How doctors actually involve families in decisions to continue or discontinue life-sustaining treatment in neonatal, pediatric and adult intensive care: A qualitative study

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Intensive care doctors have to find the right balance between sharing crucial decisions with families of critically ill patients on the one hand and not overburdening them on the other hand. This requires a tailored approach. In this observational study, we explored how doctors actually involve families in the decision-making process regarding continuation or discontinuation of life-sustaining treatment. For this purpose, we performed an inductive thematic analysis of 101 audio-recorded conversations. 104 family members and 71 doctors of 36 patients admitted to a neonatal, pediatric or adult intensive care unit of a large university medical center participated. Doctors showed eight relevant and distinct communicative behaviors to involve families in the decision-making process. These behaviors complemented each other – reflecting either a shared or a physician-driven approach – or appeared to be contradictory, i.e. vacillating between a shared approach and a physician-driven approach. Doctors more often displayed a physician-driven or a vacillating approach than a shared approach, especially in the adult intensive care. Doctors did not verify whether their chosen approach matched the families’ decision-making preferences. Families showed very little active input due to doctors’ communicative behaviors. Even though tailoring doctors’ communication to families’ preferences is advocated, it does not seem to be integrated into actual practice. To allow for true tailoring, doctors’ awareness regarding the impact of their communicative behaviors is key. Educational initiatives should especially focus on improving doctors’ skills in tactfully exploring families’ decision-making preferences and in mutually sharing knowledge, values and treatment preferences.
What factors play a role among pregnant women in the decision for maternal pertussis vaccination?

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Introduction: Maternal Pertussis Vaccination (MPV) was introduced in the Netherlands in December 2019. To inform the development of communication, we explored factors involved in MPV acceptance among pregnant women, and their preferences for information about and organisation of MPV.

Methods: We conducted focus group-interviews (5 groups, N=19) and a cross-sectional online survey (n=202) among pregnant women prior to the implementation of MPV in the Netherlands. Interviews were analysed using thematic analysis, and survey data using descriptive statistics.

Results: Main findings were: (1) beliefs about effectiveness and risks of MPV were decisive factors in MPV acceptance, (2) support from social environment (partner, friends) was considered important for MPV acceptance (3), participants perceived pressure to vaccinate from existing communication, and (4) refusing MPV was perceived as the safe choice over accepting MPV among those in doubt. In the survey, most participants indicated wanting to be informed at or after 20 weeks of pregnancy, preferably by their obstetric care provider (OCP) or their general practitioner. Participants also preferred receiving the vaccine from their OCP, and identified having to go to another care provider to be a barrier to accepting MPV.

Conclusion: Women felt uncertain about effectiveness and safety of MPV. This is likely to result in vaccine hesitancy and decisional conflict. Promoting an informed choice in communication is essential. The OCP is the most trusted source of information about MPV. Although the delivery of the vaccine is organised via youth care, it would be important to involve the OCP when communicating about MPV.
The role of general practitioners and nurses in shared decision-making about palliative cancer treatment

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Background: Patients with incurable cancer face preference-sensitive treatment decisions that require shared decision-making (SDM). Next to medical specialists, general practitioners (GPs) and nurses discuss treatment with patients. There still is much unknown about the role these healthcare providers have or could have to support SDM. Our aim was to explore GPs’ and nurses’ perception of their contribution to SDM about palliative (oncological) treatment decisions and the preconditions for such contribution.

Methods: In two separate qualitative studies, 15 GPs and 18 hospital nurses were interviewed. The audio recordings were transcribed verbatim and analysed thematically by two researchers.

Findings: Both GPs and nurses described experiencing various degrees of influence on treatment decision-making. Although not all participants recognised their contribution to SDM, they all described engaging in SDM-supporting behaviour to some extent. Overall, we distinguished three strategies for supporting SDM: 1) checking the quality of a decision, 2) complementing SDM and 3) facilitating SDM. Preconditions differed for each discipline, but overall themes deemed important were: 1) a good relationship and cooperation with the patient and medical specialist, 2) good transfer of information between healthcare providers and 3) consciousness, knowledge and skills to engage in conversations with patients about treatment decision-making.

Discussion: GPs and hospital nurses contribute to SDM about palliative (oncological) treatment in various ways, but are not always aware of this role. In order to increase their contribution to SDM, it is important to advance awareness and provide tools for supporting SDM. We developed and are evaluating a training on this topic.

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Introduction: The aim of the study was to assess whether cognitive reappraisal and acceptance are effective emotion regulation strategies to decrease negative affect when deciding about maternal pertussis vaccination (MPV). Methods: An online randomized controlled trial with baseline and two follow-up moments was conducted among pregnant women in the Netherlands. Participants were selected after baseline measurements (n=382) and randomized into three groups: cognitive reappraisal intervention, acceptance intervention or control group. Multilevel analyses were performed to examine the effect of the interventions on the primary outcome (negative affect) and secondary outcomes (intention, cognitive attitude and affective attitude). A moderation analysis was performed with participants who completed baseline measurements (n=1,269) to examine whether negative affect moderates the association between affective and/or cognitive attitude and intention.

Results: All participants in the cognitive reappraisal, acceptance and control group showed a decrease in negative affect (all p's<.001). No differences were found between the three groups on negative affect. Participants in the cognitive reappraisal group increased their affective and cognitive attitude between baseline and first follow-up compared to the control group (p<0.03; p<0.04, respectively). Negative affect moderated the association between cognitive attitude and intention (p<0.006).

Conclusion: No additional value of the interventions was found compared to the control group. However, cognitive attitude and intention were less associated under high negative affect. This study stressed the relevance for communication strategies to consider emotions pregnant women experience during the MPV decision-making process. This can be done by actively checking whether women experience negative affect during this process.