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Résumé

L'intention du personnel infirmier de favoriser la prise de décision éclairée en matière de dépistage du cancer du sein par mammographie

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La prise de décision éclairée en matière de dépistage du cancer du sein par mammographie suscite un intérêt croissant et le mouvement pour la diffusion d'une information équilibrée sur les bienfaits et les méfaits potentiels de cette technologie prend de l'ampleur. Les auteurs font rapport d'une enquête évaluant l'intention du personnel infirmier à fournir un soutien aux femmes ciblées par le programme de dépistage du cancer du sein du Québec dans une prise de décision éclairée en matière de dépistage du cancer du sein par mammographie. Des 840 questionnaires remplis, 618 ont été utilisés pour l'analyse de données. La moyenne + et l'écart type quant à l'intention était de 1,7 + 1,2 sur une échelle de Likert de 6 points, allant de -3 à +3, indiquant la présence d'une forte intention d'apporter un soutien aux femmes ciblés. Le contrôle comportemental perçu constituait la variable théorique la plus étroitement associée à l'intention, suivi de l'attitude et de la norme sociale. Ces résultats peuvent être utilisés pour élaborer des interventions pédagogiques qui amèneront les infirmières et les infirmiers à intégrer des interventions favorisant la prise de décision éclairée en matière de dépistage du cancer du sein par mammographie à leur pratique, et pour concevoir des outils d'aide à la prise de décision pertinents.

Mots clés : dépistage du cancer du sein, prise de décision éclairée, intention, attitude, contrôle, norme

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Nurses' Intention to Support Informed Decision-Making About Breast Cancer Screening With Mammography: A Survey

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There is growing interest in informed decision-making about breast cancer screening with mammography and growing advocacy for the provision of balanced information about potential benefits and harms. The authors report on a survey evaluating nurses' intention to support women targeted by the Quebec Breast Cancer Screening Program in making informed decisions about breast cancer screening with mammography. Of the 840 questionnaires completed, 618 were included in the data analysis. The mean ± standard deviation score for intention was 1.7 ± 1.2 on a 6-point Likert scale ranging from -3 to +3, indicating strong intention to support the targeted women. Perceived behavioural control was the theory-based variable most strongly associated with intention, followed by attitude and social norm. These results can be used to develop interventions to train nurses in integrating informed decision-making about breast cancer screening with mammography into their practice and to design relevant decision support tools.

Keywords: breast cancer screening, informed decision-making, nurses' intention, attitude, control, norm

Background

In 1998 the Quebec Ministry of Health and Social Services (MHSS) began recommending that all women aged 50 to 69 participate in the Quebec Breast Cancer Screening Program (QBCSP). Its slogan was "Breast cancer screening saves lives." However, since controversies arose about the net benefit of breast cancer screening with mammography (Gøtzsche & Nielsen, 2011; Green & Steph, 2003; Gummersbach et al., 2009; Jørgensen & Gøtzsche, 2009; Jørgensen, Klahn, & Gøtzsche, 2007) and the emergence of scientific evidence about the benefits of informed decision-making for cancer screening (Briss et al., 2004; Joosten et al., 2008; Rimer, Briss, Zeller, Chan, & Woolf, 2004; Stacey et al., 2012; Stefanek, 2011), in 2008 the MHSS revised its policy and the QBCSP

replaced its slogan with "Screening for breast cancer: A choice that belongs to you." This new approach is aimed at informed decision-making. Informed decision-making is said to occur when an individual understands the disease or condition being addressed and comprehends what the clinical service involves, including its benefits, risks, limitations, alternatives, and uncertainties; has considered his or her preferences and makes a decision consistent with them; and believes he or she has participated in decision-making at the desired level (Rimer et al., 2004). This significant paradigm shift encourages women to choose the option they feel most comfortable with.

The MHSS believes that women will wish to consult health professionals for assistance with the decision and that nurses will be called upon to play this role. In addition to being a trusted source of health-related information (Koutsopoulou, Papathanassoglou, Katapodi, & Patiraki, 2010), an increasing number of nurses are the first point of direct contact with patients in primary care (Marleau, 2012; Swiadek, 2009) as well as first to assume an advocacy role and promote informed decision-making (Bu & Jezewski, 2007; Stacey et al., 2008).

While the new QBCSP approach is not yet (as of March 2013) fully operational, the new slogan has appeared on the MHSS Web site, along with a discussion of advantages and disadvantages, and new leaflets have been produced. In addition, the MHSS is making plans to develop interventions, including training programs, to better equip health professionals in contact with women targeted by the QBCSP, mainly primary care physicians and nurses, to play a decision support role. As intention has been repeatedly shown to predict behaviour (Eccles et al., 2006; Godin, Bélanger-Gravel, Eccles, & Grimshaw, 2008), it is worth investigating whether nurses intend to play this supporting role and what might facilitate or hinder their assuming the role along with its associated behaviour.

The Theory of Planned Behaviour (TPB) (Azjen, 1991) has proved an adequate model for predicting health professionals' intention to adopt new behaviour (Armitage & Conner, 2001; Conner & Norman, 2005; Eccles et al., 2006; Godin et al., 2008). According to the TPB, behaviour is directly determined by intention to engage in the behaviour, but also by perceived control over the behaviour. Intention, in turn, is determined by attitude towards the behaviour, social norms, and perceived behavioural control (Azjen, 1991; Conner & Norman, 2005). The primary objective of this study was to measure nurses' intention to support women targeted by the QBCSP to make informed decisions about breast cancer screening with mammography and to identify determinants of this intention. The secondary objective was to identify barriers and facilitators that nurses perceive in adopting this behaviour.

Methods

Participants and Recruitment Strategy

In order to identify primary care nurses in the province of Quebec who might be in contact with women targeted by the QBCSP, we used the 2010–11 registry of the Quebec Order of Nurses. A total of 10,447 nurses, including nurse practitioners, reported working in primary care domains (Marleau, Lapointe, Saint-Georges, & Lord, 2011). Of these, we identified 7,199 nurses who might be in contact with women targeted by the QBCSP (women aged 50–69), excluding those working exclusively in maternal, child, and adolescent health care, and selected 2,267 who had given authorization to be contacted for research purposes and provided a valid e-mail address to the Order of Nurses at the time of their annual registration. During December 2010 and January 2011 we contacted these nurses, as well as all 92 nurses working with the QBCSP, by e-mail and invited them to complete an online questionnaire hosted on the Survey Monkey Web site (http://www.surveymonkey.com/). Duplicate e-mail addresses were deleted. Two reminder e-mails were sent at 3-week intervals. Each respondent could complete the questionnaire only once, in order to avoid duplicate responses.

Data Collection

The questionnaire, consisting of 17 questions in French, was divided into four parts and was preceded by a brief description of the QBCSP, including its old and new slogans (Appendix 1). The first part (question 1) was aimed at identifying nurses who might be in contact with women targeted by the QBCSP (our eligibility criterion). The second part (questions 2 to 10 — 12 TPB-based items) measured respondents' intention to support women targeted by the QBCSP in making informed decisions about breast cancer screening and assessed the determinants of this intention (attitude, social norm, and perceived behavioural control) (Azjen, 1991). Each of four socio-cognitive variables (intention, perceived behavioural control, attitude, and social norm) was assessed by means of three items using a six-point Likert scale ranging from -3 to +3. Chomeya (2010) and Preston and Colman (2000) have demonstrated that the six-point Likert scale is reliable and one of the easiest and quickest scales to use. The internal consistency of the socio-cognitive variables was acceptable as measured in our study by their respective Cronbach's alphas: intention (0.71), attitude (0.67), social norm (0.78), perceived behavioural control (0.72).

The third part of the questionnaire consisted of two questions about factors that might hinder (question 11) or facilitate (question 12) nurses in supporting women targeted by the QBCSP in making informed deci-

sions about breast cancer screening. The fourth part (questions 13 to 17) was aimed at collecting sociodemographic data.

Data Analysis

Data from the questionnaires were independently entered into a Miscrosoft Access database and validated by two trained assistants. We excluded from the analysis nurses who reported not being in contact with women targeted by the QBCSP as well as those who either did not answer any of the 12 items used in assessing intention (three items) and its three determinants (attitude, social norm, and perceived behavioural control, with three items per determinant) or who answered only one of the three items assessing each of the socio-cognitive variables. We imputed missing values using the Monte Carlo method (Roth, Switzer, & Switzer, 1999) for all respondents who provided answers to two out of the three items assessing each socio-cognitive variable. The proportion of missing values was 135/7415 (1.8%).

Nurses' reported level of contact with the targeted women was dichotomized into high contact (often in contact) and low contact (sometimes or rarely in contact). We computed descriptive statistics for all variables collected. The proportion of nurses with a strong or very strong intention (score of 2 or more) and its 95% confidence interval (CI) was calculated. Means were presented with their standard deviation (SD). In order to identify which of the TPB determinants of intention (attitude, social norm, and perceived behavioural control) might best explain the variation in nurses' intention, we first calculated the Spearman's rank correlation coefficients between intention and each of the variables. Then, in order to evaluate the adjusted effect of each variable on the intention, we performed a multivariate analysis. We could not use multiple linear regressions for data analysis due to violation of the normality and linearity assumptions that persisted even after attempting to transform the data. We therefore used multinomial logistic regression, specifically the partial proportional odds model. We could not use the proportional odds model (multinomial ordinal logistic regression) because the data violated the proportional odds assumption due to lack of proportionality in the attitude variable (Kleinbaum & Klein, 2010; Stokes, Davis, & Koch, 2003). We categorized socio-cognitive variable scores into either two (attitude) or three (all other variables) categories, according to the distribution of scores for each variable.

We also computed the proportion of nurses who selected or mentioned each of the facilitating or hindering factors vis-à-vis supporting women targeted by the QBCSP in making an informed decision about breast cancer screening. All analyses were done using the Statistical Analysis System software, Version 9.2 (SAS Institute, Cary, NC, USA).

Results

Of the 2,359 nurses invited by e-mail to participate in the study, 840 (36%) completed the questionnaire. Of this number, 716 (85%) reported being in contact with women targeted by the QBCSP. The number of nurses eligible for data analysis was 618 (86%) after the exclusion of 89 who did not answer any of the 12 items assessing the socio-cognitive variables as well as nine who answered only one of the three items assessing each socio-cognitive variable. Table 1 shows the sociodemographic characteristics of participants. As expected, there was a strong gender imbalance, with most participants being female. Most had a bachelor's degree (58%) or a college diploma (30%) and many years' experience. They were most likely to be working in a local community service centre or in a private primary care clinic. More than half of the participants reported being "rarely" or "sometimes" in contact with the women targeted by the QBCSP.

Table 1 ***Sociodemographic Characteristics of Nurses (N = 618)***

Characteristic	***n*** **(%)**
Gender	
Male	38 (6.3)
Female	565 (93.7)
Mean ± SD years in practice (n = 589): 20.7 ± 11.9	
Frequency of Contact With Targeted Women	
Often	248 (40.1)
Sometimes	234 (37.9)
Rarely	136 (22)
Education	
Master's or PhD degree	40 (6.6)
Postgraduate diploma (specialized studies)	33 (5.5)
Bachelor's degree	349 (57.7)
College diploma	183 (30.2)
Practice Domain	
Primary care private clinic	187 (30.9)
Local community service centre (home care, frontline care)	347 (57.3)
Public health service	35 (5.7)
Other (community pharmacy, nurse manager)	37 (6.1)

Note: The denominators for some characteristics differ from the sample size due to missing values.

Participants had a strong intention to support women in making informed decisions about screening for breast cancer, with a mean ± SD and median intention score of 1.7 ± 1.2 and 2.0, respectively. The proportion of nurses who had strong or very strong intention (score = 2.0 or more) was 53% (95% CI 49% to 57%). The distribution of the scores for all socio-cognitive variables was skewed to the left, with scores for attitude and social norm even more so than those for intention and perceived behavioural control. The distribution of scores for intention to support women in making an informed decision about breast cancer screening was significantly different between high-contact nurses (2.0 ± 0.9) and their low-contact counterparts (1.4 ± 1.2) (Student's t-test, $p < 0.001$).

Table 2 ***Association Between Intention and Its Theory of Planned Behaviour Determinants: Multinomial Logistic Regression (Partial Proportional Odds Models)***

Determinants of Intention	Low-Contact Nurses OR (95% CI)[a]	High-Contact Nurses OR (95% CI)	All Nurses OR (95% CI)
Attitude			
Higher score (low/medium vs. high intention score)	7.3[b]	9.4[b]	7.9[b]
Higher score (low vs. medium/high intention score)	1.7 (1.0–3.1)	4.0 (1.8–9.1)	2.2 (1.4–3.4)
Lower score[c]	1	1	1
Social Norm			
Higher score	2.4 (1.3–4.6)	1.1 (0.4–2.9)	1.6 (1.0–2.6)
Medium score	1.7 (0.9–2.9)	1.0 (0.5–2.2)	1.2 (0.8–1.8)
Lower score	1	1	1
Perceived Behavioural Control			
Higher score	2.7 (1.6–4.6)	7.0 (3.0–16.3)	3.9 (2.5–6.0)
Medium score	1.9 (1.1–3.2)	3.7 (1.8–7.8)	2.4 (1.5–3.7)
Lower score	1	1	1

[a] OR = odds radio; CI = confidence interval
[b] CI could not be calculated.
[c] Lower score: reference category

There was moderate correlation between intention and attitude (0.47, $p < 0.001$), social norm (0.43, $p < 0.001$), and perceived behavioural control (0.56, $p < 0.001$). The results of the multinomial ordinal (partial proportional odds model) logistic regression analysis of the association between intention and its determinants are shown in Table 2. Only results from the model without missing values imputed are reported, as results with and without them were similar. The odds ratio between low/medium and high intention scores and between low and medium/high intention scores were assumed to be similar for social norm and perceived behavioural control. Attitude did not meet the proportionality of odds assumption. Therefore, odds ratios are presented for low/medium versus high intention scores and for low versus medium/high intention scores. These analyses confirmed that, overall, all three determinants were associated with the nurses' intention.

The nurses' level of contact with women targeted by the QBCSP had a modifying effect on the association between intention and its socio-cognitive determinants (Table 2). The association between intention and two of its determinants, perceived behavioural control and attitude, was stronger for high-contact nurses than for their low-contact counterparts. In contrast, the association between social norm and intention was stronger for low-contact nurses. The association between intention and social norm was neither statistically nor clinically significant for high-contact nurses. None of the sociodemographic factors (number of years in practice, gender, education level, and domain of practice) was associated with nurses' intention to support the targeted women.

Table 3 ***Barriers to and Facilitators of Supporting Women in Making Informed Decisions About Breast Cancer Screening (N = 618)***

	Barrier		Facilitator	
Factor	***n***	**(%)[a]**	***n***	**(%)[a]**
Time constraints	240	39	–	–
Training	430	70	545	65
Relevant tools[b]	336	45	551	66
Other[c]	26	4	21	3

[a] % of nurses who selected or cited the factor
[b] Information and decision support tools for both nurses and patients
[c] Other barriers: state of scientific knowledge, $n = 3$; self-efficacy, $n = 2$; motivation, $n = 1$; public awareness, $n = 3$; preferences of targeted women, $n = 4$; organizational factors, $n = 13$. Other facilitators: state of scientific knowledge, $n = 1$; self-efficacy, $n = 6$; motivation, $n = 3$; public awareness, $n = 2$; awareness of targeted women, $n = 2$; organizational factors, $n = 7$

Barriers and facilitators vis-à-vis supporting women targeted by the QBCSP in making informed decisions about breast cancer screening are presented in Table 3. The most frequently cited or selected factors were time constraints (barrier) and availability of relevant information and decision support tools both for nurses and for patients (facilitators). Other relevant factors were the state of scientific knowledge, self-efficacy, motivation, general public awareness, preferences of targeted women, organizational factors (e.g., organization structure, preferences of managers or supervisors, remuneration, availability of other human resources), and awareness among targeted women of benefits and risks of breast cancer screening with mammography. When asked about the preferred mode of training in informed decision-making, more participants preferred online training (57%) to classroom training (43%).

Discussion

Our findings show that nurses who participated in the study had strong intentions to support women in making informed decisions about breast cancer screening. As expected, the mean intention of nurses who reported being often in contact with women targeted by the QBCSP was significantly higher than that of their low-contact counterparts. Perceived behavioural control was the strongest determinant of this intention, followed by attitude, no matter what the nurses' level of contact. Social norm was associated only with intention of low-contact nurses.

Perceived behavioural control has been identified as the strongest determinant predicting nurses' intention in other clinical contexts. Edwards et al. (2001) found that perceived behavioural control was the strongest predictor of nurses' intention to administer opioids for pain relief. In the same vein, Nash, Edwards, and Nebauer (1993) found that perceived behavioural control was the strongest predictor of nurses' intention to assess patients' pain. In another study, Coté, Gagnon, Kouffé-Houme, Ben-Abdeljelil, and Gagnon (2012) used the TPB to show that nurses' intention to integrate research evidence into clinical practice was explained by perceived behavioural control, normative beliefs, and past behaviour. The trend of results in these studies and ours concurs with the results of a systematic review by Armitage and Conner (2001) to assess the efficacy of the TPB in predicting intention and behaviour. They documented that health professionals' perceived behavioural control was the strongest predictor of intention, followed by attitude, while social norm was the weakest. While these findings are congruent with ours, they are not directly comparable because, to the best of our knowledge, ours is the

first study based on a theoretical model to assess nurses' intention to support women in making informed decisions about screening for cancer. These other findings, however, reinforce our results and indicate the need for interventions to make nurses believe they are capable of supporting women in making informed decisions about breast cancer screening. This can be achieved by overcoming barriers relating to perceived control and attitude.

While some studies have pointed out the difficulties of informed/shared decision-making in clinical practice (Sinding et al., 2010; Sinding, Miller, Hudak, Keller-Olaman, & Sussman, 2012), many research findings have illustrated its numerous potential benefits (Adamsen, Larsen, Bjerregaard, & Madsen, 2003; Joosten et al., 2008; Légaré, Shemilt, & Stacey, 2011; Rimer et al., 2004; Stacey et al., 2012). However, health professionals still perceive many barriers to its implementation. Hutchinson and Johnston (2004) document time constraints, lack of awareness of the research literature, and difficulty understanding statistical analyses as the chief factors influencing uptake of research findings by nurses. In the same vein, Carlson and Plonczynski (2008) report that insufficient time for nurses to implement new ideas was the most frequently mentioned barrier in 73% of the studies included in their review. Adamsen et al. (2003) found that 90% of the participants in their study saw the overwhelming amount of research findings as a barrier, while 75% complained of difficulty understanding them. Carlson and Plonczynski (2008) also found that 29% of studies included in their review reported mostly on the difficulty of understanding research findings. The barriers and facilitators reported by these researchers are closely related to those encountered by other health professionals in the implementation of informed decision-making or shared decision-making (Charles, Gafni, & Whelan, 2004; Légaré, Ratté, Gravel, & Graham, 2008).

These findings are similar to our own, in which the most widely reported barriers to supporting women in making informed decisions about breast cancer screening were as follows: lack of relevant decision aids; lack of training (in helping women make informed decisions about breast cancer screening and in using evidence-based decision aids); and lack of time, including organizational constraints. Interventions that target the barriers and facilitators identified in our study are likely to be successful in helping nurses, and possibly other health professionals, support women targeted by the QBCSP. According to the TPB, the barriers and facilitators identified by nurses in this study represent external factors that collectively are mainly associated with perceived behavioural control and attitude.

The TPB suggests that optimal intention and subsequent behavioural change are possible if interventions address issues that our study found to be related to the principal determinants of intention: (1) perceived behavioural control — nurses feel they could easily adopt this behaviour, do not perceive obstacles (such as lack of training or organizational barriers related to the health-care system), and feel they would be provided with relevant support tools; and (2) attitude — nurses consider this behaviour useful and responsible and see more advantages than disadvantages to adopting it. Interventions targeting nurses who are seldom in contact with targeted women may add components reinforcing the fact that this behaviour is the socio-professional norm.

Strengths and Limitations

This study has a number of strengths. Firstly, as intention has been shown repeatedly to predict behaviour (Eccles et al., 2006), our questionnaire was based on the TPB, a theoretical model validated and used in many international research projects to predict intention and its determinants regarding the adoption of health-care behaviours (Godin et al., 2008). Secondly, we complemented the assessment of intention and its determinants by asking nurses to identify barriers to and facilitators of adoption of the behaviour, allowing us to make concrete suggestions for designing interventions and techniques targeting behavioural change. Thirdly, the list of studies included in a systematic review by Godin et al. (2008) indicates that ours is one of the largest studies based on a socio-cognitive theory to assess the intentions of health professionals.

This study also has limitations. Of the total population of 7,291 nurses assumed to be in contact with women targeted by the QBCSP and potentially eligible to participate, our sample was restricted to the 2,359 (32%) who had given authorization to be contacted for research purposes and had provided a valid e-mail address. In addition, the response rate among these was only 36%. However, this rate is very close to the expected mean e-mail survey response rate of 37%, based on a review of 31 studies (Sheehan, 2001). Furthermore, the mean number of years in practice for the 618 nurses eligible for data analysis (21 ± 12) did not differ widely from that of the 7,291 nurses potentially eligible for our study, whose mean number of years in practice was 20. In addition, the distribution of the 618 participants by gender (6% male, 94% female) and education level (58% bachelor's degree, 30% college diploma) is comparable to that observed in the total population of 7,291 potential eligible nurses (7% male, 93% female; 44% bachelor's degree, 38% college diploma). Another limitation is that the intention of participants may have been overestimated due to a socio-professional desirability bias towards informed decision-making.

Conclusions

Nurses will likely play an increasingly important role in supporting women in making informed decisions about breast cancer screening with mammography. The results of this study could be used to develop interventions aimed at helping nurses play this role. Using the components of perceived behavioural control and attitude to train nurses in how to integrate informed decision-making into their practice and providing both nurses and targeted women with decision support tools could foster the targeted behaviour. Interventions may also consider the importance of socio-professional norm for nurses who are not often in contact with the targeted women. The feasibility and effectiveness of these interventions should be further evaluated.

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Appendix 1 ***Questionnaire***[1]

For the past 10 years the Quebec Ministry of Health and Social Services (MHSS) has sent a letter to all women aged 50 to 69 inviting them to participate in the Quebec Breast Cancer Screening Program (QBCSP). Until recently the QBCSP encouraged all women in this age group to participate. The MHSS will now be changing this approach.

In line with its current slogan, "Screening for breast cancer: A decision that belongs to you," the QBCSP will put in place mechanisms to inform women about the potential disadvantages as well as the benefits of breast cancer screening, based on the best scientific evidence. These will consist of awareness campaigns targeting the general public and health professionals, leaflets, a Web site for women invited to participate in the program, and training for health professionals in informed decision-making about breast cancer screening.

The goal is to ensure that every woman contacted by the QBCSP is able to make an informed decision whether to undergo breast cancer screening. According to this approach, there is no best decision (to screen) or worst decision (not to screen). Both options are acceptable. Each woman has to choose the option she feels most comfortable with after having reviewed the information provided. Please imagine that this approach has already been adopted and then respond to the following questions.

[1] Translated from the original French. Only questions 1 to 11 are included here. The full version (17 questions) may be obtained by contacting Michel Labrecque at michel.labrecque@fmed.ulaval.ca.

1. In my current practice, I meet women targeted by the QBCSP:

☐ OFTEN ☐ SOMETIMES ☐ RARELY ☐ NEVER

2. I intend to help women targeted by the QBCSP in making informed decisions about screening for breast cancer:

STRONGLY DISAGREE — STRONGLY AGREE

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

3. The likelihood that I will help women targeted by the QBCSP in making informed decisions about screening for breast cancer is:

VERY WEAK — VERY STRONG

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

4. I feel that helping women targeted by the QBCSP in making informed decisions about breast cancer screening is:

USELESS — VERY USEFUL

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

VERY DIFFICULT — VERY EASY

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

VERY UNLIKELY — VERY LIKELY

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

VERY IRRESPONSIBLE — VERY RESPONSIBLE

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

5. Most people in my work environment would approve/disapprove of my helping women targeted by the QBCSP in making informed decisions about screening for breast cancer:

STRONGLY DISAPPROVE OF — STRONGLY APPROVE OF

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

6. I don't see any obstacles in helping women targeted by the QBCSP in making informed decisions about screening for breast cancer:

STRONGLY DISAGREE — STRONGLY AGREE

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

7. I believe that there are more advantages than disadvantages for women targeted by the QBCSP if I help them in making informed decisions about screening for breast cancer:

STRONGLY DISAGREE — STRONGLY AGREE

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

8. Most people who are important to me would approve/disapprove of my helping women targeted by the QBCSP in making informed decisions about screening for breast cancer:

STRONGLY DISAPPROVE OF — STRONGLY APPROVE OF

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

9. I am able to help women targeted by the QBCSP in making informed decisions about screening for breast cancer:

STRONGLY DISAGREE — STRONGLY AGREE

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

10. Most of my patients targeted by the QBCSP would approve/disapprove of my helping them in making informed decisions about screening for breast cancer:

STRONGLY DISAPPROVE OF — STRONGLY APPROVE OF

☐ -3 ☐ -2 ☐ -1 ☐ 1 ☐ 2 ☐ 3

11. Factors that could hinder me from supporting women targeted by the QBCSP in making informed decisions:

☐ LACK OF TIME

☐ LACK OF TRAINING (TRAINING IN INFORMED DECISION-MAKING)

☐ LACK OF RELEVANT DECISION SUPPORT TOOLS

☐ LACK OF TIME

☐ OTHER (PLEASE SPECIFY) _____