostate cancer, researchers documented that patients had multiple treatment options and that their own personal factors and preferences were significantly influential in the final treatment decision (Berry et al., 2003; Zeliadt et al., 2010). In this clinical situation, nurses were clearly well poised to advocate for the patient so that their patient’s personal preferences and values were taken into account during the final treatment decision.

Despite best efforts, there is a gap between the role that nurses actually performed and their ideal role during health care–related decision making. A study on intensive care unit (ICU) nurses’ involvement in end-of-life decision making showed family members of patient desiring more involvement from their nurses (Lind, Lorem, Nortvedt, & Hevroy, 2012). Researchers from this

study have suggested that more studies are needed to delineate the various nursing roles as well as identify the barriers to the full participation of nurses during health care–related decision making.

Hanks (2005) has proposed the sphere of nursing advocacy model, reflecting a semi-permeable sphere of advocacy when a patient is unable to advocate for self, due to vulnerability secondary to health issues. According to this advocacy model, when the patient health condition improves and the patient can speak for himself or herself, the nurse should immediately allow the patient to freely advocate for himself or herself within the limits of his or her health context. This model was conceptualized using a sphere with open pores of the sphere surrounding the patient. It supports the proposition that the patient must be allowed to exercise self-advocacy when the patient is both mentally and physically capable. Moreover, Hanks (2005) proposed that both the clinician and the patient can be self-advocates for the patient simultaneously. Hanks' proposition must be taken with caution. One could argue that if the patient is too weak (but still competent), patients must continue to make decisions regarding treatment. Vulnerability must not be strictly construed as a sign of giving up patient's autonomy.

Method

Design

This study used a descriptive, qualitative study design using semi-structured interviews. The barriers and promoters of oncology nurse and nurse practitioner's participation in SDM are complex health care phenomena that have not been previously studied in nursing; thus, a qualitative approach was used to gain broad perspectives on the nurse and nurse practitioner's participation and role throughout the cancer SDM process.

Setting

Inpatient and outpatient oncology settings in a large metropolitan area in the Midwest region of the United States.

Participants

The 30 participants in this study consisted of 19 oncology nurses and 11 oncology nurse practitioners. They were recruited through the Chicago Chapter Oncology Nursing Society (CCONS) membership email listserv and the International Myeloma Foundation Nurse Leadership Board (IMF NLB). Institutional Review Board approval was obtained from DePaul University

Office of Research Services, Research Protections Division. The nurses in the study are mostly outpatient nurse clinicians and nurse practitioners who have identified themselves as having a role in the cancer SDM process.

Procedures

A semi-structured interview was conducted in a designated research-related conference room at the DePaul University School of Nursing and during the IMF NLB meeting. Interview was conducted in a private meeting room. All interviews were conducted by the principal investigator (J.D.T.) to ensure consistency and reliability. The room was assigned for research use and meets the standards for patient privacy. The focus of this study is the process of cancer treatment SDM between the nurse and the patients, but nurses also referred to the barriers and promoters between the nurse and the physician throughout the cancer treatment SDM process. Open-ended questions included, "What improvement can be done to enhance your participation to cancer treatment decision making?" Participants were asked specific probing question about their perceived barriers and promoters to cancer SDM participation and their personal values and preferences relevant to cancer SDM participation. Probe questions included, "Are there any barriers or promoters to your participation in cancer treatment decision making?" Saturation of data was reached and determined by the principal investigator who performed all the interviews for this study.

All study interviews were audio-recorded and then transcribed verbatim by three graduate students. Identifying names or proper nouns were not included in the transcription to ensure participant protection, confidentiality, and anonymity. All transcripts were checked against the original audio recording by the principal investigator (J.D.T.). The study was completely anonymous. There was no sensitive participant identifier collected during the study, which could be used as a link to a specific participant. The principal investigator used a code book to match the transcript, and only the principal investigator has access to this code book.

Analysis

Directed content analysis procedures (Hsieh & Shannon, 2005) were used to develop major themes from the interviews. Initial themes were developed by the research team members, including the team coders (N.S. and S.P.M.), based on a literature review of factors influencing cancer treatment decisions (Tariman, Doorenbos, Schepp, Becker, & Berry, 2014) and an integrative review of barriers for nursing advocacy in clinical practice (Oliveira &

Tariman, 2015). Interview text was read line by line by the principal investigator (J.D.T.) and then imported to NVivo 10 (NVivo, 2008), a qualitative data software analytic program. Initial themes and definitions were also imported to NVivo. The minimum unit of analysis was typically one sentence, but sometimes the unit was a single word or an entire paragraph, depending on variable scenarios when the participants answered the interviewer's questions briefly or shifted the topic in a different direction other than what was asked in the interview schedule.

After coding 67% of the preliminary data, the research team met to discuss initial and emerging themes, and agreed on the defined categories using consensual validation to ensure reliability and credibility in coding (Hill, 1997). A coding comparison query of the preliminary data showed an overall rate of agreement of 94.3% for coded sections, which included interviews where both coders (S.P.M. and N.S.) agreed that no themes of interest were present, thus ensuring dependability among our coders. This is consistent with the methodology used in prior qualitative research on this topic (Tariman, Doorenbos, Schepp, Becker, & Berry, 2014).

Thereafter, the research team completed coding and met again to discuss and validate the results. The final overall coding agreement between the coders was 92.79%. The codes with the highest levels of agreement were *Administration as a Barrier* (97.38%) and *Cost Consideration* (96.49%). The codes with the lowest levels of agreement were *Advocacy Role* (86.85%), *Nurse's Various Levels of Influence or Involvement* (88.73%), and *Multidisciplinary Team Approach* (88.98%). All codes with low levels of agreement met the minimum requirement of 80% agreement between the coders, as suggested by Hill (1997).

Validity of the results was sought through the reviews of this article by one registered nurse and one nurse practitioner who participated in this study. Both study participants concurred with the study findings.

Results

A total of 30 participants from CCONS and IMF NLB responded to the email recruitment script and participated in the recorded interviews from August 2014 through November 2014. Table 1 shows the socio-demographic characteristics of participants. The majority of participants were female, worked full-time, were between the ages of 40 and 59 years, and had more than 10 years of working experience as a nurse or nurse practitioner.

The semi-structured interviews yielded rich, dense, detailed descriptions of the barriers and promoters to nurses' and nurse practitioners' participation during cancer SDM.

Table 1. Demographics of Study Participants.

Category	Response	N = 30 (Frequency) %
Gender	Male	(2) 6.7
	Female	(28) 93.3
Work status	Full-time	(27) 90.0
	Part-time	(3) 10.0
Age (years)	30-39	(2) 6.7
	40-49	(12) 40.0
	50-59	(14) 46.7
	60+	(2) 6.7
Years of practice experience	3-5	(1) 3.3
	6-9	(5) 16.7
	10 and above	(24) 80.0
Education	Associate degree	(4) 13.3
	Bachelor's degree	(9) 30.0
	Master's degree	(14) 46.7
	Doctoral degree	(3) 10.0
Job title	OP NC	(5) 16.7
	NP	(11) 36.7
	CNS	(2) 6.7
	CRN	(5) 16.7
	OP RNC	(3) 10.0
	RNN	(2) 6.7
	IP NC	(2) 6.7

Note. OP NC = outpatient nurse clinician; NP = nurse practitioner; CNS = clinical nurse specialist; CRN = clinical research nurse; OP RNC = outpatient RN coordinator; RNN = registered nurse navigator; IP NC = inpatient nurse clinician; RN = registered nurse.

Major Themes Pertaining to the Barriers Category

Practice barriers. Lack of uniform practice standards for nursing participation in cancer SDM.

Patient barriers. Lack of patient’s emotional and mental readiness to participate in cancer SDM. Patient’s preference for a physician during the cancer SDM process.

Institutional policy barriers. Institutional policy requiring physician supervision instead of collaboration between physician and nurse practitioner. Undefined roles for nurses resulting in lack of direction in participating in the cancer SDM.

Professional barriers. Lack of professional training and experience. A professional culture nonconductive to nurse participation in cancer SDM.

Scope of practice barriers. When nurses or nurse practitioners cannot initiate new cancer therapy or practice independently in cancer SDM due to regulations by state or federal laws.

Insurance coverage as a barrier. When insurance payment for service is low, the nurse practitioner is required to see more patients and is hindered by time constraints and increased patient volume. Insurance does not cover the desired treatment sufficiently for the treatment to be an option.

Administration as a barrier. When administration does not provide adequate resources or staff support and empowerment to nurses and nurse practitioners.

Table 2 shows a summary of the major themes and the frequencies of occurrences related to the barriers to nurses' role throughout the cancer SDM with exemplar quotes from the nurses and nurse practitioners.

Major Themes Pertaining to the Promoter's Category

Multidisciplinary team approach. Nurses and nurse practitioners have increased participation in cancer SDM when there is a consistent multidisciplinary or team approach in the practice.

Nurses having a voice during cancer SDM. When nurses perceive that their input is valued, they feel they are more likely to participate in cancer SDM.

Higher level of disease knowledge and its treatment. When nurses know more about the disease and its treatment, they feel they can better participate in the decision-making process.

Personal valuation of nurse for cancer SDM participation. Nurses who personally value participation in cancer SDM are more actively involved in the treatment decision-making process.

Table 3 outlines the promoters for nurses and nurse practitioners' role throughout the cancer SDM process with exemplar quotes. Frequencies of occurrences are also included in the table to provide quantitative information on how often these promoters to cancer SDM were discussed by participants during the interviews.

Table 2. Major Themes on the Barriers for Nurses' Role Throughout the Cancer SDM Process.

Themes	Exemplar Quotes	Sources (N = 30)
Institutional policy barrier	NP017: "I have been here in the VA for ten years. Before, it wasn't a problem, practicing how we practice, more recently it has become one and my opinion is it has something to do with the fact that in the past we were under the department of medicine."	24 (80%)
Patient barrier	NP010: "I see that often times that patients actually defer the decision back to us rather than them taking, you know, rather them taking that on to make a decision."	19 (63.3%)
Professional barrier	NP013: "I think that what it's lacking, so, we um, you know, have started the...the society, the advanced practitioner society for hematology-oncology (APSHO), and we did the practice survey and we asked people in varying levels, and we asked people you know how they were trained and mostly that was on the fly. So the job training was no formal training and I think what happens in that situation is that the Nurse Practitioner is always, its secondary, not just necessarily but they are basically not acculturated to necessarily create a truly collaborative practice and, and develop some level of independence."	19 (63.3%)
Professional practice barrier	NP018: "There is a paternalistic outlook from some of the physicians, how they were trained, where they were trained." RN022: "If you get a culture where people, you know, use cookbook nursing as they call it you're going to have less of people feeling comfortable doing the more critical thinking piece where they move on beyond the policy and procedure book."	15 (50%)
Scope of nursing practice barrier	NP011: "As a nurse practitioner in the state of Pennsylvania, I know that I'm unable to initiate chemotherapy. I can continue therapy and I can adjust dosing based on toxicity but initiating a new regimen, I am unable to do in my level or scope of practice." NP020: "I think limiting your prescriptive authority for narcotics be limited to five has no specific basis or facts, you know, or objectives content. If you can do one why can't you do five you know, do three why can't you do ten; I see no back up there or no reason for that."	15 (50%)

(continued)

Table 2. (continued)

Themes	Exemplar Quotes	Sources (N = 30)
Administrative barrier	RN025: "Administration would say "Oh yes." Oh sure they're supportive of it but I mean, in mouth, but then I don't think we always have the bodies to, you know, to execute."	10 (33.3%)
Insurance barrier	RN019: "Definitely one of the big things that you worry about now, with me and clinical trials, is the whole billing issue. No patient wants an extra bill and it's really hard to be 100% sure that billing is going to go off without a hitch. You just never know what insurance is going to do. That's really scary for a lot of patients. A lot of patients are worried about that. They may say, 'I don't want to do this clinical trial therapy because I don't want any extra expense' even though there may not be one but I can definitely understand their fear."	9 (30%)

Note. SDM = shared decision making; NP = nurse practitioner; RN = registered nurse.

Discussion

This study highlights the many barriers and promoters to participation in SDM as perceived by oncology nurses and nurse practitioners. This is the first study that examined the nursing perspectives of SDM in cancer setting. As nursing practice expands and clinicians adapt to health care changes, so will nursing responsibilities. Oncology nurses and nurse practitioners are well-trained and well-educated to support patients from the time of diagnosis and throughout the SDM process. As a result, nurses can play an integral role in the cancer treatment continuum. This study provides initial evidential support that the role of the oncology nurses and nurse practitioners in this era of SDM process is dynamic and evolving (Tariman & Szubski, 2015).

The study participants have clearly expressed institutional and professional barriers in this study. These findings indicate that the onus to remove these barriers does not belong to nurse and nurse practitioner only. Much of the responsibility to fully actualize SDM in oncology nursing practice also relies on organizational support and leadership in nursing. Nursing executives must continue to support nurse clinicians and the interests of the nursing profession. Nurse leaders must include in their strategic approaches making significant investment in training and advising nurses related to their roles in

Table 3. Major Themes on the Promoters for Nurses’ Role Throughout the Cancer SDM Process.

Themes	Exemplar Quotes	Sources (N = 30)
Having a voice.	RN012: “My opinion is respected by many. Since I do feel I am a very strong patient advocate, I feel it’s important that I am heard when it’s an important issue.”	30 (100%)
Multidisciplinary or team approach.	NP012: “Yes. I think it’s essential, too, that the physicians let patients know up-front that there’s a team approach and it’s probably more than half the time they’re going to see the Advanced Practice Provider and not the physician.”	29 (96.6%)
Personal valuation of nurse for cancer SDM participation	NP019: “I think that treatment decision making has to be a team approach because, if I have to carry out that treatment plan, I need to know what the treatment plan is, and I need to know what the patient thinks up front.”	25 (83.3%)
Higher level of disease knowledge and its therapy.	NP010: “I think if you don’t have a knowledge base that you can’t really assist your patient in decision making.” RN022: “I think education is always important in empowering anybody, and so that is a whole piece that I think is being taken up in the nursing schools, perhaps when I went to nursing school, about using evidence-based information to give your opinion to try to impact on decision making.”	20 (66.6%)

Note. SDM = shared decision making; RN = registered nurse; NP = nurse practitioner.

cancer treatment SDM. In addition, nursing leadership should build strong multidisciplinary teams around the patient. Nurses’ roles and responsibilities during SDM in cancer care must be valued by their own leaders.

This study has shown that oncology nurses and nurse practitioners are key players in cancer treatment SDM; however, they are faced with challenges, which include barriers in practice, education, institutional policies, and administration, to name a few. Additional investigation is needed in this area,

and financial support for nursing research and education is recommended. The authors of this article believe that expanding the oncology nurse practitioner's role and increasing autonomy with respect to the cancer treatment decision-making process will result to improve patient outcomes, overall patient satisfaction with treatment decision. As originally conceptualized by Charles and colleagues (1997), oncology nurses and nurse practitioners must be active in providing patient education and advocacy to achieve a mutually agreed and satisfactory treatment decision.

Many promoters are found encouraging oncology nurses and nurse practitioners to participate in cancer treatment SDM process. These promoters include adopting a multidisciplinary team approach, expanding the nursing voice, personal valuation in participation, and higher nursing knowledge of disease and therapies. Lind and colleagues (2012) also found that patients value and desire more active nursing participation in the decision-making process. Therefore, it is important that promoters for nursing team participation in cancer treatment SDM should be encouraged and supported in practice to improve patient satisfaction and prevent decisional regrets.

Although previous research describes various barriers and promoters among health care professionals in numerous clinical decision-making settings, there is limited research that has examined and confirmed these barriers and promoters specific to nurse and nurse practitioner participation in cancer treatment SDM (Legare et al., 2008). This study has revealed new barriers, such as institutional and scope of practice barriers, as well as promoters, such as nursing voice and disease knowledge level, which were previously not described in literature.

The oncology nurse and nurse practitioner are pivotal players in all aspects of the cancer treatment SDM process, but there are many barriers to the fulfillment of the nursing team's role throughout the cancer treatment SDM process. Nurses and nurse practitioners must continue to work vigorously to remove barriers at the institutional or national organizational level and must strive to attain full participation throughout the cancer treatment SDM process, but within the scope of nursing practice.

The researchers of this study consequently found the presence of concepts that may exist in nursing cancer SDM only, which could potentially affect participation in cancer treatment SDM process. These concepts include competence level and level of interest of nurses and nurse practitioners during cancer treatment SDM process. Due to the qualitative nature of the study, these concepts remain unmeasured. One of the authors' recommendations for future research is to develop a measure of nursing competency in oncology SDM process to objectively measure the capacity to participate safely and effectively in cancer treatment SDM process.

Several limitations of the current study include a sample that was recruited from the IMF NLB. The values and opinions described by these participants may not reflect those of the general oncology nursing population. Although saturation of data was reached, this study has a relatively small sample size for inpatient and outpatient oncology nursing practitioners. The major strength of the current study was the representativeness of various nursing job titles, which lends a very broad perspective on nursing participation in the era of SDM and the barriers that nurses face in many oncology settings.

Oncology nurses and nurse practitioners face many barriers to their participation during SDM. Organizational support and health care system-wide culture of SDM are essential to achieve better cancer treatment decision outcomes such as fewer decisional regrets and more decisional satisfaction on both the patient and the clinician sides. Additional studies are needed to determine the factors that can promote more participation among nurse practitioners in this new era of SDM and changing professional regulatory environment.

Authors' Note

All authors have reviewed and approved the submission of this manuscript to *Western Journal of Nursing Research*.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors received \$3,000 funding from the Chicago Chapter of the Oncology Nursing Society which covered the costs for conducting the research. The authors received no financial support for authorship, and/or publication of this article.

References

- American Association of Colleges of Nursing. (1998). *The essentials of baccalaureate education for professional nursing practice*. Washington, DC: Author.
- American Association of Colleges of Nursing. (2010a). *Adult-gerontology clinical nurse specialist competencies*. Washington, DC: Author.
- American Association of Colleges of Nursing. (2010b). *Adult-gerontology primary care nurse practitioners competencies*. Washington, DC: Author.
- American Association of Colleges of Nursing. (2012). *Adult-gerontology acute care nurse practitioner competencies*. Washington, DC: Author.

- Berry, D. L., Ellis, W. J., Woods, N. F., Schwien, C., Mullen, K. H., & Yang, C. (2003). Treatment decision-making by men with localized prostate cancer: The influence of personal factors. *Urologic Oncology*, 21, 93-100.
- Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). *Social Science & Medicine*, 44, 681-692. doi:10.1016/S0277-9536(96)00221-3
- Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician-patient encounter: Revisiting the shared treatment decision-making model. *Social Science & Medicine*, 49, 651-661. doi:10.1016/S0277-9536(99)00145-8
- Clancy, C. M. (2012). Patient-centered outcomes research and nurse practitioners' role in shared decision making. *Journal of the American Academy of Nurse Practitioners*, 24, 59-61. doi:10.1111/j.1745-7599.2011.00692.x
- Gallup, Inc. (2014). *Americans rate nurses highest on honesty, ethical standards*. Retrieved from <http://www.gallup.com/poll/180260/americans-rate-nurses-highest-honesty-ethical-standards.aspx>
- Hamilton, D. W. (2014). Shared decision making asks patients to share their aims and values for treatment. *British Medical Journal*, 348, Article 1435.
- Hanks, R. (2005). Sphere of nursing advocacy model. *Nursing Forum*, 40(3), 75-78.
- Hill, C. E. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist*, 25, 517-572.
- Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15, 1277-1288. doi:10.1177/1049732305276687
- Jansson, B. S., Nyamathi, A., Duan, L., Kaplan, C., Heidemann, G., & Ananias, D. (2015). Validation of the patient Advocacy Engagement Scale for health professionals. *Research in Nursing & Health*, 38, 162-172. doi:10.1002/nur.21638
- Kane, H. L., Halpern, M. T., Squiers, L. B., Treiman, K. A., & McCormack, L. A. (2014). Implementing and evaluating shared decision making in oncology practice. *CA: A Cancer Journal for Clinicians*, 64, 377-388. doi:10.3322/caac.21245
- Kon, A. A. (2010). The shared decision-making continuum. *Journal of the American Medical Association*, 304, 903-904. doi:10.1001/jama.2010.1208
- Kon, A. A. (2012). Difficulties in judging patient preferences for shared decision-making. *Journal of Medical Ethics*, 38, 719-720. doi:10.1136/medethics-2012-100725
- Legare, F., Ratte, S., Gravel, K., & Graham, I. D. (2008). Barriers and facilitators to implementing shared decision-making in clinical practice: Update of a systematic review of health professionals' perceptions. *Patient Education & Counseling*, 73, 526-535. doi:10.1016/j.pec.2008.07.018
- Lind, R., Lorem, G. F., Nortvedt, P., & Hevroy, O. (2012). Intensive care nurses' involvement in the end-of-life process—perspectives of relatives. *Nursing Ethics*, 19, 666-676. doi:10.1177/0969733011433925
- Lipkin, M. (2013). Shared decision making. *JAMA Internal Medicine*, 173, 1204-1205. doi:10.1001/jamainternmed.2013.6248
- Masters, K. (2014). *Role development in professional nursing practice*. Burlington, MA: Jones & Bartlett Learning.

- National Organization of Nurse Practitioners Faculties. (2012). *Nurse practitioners core competencies*. Retrieved from <http://c.ymcdn.com/sites/www.nonpf.org/resource/resmgr/competencies/npcorecompetenciesfinal2012.pdf>
- NVivo. (2008). NVivo Qualitative Data Analysis Software (Version 10) [Computer software]. QSR International. Available from <http://www.qsrinternational.com/>
- Obeidat, R. F., Homish, G. G., & Lally, R. M. (2013). Shared decision making among individuals with cancer in non-Western cultures: A literature review. *Oncology Nursing Forum*, 40, 454-463. doi:10.1188/13.ONF.454-463
- Oliveira, C., & Tariman, J. D. (2015). *Barriers of patient advocacy role in clinical nursing practice: An integrative review of the literature* (Unpublished master's thesis). DePaul University, Chicago, IL.
- Tariman, J. D., Berry, D. L., Cochrane, B., Doorenbos, A., & Schepp, K. G. (2010). Preferred and actual participation roles during health care decision making in persons with cancer: A systematic review. *Annals of Oncology*, 21, 1145-1151.
- Tariman, J. D., Doorenbos, A., Schepp, K. G., Becker, P. S., & Berry, D. L. (2014). Patient, physician and contextual factors are influential in the treatment decision making of older adults newly diagnosed with symptomatic myeloma. *Cancer Treatment Communications*, 2(2-3), 34-47. doi:10.1016/j.ctrc.2014.08.003
- Tariman, J. D., Doorenbos, A., Schepp, K. G., Singhal, S., & Berry, D. L. (2014). Older adults newly diagnosed with symptomatic myeloma want to participate in treatment decision making. *Oncology Nursing Forum*, 41, 411-419.
- Tariman, J. D., & Szubski, K. (2015). The evolving role of the nurse during the cancer treatment decision making process: A literature review. *Clinical Journal of Oncology Nursing*, 19, 548-556.
- Thornton, M., Parry, M., Gill, P., Mead, D., & Macbeth, F. (2011). Hard choices: A qualitative study of influences on the treatment decisions made by advanced lung cancer patients. *International Journal of Palliative Nursing*, 17, 68-74.
- Zeliadt, S. B., Ramsey, S. D., Van Den Eeden, S. K., Hamilton, A. S., Oakley-Girvan, I., Penson, D. F., . . . Potosky, A. L. (2010). Patient recruitment methods to evaluate treatment decision making for localized prostate cancer. *American Journal of Clinical Oncology*, 33, 381-386. doi:10.1097/COC.0b013e3181b215d5