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Treatment-Related Decisional Conflict, Quality of Life, and Comorbid Illness in Older Adults with Cancer

Jeannette Kates, PhD, MSN, GNP-BC
Thomas Jefferson University, College of Nursing

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Background

- Sixty percent of cancers and two-thirds of cancer deaths occur over the age of 65 years (American Cancer Society, 2013).
- On average, people 65 years of age and over, with cancer, suffer from three additional diseases (Mareno et al., 2008).
- Cancer treatment-related decisions are multiaxial and complex for health care providers, patients, and families.
- Decisions can lead to decisional conflict: “a state of uncertainty about which course of action to take when choices among competing actions involve risk, loss, regret, or challenge to personal life values” (Leacche, O'Connor, Graham, Wells, & Tremblay, 2006, p. 374).
- With their focus on patient-centered care, oncology nurses are a crucial part of the multidisciplinary cancer team that can empower older cancer patients to communicate their values and preferences regarding cancer treatment.

Purpose

The purpose of this study was to examine the relationships between and among treatment-related decisional conflict, QOL, and comorbidity in older adults with cancer.

Research Questions

1. What is the relationship between and among treatment-related decisional conflict, QOL, and comorbidity in older adults with cancer?
2. To what degree does the variability in QOL and level of comorbidity predict decisional conflict?

Methodology

Study design:
- Cross-sectional
- Descriptive
- Correlational
- Survey method

Instruments:
- **Decisional Conflict Scale (DCS)** (O'Connor, 1995):
  - 16 items consisting of 3 subscales:
    - Informed
    - Values clarity
    - Support
    - Uncertainty
    - Effective decision
    - 5-point Likert scale (1=strongly agree, 5=strongly disagree)
    - Scores range from 0 (no decisional conflict) to 100 (extremely high decisional conflict)
- **Self-Administered Comorbidity Questionnaire (SCQ)** (Sangha et al., 2003):
  - 13 items with the option of adding 3 additional conditions in an open-ended fashion
  - For each medical condition, the following is asked:
    - Do you have the problem?
    - Do you receive treatment for it?
    - Does it limit your activities?
    - Maximum of 3 points per condition/condition
- **European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30)** (Aaronson et al., 1993):
  - 30 items
  - 5 function scales (physical, role, cognitive, emotional, social)
  - 3 symptom scales (fatigue, pain, nausea/vomiting)
  - 2 global health/QOL
  - Additional symptoms
  - Global health/QOL items: 7-point Likert scale (1=very poor, 7 = excellent)
  - Remaining items: 4-point Likert scale (1=not at all, 4=very much)
  - Demographic Information Form
    - 17 items
    - 5 open-ended items
    - 12 items with list of choices

Results

Descriptive statistics:
- N=200
- 73.4 years mean age
- 51.6% female
- 50.5% married
- 87.5% white
- Lung cancer most common (n=46)
- Decisional conflict and QOL:
  - Scores range from 0 (no decisional conflict) to 100 (extremely high decisional conflict)

Correlation analyses:
- Decisional conflict and QOL: r(198) = .85, p = .009
- QOL and comorbidity: r(198) = .40, p = .001
- Decisional conflict and comorbidity: r(198) = .29, p = .070

Regression analyses:
- **DCS total**
  - Emotional function
  - Financial problems
  - **DCS 1 (informed subscale)**
    - Scores range from 0 (no decisional conflict) to 100 (extremely high decisional conflict)
  - Physical function
  - Fatigue
  - **DCS 3 (support subscale)**
    - Fatigue
  - **DCS 4 (uncertainty subscale)**
    - Fatigue

Key points:
- Mean DCS total score was low
- Global health status/QOL was poorer in this sample compared to other studies
- There may be a relationship between decisional conflict and QOL
- There may be a relationship between QOL and comorbidity
- Several physical, psychosocial, and spiritual variables may positively or negatively impact DCS score

References


