Shared Decision-Making in the Context of African, Caribbean, and Black Patients Seeking Diabetes Care: A Concept Analysis with Implications for Cardiovascular Advanced Practice Nursing

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Abstract

Background: *Shared decision-making (SDM) enhances patient-clinician collaboration. Racism and discrimination hinder SDM for African, Caribbean, and Black (ACB) patients, who are disproportionately affected by diabetes and cardiovascular complications. There is limited evidence investigating SDM for ACB patients with diabetes and no concept analyses to date have conceptualized SDM for ACB patients with diabetes.*

Purpose: *To clarify the concept of SDM among ACB patients with diabetes.*

Methods: *Following Walker and Avant's concept analysis approach, we searched CINAHL, Nursing & Allied Health, Medline, Scopus, and Embase in November 2023. Eligible articles defined SDM, involved ACB patients, and were published after 2010.*

Results: *Of 181 records, 11 studies were included. Identified attributes include collaboration, communication, and cultural competency. Shared decision-making is conceptualized with a focus on the barriers impeding this approach.*

Conclusions: *Equitable SDM improves ACB patients' involvement in decisions. Cardiovascular Advanced Practice Nurses have an important role in implementing equitable SDM. Research should focus on supporting all members of the interprofessional team to mitigate barriers to SDM.*

Keywords: advanced practice nurses, Black patients, concept analysis, diabetes, shared decision-making

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Key Highlights

- **Disparities in Diabetes Care:** ACB patients are disproportionately affected by diabetes and cardiovascular complications. Barriers such as racial bias and discrimination further exacerbate health disparities and impede effective diabetes management.
- **Significance of SDM:** SDM is an approach that fosters collaboration between clinicians and patients, ensuring that treatment plans are tailored to individual patient needs and preferences. However, traditional SDM models often fail to address the unique cultural needs of ACB patients.
- **Cultural Competence in SDM:** Effective SDM with ACB patients requires culturally competent care that respects and integrates their values, preferences, and experiences. Clinicians must actively listen, avoid discriminatory practices, and provide culturally appropriate recommendations.
- **Operational Definition and Attributes:** The manuscript proposes a new operational definition of SDM for ACB patients with diabetes, emphasizing humanistic communication, collaboration, and culturally competent care.

Diabetes is a chronic disease affecting 1 in 10 adult Canadians (Statistics Canada, 2023). Poorly controlled diabetes, characterized by elevated glucose in the bloodstream, poses serious long-term damage to one's blood vessels, nerves, and organs (Heart and Stroke Foundation of Canada [HSFC], 2024). Among the affected organs is the heart, as elevated glucose levels over time impair the blood vessels and nerves essential for heart function, thereby increasing the risk of cardiovascular disease (CVD; HSFC, 2024). Cardiovascular diseases, which encompass conditions impacting the heart and blood vessels, are the leading cause of death globally (American Heart Association [AHA], 2024; Lindstrom et al., 2022). Diabetes is recognized as a critical risk factor for CVDs, with individuals diagnosed with diabetes being twice as likely to develop CVDs, such as heart failure and stroke (AHA, 2024; Lindstrom et al., 2022; Public Health Agency of Canada [PHAC], 2018). Effective diabetes management requires patients to regularly seek primary care services and make decisions with their clinicians regarding medication options, blood sugar monitoring, and lifestyle modifications (Peek et al., 2010a). African, Caribbean, and Black (ACB) patients are disproportionately affected by both type 1 (T1DM) and type 2 (T2DM) diabetes mellitus, experiencing twice the risk compared to White patients, and being at an increased risk for developing CVDs (Peek et al., 2010a). Furthermore, the ACB patient population with diabetes is underrepresented in the literature, with few studies focusing on the barriers contributing to this health disparity (Quinn et al., 2011).

Shared decision-making (SDM) is a recommended approach to facilitate effective collaboration between clinicians and patients when making health decisions (Peek et al., 2010a). Shared decision-making is a process where clinicians collaborate and actively engage with patients as equal partners to enable patients to make informed decisions regarding their health and wellness that align with their values, preferences, and needs (Hoefel et al., 2020; Stacey et al., 2020). Shared decision-making is important in the context of diabetes and cardiac care by ensuring that treatment plans are tailored to individual patient needs and preferences (Mhaimeed et al., 2023). The implementation of SDM has been linked to improved quality of the decision made, patient knowledge of their diagnosis and available options, patient satisfaction, and patient-clinician communication (Freeman-Hildreth et al., 2024; Kashaf et al., 2017). Emerging evidence also suggests that challenges in the implementation of SDM among ACB patients with diabetes in the global north are largely due to barriers that disproportionately impact this population, such as anti-Black racism and discrimination (Peek et al., 2010a). These barriers prevent ACB patients from receiving equitable healthcare services, leading to poor diabetes management, suboptimal mental health, and mistrust toward clinicians (Anim et al., 2024). Currently, limited studies explore SDM between clinicians and ACB patients with diabetes in primary care settings (Peek et al., 2010a). The existing concept of SDM does not fully capture the needs of ACB patients when engaging in health decisions (Mhaimeed et al., 2023; Zisman-Ilani et al., 2023). Furthermore, no existing concept analyses have conceptualized SDM in the context of ACB populations with diabetes. The purpose of this concept analysis is to explore and provide an operational definition of SDM among ACB patients who are making diabetes health decisions in primary care settings.

Methods

Study Design

A concept analysis is an approach used to explore what is known about a concept in the existing literature, understand its components, and develop a clear and precise operational definition (Walker & Avant, 2011). This study employed Walker and Avant's (2011) eight-step approach for concept analysis, chosen for its capacity to provide a comprehensive and structured framework. The first step is to select a concept for the analysis. The second step involves identifying the purpose for the concept analysis. The third step focuses on identifying all uses of the concept within a discipline. In the fourth step, the attributes that characterize the concept are determined. The fifth step involves creating a model case based on a real-life or hypothetical scenario that reflects an example of how the concept is appropriately depicted. In the sixth step, alternative cases are constructed, such as a contrary case in which an example of how the concept is not used correctly is depicted. For the purposes of our concept analysis, we have developed hypothetical scenarios. The seventh step involves identifying the antecedents, which are the necessary components preceding the concept, and the consequences, which describe what happens as a result of the concept. Finally, the eighth step defines empirical referents, which outline how the concept can be measured or evaluated. This approach was used to explore and define the concept of SDM in the context of ACB patients seeking diabetes care.

Data Collection

An independent reviewer conducted a literature search in CINAHL, Nursing & Allied Health, Medline (Ovid), Scopus, and Embase databases in November 2023 to explore how SDM in the context of ACB patients diagnosed with diabetes has been conceptualized in the existing literature. The search strategy was developed with the guidance of the University of Ottawa's Faculty of Health Science librarian (see Table 1). Search terms included the exact phrase "shared decision-making" as the concept and "diabetes" or "diabetic" as the diagnosis. The ACB population was represented using the search terms "African*," "Caribbean*," or "Black*," with an asterisk at the end of each term to address variations. The Boolean operator "and" was used to yield search results referring to all three aspects in the title or abstract.

Table 1

Database Search Terms

Concept	Title and Abstract Search Terms
Concept 1: Shared Decision Making	"Decision making" OR "making decisions" OR "informed decisions" OR "collaborative decisions" OR "decision support" OR "preferred decision" OR "information needs" OR "decision aids"
Concept 2: African, Caribbean, and Black Population	"african*" OR "caribbean*" OR "black*" OR "afro*" OR "racialized*"
Concept 3: Diabetes	"Diabetes" OR "diabetic" OR "hyperglycemia" OR "insulin resistance" OR "blood glucose monitoring"

Inclusion Criteria

Eligible articles had to explicitly define the term SDM in the article, focusing on adult ACB patients with T1DM or T2DM as the primary diagnosis. Eligible articles encompassed empirical quantitative, qualitative, and mixed-methods studies or gray literature. They had to be published in English and be from countries in the global north, where ACB populations are a minority ethnic group. We excluded articles that were not available online in the English language, did not describe SDM in the context of primary care, did not focus on the needs of ACB patients, and T1DM or T2DM were not a diagnosis that was discussed. Articles related to prediabetes, pediatrics, gestational diabetes, and technology were also excluded, as the primary focus was specifically on T1DM and T2DM. The publication year was restricted from 2010 to present to ensure relevant and timely findings for our current healthcare context.

Selection of Articles

Eligible articles obtained through the literature search were selected through a manual screening process (Figure 1). Initially, titles and abstracts of each article were reviewed to identify potentially relevant studies. This was followed by a full-text screening to ensure each selected study met the inclusion criteria.

Data Extraction and Analysis

The extraction phase involved gathering relevant data from the studies included. We began by identifying how SDM was defined and conceptualized across each study and synthesized the findings. Additionally, we examined the attributes, antecedents, consequences, and empirical referents associated with SDM. The operational definition was derived from integrating these insights, focusing on common elements in the context of ACB patients with diabetes.

Results

Steps 1 and 2 of Walker and Avant's (2011) eight-step approach for concept analysis are addressed in the article's introduction, in which the identified concept of SDM in the context of ACB patients diagnosed with diabetes and the purpose are explicitly identified. Steps 3 to 8 are addressed below, whereby we present the search results of the literature review. Finally, we propose a new operational definition for the concept.

Search Results

The initial search yielded 181 results across the selected databases (Figure 1). At the title and abstract level, we removed 88 duplicates, five sources published before 2010, and 77 sources that did not meet the inclusion criteria. After the full-text screening process, 11 sources met the inclusion criteria. These comprised one scoping review, five qualitative, two quantitative, and three mixed-methods studies.

Step 3: Identified Uses of the Concept

Definition of SDM

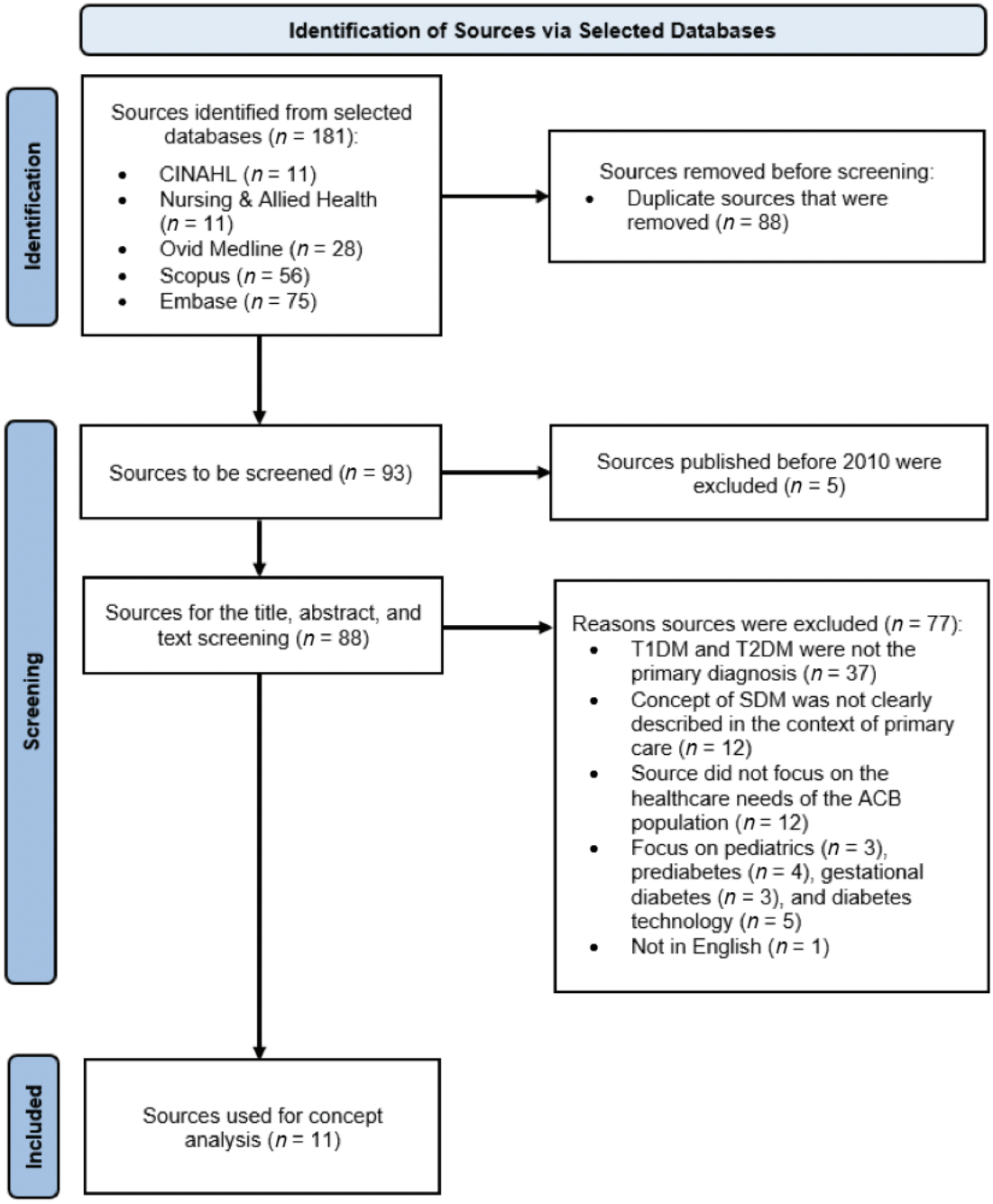
Shared decision-making has been conceptualized as an approach to facilitating patient-clinician collaboration in decision-making. For instance, Mhaimeed et al. (2023) defined SDM as a concept that "is a model of patient-clinician interaction in which both parties share information and take steps to build consensus regarding preferred treatments" (p. 1). Peek et al. (2012) defined SDM as a process in which "patients are equal partners with their physicians in the discussions and decisions about diabetes treatment and clinical care" (p. 297). This concept also focuses on equity, as Whitney et al. (2017) highlighted the importance of including patients in the decision-making process and incorporating their preferences and values. Zisman-Ilani et al. (2023) noted that SDM is "a recommended practice to improve health communication and decision making and is particularly recommended for patients with T2D" (p. 1). Together, these definitions demonstrate that SDM is a collaborative process requiring communication and equity.

Use of the Concept

Within the literature, SDM, in the context of ACB patients seeking diabetes care, focuses on the role of physicians, with no mention of nurses or other clinicians (Mhaimeed et al., 2023). When describing SDM, synonyms of this concept have been used interchangeably, such as 'collaborative,' 'participatory,' and 'informed' decision-making (Mhaimeed et al., 2023; Quinn et al., 2011). Barriers to implementing SDM that adversely affect ACB populations have also been identified. An example involved clinicians engaging in discriminatory practices, such as dismissing the patient's concerns, stereotyping, using condescending language, withholding information, and treating ACB patients differently than other patients (Peek et al., 2010b; Peek et al., 2012). This results in ACB patients not trusting clinicians and suboptimal

Figure 1

PRISMA Flow Diagram Representing the Literature Search Process



collaboration during SDM (Mhaimeed et al., 2023; Peek et al., 2010b). Another reported barrier was poor communication, which occurred when clinicians used medical jargon, lacked interpersonal skills, and did not actively listen to the patient (Peek et al., 2010b; Zisman-Ilani et al., 2023). This prevented effective information exchange and limited SDM (Mhaimeed et al., 2023; Peek et al., 2010b).

SDM Process

Included articles describe SDM as a process that begins with *bidirectional communication.* This occurs when patients share their experiences, values, and preferences while clinicians actively listen and offer information related to the condition and the available options. This enables clinicians to understand what matters most to the patient and identify

their needs. Barriers in this phase include ineffective communication, discrimination from clinicians, and clinicians appearing disengaged from the conversation (Peek et al., 2010a; Whitney et al., 2017).

In the second phase, after initial bidirectional communication, clinicians provide *culturally tailored options and recommendations.* Clinicians offer and may recommend evidence-based treatment options that incorporate the patients' cultural needs, values, and preferences. For example, recommendations for a dietary plan must align with the patient's preferred cultural meals. Patients will consider these options and be invited to ask questions for clarification. Barriers include clinicians withholding information or not eliciting or incorporating the patient's needs, values, and preferences into their recommendations (Peek et al., 2010a; Whitney et al., 2017).

Once the patient has considered each of the available treatment options, a *culturally appropriate shared decision* will be achieved in which patients and clinicians mutually agree on a patient-centred treatment plan that aligns with the patient's cultural needs, values, and preferences. This can involve the patient's family for social support, setting manageable goals, and arranging follow-up appointments. Barriers at this phase include clinicians imposing decisions on the patient, excluding the patient's support system, and disregarding the patient's cultural needs. A summary of the SDM process is depicted in Figure 2 (Mhaimeed et al., 2023; Peek et al., 2010a).

Step 4: Defining Attributes

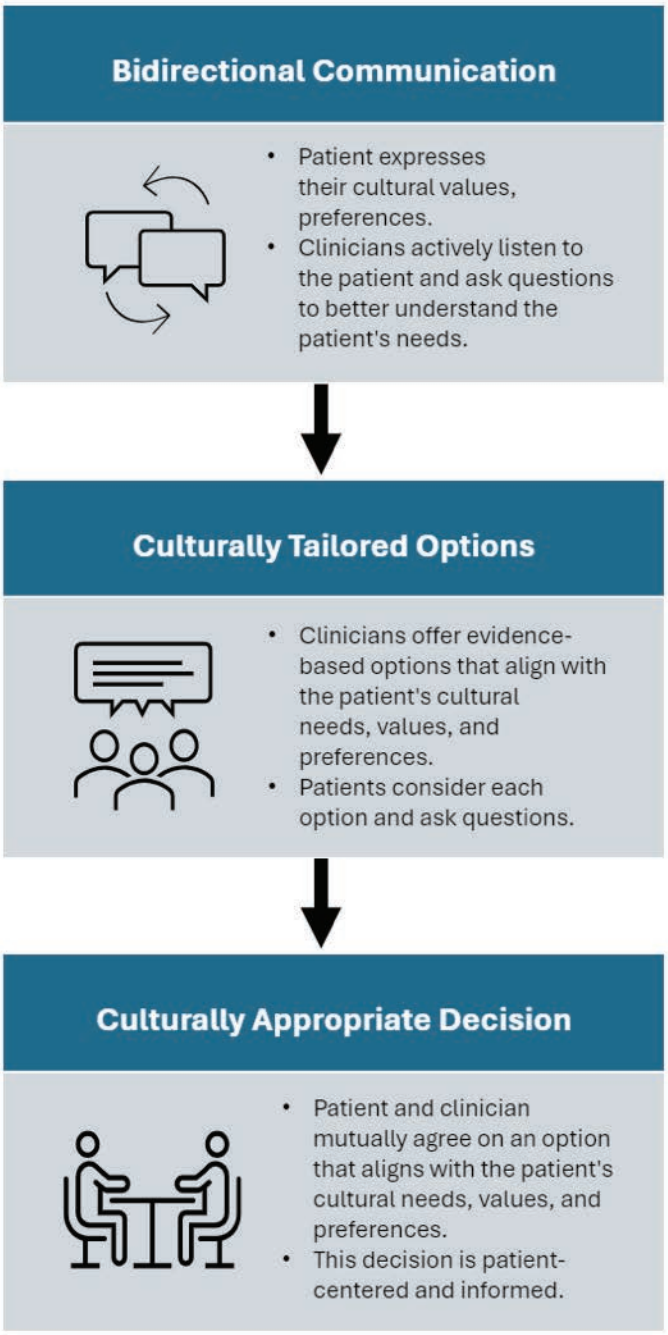
Three attributes characterize SDM. One attribute is *collaboration*, where clinicians and patients work together to identify the patient's preferences for the options and establish a treatment plan (Peek et al., 2010a). Collaboration empowers patients to make decisions with clinicians and increases patient engagement during the decision-making process (Whitney et al., 2017). This attribute requires mutual trust, respect, honesty, and open communication (Zisman-Ilani et al., 2023). This leads to a patient-centred treatment plan to achieve the best possible health outcomes (Syverud et al., 2021).

Another attribute is *humanistic communication,* whereby clinicians actively listen to the patient and understand the patient's perspective (Zisman-Ilani et al., 2023). This requires empathy (Zisman-Ilani et al., 2023), honesty (Peek et al., 2013), and respect (Whitney et al., 2017). For example, patients may need a modified medication regimen to align with their routine (Quinn et al., 2011). Clinicians demonstrated this attribute by validating the patient's concerns and educating the patient on alternative medication options during the recommendations phase (Peek et al., 2012). This resulted in patients feeling valued, increasing collaboration through SDM (Peek et al., 2010a).

The third attribute is *culturally competent or appropriate care,* which requires clinicians to provide care that respects the patient's cultural values and beliefs (Peek et al., 2012). Culture has a significant role in shaping one's perceptions and decision-making needs (Mhaimeed et al., 2023). Therefore, being aware of the patient's cultural background enables clinicians to engage the patient in developing a patient-centred treatment plan (Peek et al., 2012). For example, Whitney et al. (2017) discussed how the African-American church shares strong spiritual values. In this example, clinicians can

Figure 2

A Process for Shared Decision-Making with ACB Patients



demonstrate culturally competent care by respecting the patient's religious needs and incorporating the patient's spiritual values during the decision-making process (Whitney et al., 2017). This can increase patient satisfaction and quality decision-making (Syverud et al., 2021).

Step 5: A Hypothetical Model Case

Mrs. E is a 38-year-old Black patient of Kenyan descent. She was diagnosed with T2DM four months ago. Mrs. E scheduled an appointment with her Primary Care Nurse Practitioner (NP) to share her frustrations with her current diabetes treatment plan involving the use of a glucometer to monitor her blood sugar and follow a prescribed dietary plan.

At the appointment, the NP initiated the conversation by inquiring about Mrs. E's preferences and goals related to diabetes management. The NP also explored Mrs. E's cultural background to understand how her heritage influences her lifestyle and values. Mrs. E shared that she had difficulty using her glucometer at home to assess her blood glucose levels. Mrs. E also expressed that the prescribed diet was "too bland," making it difficult to adhere to the plan. The NP actively listened to Mrs. E by validating her experiences and acknowledging her concerns.

After listening to Mrs. E's health-related concerns, the NP actively engaged Mrs. E in discussing the importance of managing her blood sugar by accurately using a glucometer and making appropriate lifestyle changes. Specifically, the NP explained the available treatment options, which included identifying alternative glucometers available and referring the patient to a dietitian specializing in culturally tailored meal planning. The NP engaged Mrs. E in a discussion about medication options and the risks and benefits of each, how to use a glucometer, a dietary plan that incorporates traditional Kenyan meals, and explored the feasibility of recommended lifestyle modifications for Mrs. E's situation. The NP used understandable language and Mrs. E's preferred method of communication to ensure understanding. This resulted in the NP and Mrs. E collaboratively developing an individualized diabetes management plan aligned with Mrs. E's lifestyle, culture, and values. Together, they agreed on achievable short-term goals and identified ways to involve Mrs. E's family to support her. Ultimately, Mrs. E felt empowered and demonstrated increased satisfaction following this positive healthcare experience.

Step 6: A Hypothetical Contrary Case

Mr. E is a 42-year-old Black male patient of Haitian descent. Mr. E was recently diagnosed with T2DM and scheduled an appointment to meet with his Primary Care NP to seek assistance with diabetes management. During the appointment, the NP neglected to discuss Mr. E's cultural background or inquire about his values, preferences, and treatment goals related to diabetes management. When Mr. E attempted to voice concerns about previous experiences of discrimination in healthcare settings, the NP disregarded these issues.

Mr. E encountered difficulties understanding the medical terminology used by the NP, compounded by English being his second language. Despite this language barrier, the NP failed to provide adequate explanations about available treatment options, leaving Mr. E with a limited understanding of his diagnosis and potential treatment approaches. The NP proceeded to prescribe a treatment plan based on generic guidelines, which did not account for Mr. E's individual preferences, values, or goals. This impersonal approach deepened Mr. E's mistrust toward clinicians and the healthcare system, leaving him feeling disempowered and dissatisfied with his healthcare experience.

Step 7: The Antecedents and Consequences

Antecedents

For SDM to occur, patients must recognize the significance of their diabetes diagnosis, understand the need for medical treatment, demonstrate willingness to participate, and perceive themselves as capable decision-makers (Peek et al., 2012; Syverud et al., 2021). Clinicians must provide a safe space and be knowledgeable regarding diabetes pathophysiology, assessments, treatment, communication strategies, and SDM knowledge and skills (Peek et al., 2010b; Quinn et al., 2011). Additionally, clinicians need to recognize barriers to equitable healthcare and have the skills to provide culturally competent care (Quinn et al., 2011; Whitney et al., 2017). Overall, patients and clinicians must recognize that a culturally appropriate decision regarding the course of treatment must be made, exhibit willingness to collaborate and share mutual trust (Peek et al., 2012; Whitney et al., 2017).

Consequences

Effective SDM increases communication and collaboration between clinicians and patients, resulting in developing a patient-centred treatment plan that addresses the patient's values, preferences, and cultural needs (Peek et al., 2010b). Through SDM, clinicians can improve the patient's health literacy by tailoring to meet the patient's learning needs (Whitney et al., 2017). According to Peek et al. (2012), patients who actively participate in the decision-making process report increased satisfaction and empowerment in managing their care. This leads to sustained lifestyle changes, improved glycemic control, decreased blood pressure, reduced hospitalizations, etc. (Peek et al., 2010b; Quinn et al., 2011). Furthermore, patients who feel that their opinions are valued and receive culturally appropriate care through SDM are more likely to trust clinicians (Mhaimeed et al., 2023).

Step 8: The Empirical Referents

Indicators of successful SDM with ACB patients include patients who are actively engaging in discussions regarding their care, share their experiences and preferences, ask questions, and express overall satisfaction with the care provided during the decision-making process (Zisman-Ilani et al., 2021). Patients' experiences with SDM can be measured

using self-reporting tools, such as the Patient-Practitioner Orientation Scale (PPOS; Peek et al., 2011). This tool requires patients to self-report their preferences and experiences regarding SDM with physicians by answering six questions (Peek et al., 2011). Each question contains a six-point Likert scale and addresses the three phases of the SDM process, with an internal reliability Cronbach's alpha score of 0.81 (Peek et al., 2011). Similarly, Syverud et al. (2021) recommended the Desire to Participate in Shared Decision-Making (DPMD) scale, and Zisman-Ilani et al. (2023) introduced the Shared Decision-Making Questionnaire (SDM-Q9), all serving the same objective. However, these scales overlook race as a factor impacting SDM in the care of ACB patients (Zisman-Ilani et al., 2021).

Proposed New Operational Definition

A definition of SDM in the context of ACB patients with diabetes is needed to incorporate clinicians other than physicians, particularly nurses and, further emphasize cultural competence throughout the SDM process. A proposed new operational definition of SDM, specifically for ACB patients with diabetes, can be considered: a concept in health care that describes patients' and clinicians' engagement in bidirectional communication and collaboration when making decisions regarding the course of treatment. Shared decision-making, in this context, requires clinicians to actively listen to the patient, avoid barriers and discriminatory practices preventing equitable healthcare delivery, and if they arise, address them, provide culturally competent care, and tailor treatment options to meet the patient's holistic needs (Mhaimeed et al., 2023; Zisman-Ilani et al., 2023).

Discussion

This concept analysis revealed that existing definitions of SDM often overlook the significance of culturally appropriate care, which is crucial for achieving equitable and effective healthcare outcomes (Mhaimeed et al., 2023). While the uses of the concept of SDM in the context of ACB patients with diabetes aligns with the established definition of SDM (Stacey et al., 2020), there is a notable absence of cultural competency as a critical component to the established definition (Mhaimeed et al., 2023). The study findings describe SDM as a process that can be organized into three components (see Figure 2): bidirectional communication, culturally tailored recommendations, and reaching a mutually agreed-upon and culturally appropriate decision (Mhaimeed et al., 2023; Peek et al., 2010a). However, barriers, such as discrimination, disregard for the patient's cultural needs, and poor communication, impede effective and equitable SDM among the ACB population (Mhaimeed et al., 2023; Peek et al., 2010b). Although existing definitions emphasize the collaborative nature of SDM between patients and clinicians, there is a notable gap in its practical application and the breadth of research exploring culturally inclusive approaches (Whitney et al., 2017). Culturally sensitive care is an important factor in the context of the ACB population as it ensures that their values, preferences, and experiences are respected and integrated into their care (Whitney et al., 2017). Key attributes to successfully achieve SDM identified through this analysis include collaboration between patients and clinicians, humanistic communication involving empathy and honesty, and culturally appropriate care that respects the patient's cultural values and preferences (Quinn et al., 2011; Zisman-Ilani et al., 2023). Ultimately, this paper proposes a new operational definition of SDM as a process that incorporates the attributes discussed in the literature and emphasizes the need for culturally appropriate care to be practiced by all clinicians.

Implications for Practice

Primary care NPs and diabetes clinical nurse specialists (CNSs) are advanced practice nurses (APNs) who can use their clinical and academic expertise to integrate SDM strategies effectively into their care (Peek et al., 2011). SDM is a concept that can be integrated into the practice of APNs when providing care for ACB patients with diabetes (Zisman-Ilani et al., 2021). This is reflected through three competencies identified in the APN pan-Canadian framework: consultation and collaboration, direct comprehensive care, and education (Canadian Nurses Association [CNA], 2019).

Shared decision-making is related to the competency of consultation and collaboration in working with patients and families when developing a treatment plan for diabetes management. Collaboration is one of the three attributes identified in the SDM literature, as both patients and APNs need to work together to identify the patient's concerns and preferences, discuss possible treatment options, and mutually agree upon a decision. For example, suppose a patient expresses frustrations with the current dietary plan during the information exchange phase. In that case, the APN can work with the patient to find a solution during the recommendations phase. Solutions to this concern may include modifying the dietary plan to incorporate cultural meals, collaborating with the patient's family for support at home, and consulting a dietitian for additional resources. This individualized plan meets the patient's preferences and cultural needs, which empowers patients to engage in SDM and follow the treatment plan. This also encourages APNs to consult other clinicians, such as physicians or social workers, to optimize patient care. This has implications for interprofessional SDM, where two or more clinicians collaborate to deliver patient-centred care and support patients in decision-making (CNA, 2019; Peek et al., 2011; Stacey et al., 2016).

Direct comprehensive care is achieved when APNs communicate with the patient, apply their knowledge of diabetes pathophysiology, and collaboratively develop a patient-centred treatment plan. Shared decision-making has a direct role within this competency, as APNs need to collaborate with patients to provide patient-centred care throughout the three

phases of the SDM process. For example, APNs need SDM when caring for patients who report difficulty using their glucometer to monitor blood glucose levels. This is achieved by listening to their concerns and identifying the patient's preferences during the information exchange phase. In the recommendation and deliberation phase, APNs identify strategies to educate patients on glucose monitoring, explain the importance of glycemic control, and provide resources to support patients in using their glucometer. Advanced practice nurses collaborate with patients to mutually agree upon a decision and plan follow-up appointments to monitor outcomes during the decision-making phase. SDM ultimately promotes therapeutic communication and collaboration between patients and APNs (CNA, 2019; Zisman-Ilani et al., 2023).

Finally, education is a competency in which SDM has a direct role in APN practice. Through humanistic communication, APNs are responsible for interacting with patients and evaluating the patient's learning needs. Based on this assessment, APNs provide education to their patients regarding diabetes pathophysiology during the information exchange phase, and the available treatment options during the recommendations and deliberation phase. For instance, APNs can educate patients on how to use a glucometer to monitor their blood sugar by demonstrating this skill to the patient. Shared decision-making impacts patient education by improving the patient's health literacy and empowering them to make decisions regarding glucose management. Patient education should be culturally tailored and involve the appropriate language to ensure the patient's understanding (CNA, 2019; Peek et al., 2010a).

Relevance for Nursing

Understanding SDM in the context of ACB patients with diabetes seeking primary care services is required to address this gap and overcome racial barriers (Zisman-Ilani et al., 2023). This will allow clinicians to understand the impact of SDM on ACB patients and how to provide culturally competent patient-centred care (Mhaimeed et al., 2023). Advanced practice nurses, including NPs and CNSs, are well-positioned to implement patient-centred SDM strategies and address barriers preventing equitable healthcare delivery to promote positive health outcomes and experiences (Peek et al., 2011; Zisman-Ilani et al., 2021).

Strengths and Limitations

This concept analysis has several notable strengths. First, it addresses a gap in the existing literature by focusing on the concept of SDM in the context of ACB patients diagnosed with diabetes, a group that is disproportionately impacted by diabetes and under-represented in research. The analysis implemented Walker and Avant's (2011) systematic eight-step method to allow for a rigorous and structured approach to analyzing the concept of SDM. The inclusion of studies employing different study designs allows for a diverse exploration of the factors influencing SDM for ACB patients. Yet, our findings need to be considered in view of some limitations. First, we identified a limited variety of sources, as Peek was the first author for five of the 11 included studies. Another limitation is that 10 studies were based in the United States and none focused exclusively on the Canadian context. Despite this, the findings remain relevant to the experiences of ACB populations seeking healthcare services in the Canadian healthcare system, with barriers to care, such as anti-Black racism, medical mistrust, and paternalistic care having been documented in Canadian studies as well (Williams et al., 2024). Finally, the screening process was conducted by a single reviewer, as this concept analysis was part of a graduate nursing course that required the primary author to conduct screening independently, which may have introduced possible selection bias. To reduce the possibility of bias, the screening criteria and data extraction processes were clearly defined, and the study findings were reviewed by two co-authors.

Recommendations for Research

Future research needs to prioritize examining SDM among the ACB population with diabetes to address the gaps highlighted in this paper. Systemic barriers impeding equitable SDM need to be further examined to determine ways to address this in clinical practice and promote cultural competency. Additionally, greater attention needs to be placed on the role of nursing in the implementation of interprofessional SDM, as opposed to solely focusing on the role of physicians. Finally, future work should adopt a research co-production approach, including patient partners, nurses and other clinical members of the interprofessional team, on research teams, to ensure that the work is relevant and aligns with the perspectives and lived experiences of this patient population and the people caring for them.

Conclusion

This paper aimed to provide a clear and precise operational definition of SDM to support an appropriate understanding of the term, improve SDM practices, and address the research gap concerning the decision-making needs of ACB patients with diabetes. It also aimed to conceptualize SDM to support clinicians in fostering culturally appropriate SDM, when caring for ACB patients diagnosed with diabetes. Clinicians are responsible for addressing racial inequities and providing culturally appropriate care to promote patient-centred care, patient satisfaction, and positive health outcomes and experiences. Within the context of the ACB population with diabetes, APNs and other clinicians need to encourage SDM that addresses racial inequities acting as barriers during the decision-making process. This also requires clinicians to address racial bias and discriminatory practices. By addressing these barriers, clinicians can provide equitable care throughout the three phases of the SDM process. This can thereby mitigate the burden of diabetes and risk for CVDs. Future studies should focus on developing culturally

tailored decision support strategies, such as decision aids, to facilitate SDM in clinical practice for ACB patients (CNA, 2019; Peek et al., 2013).

Author Note

There are no conflicts of interest to disclose.

Disclosures

Co-Editor-in-Chief Davina Banner handled the review process for this article. Krystina B. Lewis had no access to the paper during the review process in her role as co-Editor-in-Chief or reviewer.

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