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

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Background

- Seventy 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 (Marenco et al., 2008).
- Cancer treatment-related decisions are multifactorial and complex for healthcare 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” (Deaton, O’Connor, Graham, Wells, & Tremblay, 2006, p. 374).
- With their focus on patient-centered care, oncology nursing is 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, comorbid illness, and quality of life (QOL) 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 decision conflict?

Methodology

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

Instruments:

- Decisional Conflict Scale (DCS) (O’Connor, 1995)
  - 16 items consisting of 5 subscales:
    - Informed
    - Values clarity
    - Support
    - Uncertainty
    - Effective decision
  - 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 receive treatment for it?
    - Does it limit your activities?
    - How do you rate your treatment?
  - Maximum of 3 points per condition/item
- European Organization for Research and Treatment of Cancer 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)
  - Demographic Information Form
  - 17 items
  - 5 open-ended items
  - 12 items with list of choices

Results

Descriptive statistics:
- N=200
- 73.1 years mean age
- 51% female
- 50.5% married
- 27.5% white
- Lung cancer most common (n=46)
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- 73.1 years mean age
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Correlation analyses:
- Decisional conflict and QOL: r(196) = .35, p = .009
- QOL and comorbidity: r(196) = .40, p = .001
- Decisional conflict and comorbidity: r(196) = .29, p = .070

Regression analyses:
- DCS total
  - Emotional function
  - Financial problems
- DCS 1 (informed subscale)
  - Emotional support
  - Financial problems
- DCS 2 (values clarity subscale)
  - Emotional support
  - Financial problems
- DCS 3 (support subscale)
  - Emotional support
  - Financial problems
- DCS 4 (uncertainty subscale)
  - Emotional support
  - Financial problems
- DCS 5 (effective decision subscale)
  - Emotional function
  - Nausea/vomiting
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