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Prostate Cancer Screening and Shared Decision-Making among Deaf Male Patients[1]

Introduction

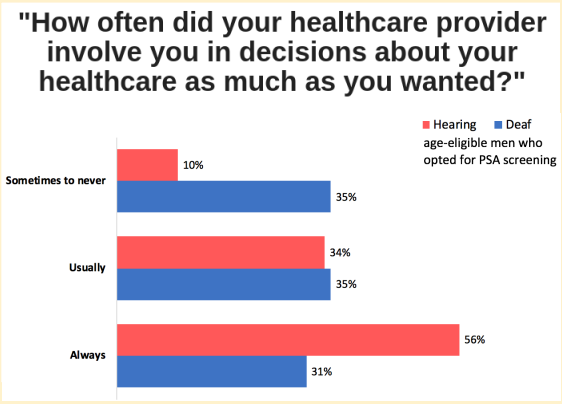
In the United States, prostate cancer is the second most common cause of deaths from cancer. Currently, there is a lack of effective screening tools to distinguish harmless prostate cancer from aggressive prostate cancer. The most common tool used today for early detection screening is prostate-specific antigens (PSA), which has its own limitations associated with higher false positive results.

Shared decision-making between patients and physicians thus becomes especially important in allowing patients to make informed decisions about their prostate health and whether to use PSA for screening. Shared decision-making is critical for patients who have lower health knowledge and are underserved in healthcare.[2]

To fully participate in shared decision-making, patients need to be able to access and understand health information. For deaf adults, shared decision-making can become difficult if providers do not share the same language, which may impact diagnosis and treatment adherence.[3,4] In this study, researchers compared shared decision-making experiences between deaf and hearing males who were either age-eligible for prostate cancer screening (45 – 69 years old) or younger than 45 years old with a family history of cancer. Data from the Health Information National Trends Survey in ASL (HINTS ASL) and English (HINTS) were used.[5]

Quick Facts

- A national sample of 318 deaf adults and 900 hearing adults
- Collected between October 2015 and April 2018
- Age-eligible (45 – 69 years old) felt less involved in shared decision-making with their providers compared to their hearing peers
- Younger deaf men with family history of cancer (18 – 44 years old) felt less involved in shared decision-making with their providers compared to their hearing peers



Findings

Based on a national sample of 318 deaf men and 708 hearing men aged 18 or over, both groups of deaf men who are age-eligible for prostate cancer screening and younger deaf men with a family history of cancer generally felt less engaged in shared decision-making with their healthcare providers compared to their hearing peers.

Deaf respondents were more likely to experience suboptimal communication with their providers, impacting the level of engagement in shared decision-making. Deaf men who used American Sign Language directly or through an interpreter with their healthcare provider were two times more likely to get PSA screening compared to deaf men who used English, written or orally.

To achieve more effective shared decision-making, the study's results indicate a need for **more culturally and linguistic providers, available interpretation services, and more accessible language in health education programs for deaf patients**.[6]

About Deaf Health Communication and Quality of Life Center

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The Deaf Health Communication and Quality of Life Center's mission is to conduct research that links accessibility to health outcomes among deaf/hard of hearing individuals.

The Center's briefs provide a snapshot of noteworthy, data-driven research findings from the Center. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

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