Patient-centered care was most recently defined by the National Academy of Sciences in 2001 as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.” Notably, this care approach counters a unidirectional, clinician-driven model where the clinician’s voice and expertise is paramount. The introduction of the Patient Protection and Affordable Care Act in 2010 also heralded a major reform of the US health care delivery system, with an increased focus on patient-centered care delivery and research. The subsequent impact on cancer care payment through oncology patient-centered medical homes; alternative payment models such as the Oncology Care Model and its successor, the Enhancing Oncology Care Model; along with comprehensive investment in research, has further demonstrated an increasing prioritization of patient engagement to improve cancer care outcomes. Most recently, the US Department of Health and Human Services, in collaboration with the National Cancer Institute, released the National Cancer Plan roadmap, which is focused on 8 essential goals to improve the lives of people diagnosed with cancer, including delivery of evidence-based, patient-centered care.

Cornerstone to patient-centered care is a highly functional patient–clinician relationship that is based on a collaborative partnership that promotes bidirectional communication, empathy, respect, comfort, and perspective-sharing. This partnership allows clinicians to better understand their patients as individuals with unique experiences, values, preferences, and care needs, and helps patients to better grasp their condition and evidence-based care options. Further supporting a patient’s early involvement in their health care, including identification of their care goals and treatment preferences, or the extent they wish to be involved in decisions (eg, shared or delegated to family or clinicians) is essential.

Metastatic breast cancer (mBC), an advanced and incurable form of breast cancer, offers the opportunity to consider how a patient-centered approach can be operationalized in today’s oncology care environment. Given the complex nature of an mBC diagnosis, care teams often comprise multiple specialists, and treatment choices require weighing risks and benefits. Prioritizing the patient–clinician relationship is essential for guiding clinical decisions and delivering high-quality care that aims to improve outcomes. In 2022, a multidisciplinary working group comprising expert key partners in breast oncology, health services research, decision sciences, health literacy, and patient advocacy convened to form the Innovative Patient-Centered Decision-Making Consortium (I-PCDMC). Across 2 separate in-person meetings (July and October), the I-PCDMC discussed the current state of treatment decision-making in mBC care, including the key components of patient-centered decision-making (PCDM), best practices for implementation, and measurement of PCDM.

This commentary provides an expert-guided synthesis of the hypotheses, findings, components, and research gaps of PCDM for mBC care delivery, with the intent to optimally support the practice and measurement of PCDM over the long term. We propose

**Patient-Centered Decision-Making in Metastatic Breast Cancer Care Delivery: A Call to Action**

Gabrielle B. Rocque, MD, MSPH; Manali I. Patel, MD, MSPH, MS; Lauren P. Wallner, PhD, MPH; Stacy C. Bailey, PhD, MPH; Rebekkah Schear, MIA; Christine M. Gunn, PhD, MA; Jamil Rivers, MBA, MS; Rozanne Wilson, PhD; Emily C. Freeman, PhD, MSc; Trudy L. Buckingham, MSPH; Suepattra G. May, PhD, MPH; and Arif H. Kamal, MD, MBA, MHS

**Affiliations:** 1 Divisions of Hematology & Oncology and Gerontology, Geriatrics, & Palliative Care, University of Alabama, Birmingham, Alabama; 2 Department of Medicine, Stanford University, Stanford, CA, and Medical Services, VA Palo Alto Health Care System, Palo Alto, California; 3 Departments of Internal Medicine and Epidemiology, University of Michigan, Ann Arbor, Michigan; 4 Division of General Internal Medicine, Feinberg School of Medicine, Northwestern University, Chicago, Illinois; 5 Polaris Global Health Solutions, Austin, Texas; 6 The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine; Dartmouth Cancer Center, Lebanon, New Hampshire; 7 The Chrysalis Initiative, Philadelphia, Pennsylvania; 8 PRECISIONheor, Vancouver, BC, Canada; 9 Gilead Sciences, Inc., Foster City, California; 10 PRECISIONheor, New York, New York; and 11 American Cancer Society, Charlotte, North Carolina.

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**Correspondence:** Trudy Buckingham, MSPH, Gilead Sciences, Inc., 333 Lakeside Drive, Foster City, CA 94404. Email: Trudy.Buckingham@gilead.com

**Commentary**

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The ideas and viewpoints expressed in this commentary are those of the author and do not necessarily represent any policy, position, or program of NCCN.
a call to action for community-engaged, patient-centered research to identify strategies for implementation and measurement of PCDM in clinical practice.

Treatment Decision-Making in Oncology

To date, considerable scholarship has focused on shared decision-making (SDM) in the clinical practice setting. SDM focuses on eliciting patient preferences and values in evidence-based medical decision-making. It originated from a need to address observed clinical practice pattern variations that were unrelated to patients' health status during preference sensitive decisions, as well as an increased focus on matching preferences and values to the available evidence-based options. Its emergence resulted in a shift away from a predominantly paternalistic model of decision-making. Despite being widely studied, routine uptake of SDM in oncology has been challenging, due to factors including variations in model definitions, existing research gaps, clinician-level barriers (eg, hesitancy/uncomfort with how to engage in SDM), and systemic- and institutional-level obstacles. Thus, there is an opportunity to shift the focus from individual decision-support tools for SDM to a broader decision-making model focused on preference-aligned decision-making that fosters an ongoing collaborative therapeutic alliance between the patient and clinician. Specifically, a PCDM approach encompasses the broader contextual factors that both the patient and the clinician bring to treatment decisions at various time points throughout the disease course.

Patient-Centered Decision-Making

A person-centered orientation throughout the care continuum is fundamental to PCDM. Core to the PCDM model is that the patient and the clinician have shared values and preferences, comprehensively discussed options, and then arrived collaboratively at treatment decisions that are preference-aligned. A PCDM approach elicits the patient's decisional role preference, desired level of information-sharing, and preferences for treatment to better understand and align with outcomes that matter most to the patient when developing an appropriate and mutually agreed upon treatment plan. Key to PCDM is the clinician sharing a recommendation during the decision-making process that serves to contextualize their understanding of the patients' knowledge, values, preferences, and goals into the decision at hand. Importantly, this approach encourages the clinician to share their own expertise, experience, and perspective, thus not placing the clinician in a passive position to merely present a myriad of options.

The I-PCDMC discussions highlighted 3 critical components of PCDM that are needed to support preference-aligned treatment decisions (Table 1). Additionally, Figure 1 depicts a proposed conceptual model for PCDM, outlining the key components of PCDM. This model could be adapted to any dyad involved in oncology care.

Implementing PCDM in Oncology

Taken together, it is imperative to define a set of outcomes by which to assess PCDM effectiveness and scalability within a health care system. Although the PCDM approach has been examined, there remains a paucity of data describing implementation of PCDM, particularly within real-world oncology care delivery. To effectively demonstrate the value of PCDM, it is critical to show precisely how a PCDM approach results in better outcomes for patients. Proximal outcomes for assessing PCDM

Table 1. Key Components of Patient-Centered Decision-Making

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<tr>
<th>Component</th>
<th>Description</th>
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<tr>
<td><strong>Fostering the patient-clinician relationship</strong></td>
<td>• Both the patient and the clinician are recognized as key partners within the clinical encounter, contributing perspectives, experiences, knowledge, and expertise to the decision-making process. • Both parties collaborate to foster a trusting, respectful, empathetic, and open patient-clinician relationship.</td>
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<tr>
<td><strong>Engaging in patient-centered communication</strong></td>
<td>• Bidirectional communication underscores patient-centered discourse and is fundamental to PCDM. • The clinician’s conversational approach includes open-ended questions, active listening, curiosity, and acknowledging emotion to better understand how the patient’s experiences and perspectives may influence treatment decision-making. • PCDM emphasizes the clinician’s critical role in gathering information and ensuring that the patient has been heard and understood. • During the bidirectional information exchange, the clinician shares their expertise, experiences, and perspectives and the patient is encouraged to ask questions to better understand the clinician’s perspectives.</td>
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<tr>
<td><strong>Understanding individual and contextual factors</strong></td>
<td>• The patient-clinician partnership includes exploring the unique individual characteristics of the patient and clinician, as well as the medical and nonmedical contextual circumstances that may influence treatment decisions. • The clinician learns more about the patient’s demographic, individual, and clinical characteristics; preferred level of engagement; desired level of and access to information; treatment preferences; skills and willingness to manage their health care; social support system; and access to and engagement in health resources and programs. The clinician likewise shares their expertise, experiences, and recommended treatment approaches, while encouraging the patient to ask questions. • Understanding personal and contextual factors ensures that the treatment decision-making process is adapted to the individual patient’s needs and preferences (ie, contextualized care), and helps the clinician to understand how patients’ preferences may evolve over time (eg, due to clinical course, age) or in different contexts. • The clinician communicates a treatment recommendation, contextualized by patient preferences and values and inclusive of the clinician’s experience and clinical knowledge.</td>
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should be relevant to the interests of key partners (eg, patients, clinicians, caregivers/families, communities, health systems, and payers). Although there exist relevant proximal outcomes (eg, decision quality, satisfaction with decision-making, reduction in decisional conflict and/or regret, side-effect management, cancer treatment outcomes, and adherence) that could be leveraged to support the use of PCDM, challenges arise when considering the measurement of more distal outcomes associated with PCDM, such as quality of life and symptom management. There remains a need for validated measures of PCDM.

**Facilitating Implementation of PCDM**

To ensure optimal implementation of PCDM in clinical practice, key facilitators of PCDM should be considered. First, infrastructure and systems to support patient and caregiver health literacy (ie, understanding and use of health information) are imperative. Specifically, it is important to ensure that health information and resources are available to support patient comprehension of their condition so that they can make informed treatment decisions, to the extent possible, that are aligned with their preferences and treatment goals. Second, implementing effective PCDM strategies requires fully appreciating the patient’s preferences around how they wish to engage in their health care decisions, their understanding and willingness to participate in the care decision process (activation), and how these preferences may change across time and in relation to disease changes. Third, the health care environment must support the clinician’s facilitation of PCDM across multiple encounters. This includes adequate time, space, and team member support to elicit preferences, the ability to provide a link to psychosocial services and support beyond the face-to-face encounter (eg, psychosocial services), and the flexibility to allow patients and caregivers to digest information, process next steps, and make a treatment decision. Finally, effective implementation of PCDM in clinical practice requires being attentive to biases that exist within the health system itself (eg, structural racism and sexism, implicit bias, authority bias) that may hinder engagement in PCDM.

**Call to Action: Recommended Next Steps**

The I-PCDMC recommendations have resulted in a “call to action” to examine the critical components of the proposed PCDM conceptual model through community-engaged, patient-centered research into the implementation of PCDM in mBC care delivery. These include the following recommendations:

1. Identify and examine current PCDM approaches, tools, programs, and interventions (small and large scale) to further develop evidence-informed PCDM care delivery models in mBC.
2. Highlight effective implementation strategies to support and sustain the uptake of PCDM in mBC treatment and use these to help to bolster and inform evidence-based best practices and guidelines around PCDM in mBC care delivery.

3. Develop a PCDM measurement strategy by identifying an initial framework for PCDM and outcomes based on the key components of PCDM, including short- and long-term outcomes to best assess the effectiveness of PCDM interventions.
   - Identify and investigate the role of relevant proximal (direct) and distal (indirect) PCDM outcomes, including consideration of how health literacy, patient activation/engagement, and health equity may impact successful attainment of PCDM or facilitate PCDM implementation.

Conclusions
Incorporating PCDM as a standard approach in mBC care delivery is needed, as this model can improve patient–clinician partnerships by ensuring preference-aligned, goal-concordant care that encompasses the whole person, and can support the selection of outcomes most meaningful to patients living with a currently incurable disease. There remains a substantial gap in understanding how oncology clinicians can optimally employ PCDM across the care continuum, as well as effective measures to assess and document its use in routine clinical practice.

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References
4. Mead KH, Wang Y, Cleary S, et al. Developing a PCDM measurement strategy by identifying the key components of PCDM and outcomes based on the proximal (direct) and distal (indirect) PCDM outcomes, including consideration of how health literacy, patient activation/engagement, and health equity may impact successful attainment of PCDM or facilitate PCDM implementation.