



Patients' preferred and perceived roles in making decisions about adjuvant chemotherapy for non-small-cell lung cancer

Erin Moth^{a,b,*}, Sue-Anne McLachlan^c, Anne-Sophie Veillard^d, Nick Muljadi^d, Malcolm Hudson^d, Martin R. Stockler^{a,b,d}, Prunella Blinman^{a,b}

^a Concord Cancer Centre, Sydney Australia

^b University of Sydney, Sydney, Australia

^c St Vincent's Hospital, Melbourne, Australia

^d NHMRC Clinical Trials Centre, Sydney, Australia

ARTICLE INFO

Article history:

Received 29 October 2015

Received in revised form 12 February 2016

Accepted 17 February 2016

Keywords:

Non-small-cell lung cancer

Adjuvant chemotherapy

Preferences

Decision-making

ABSTRACT

Background: People with cancer have varying preferences for involvement in decision-making between active, collaborative and passive roles. We sought the preferred and perceived involvement in decision-making among patients considering adjuvant chemotherapy (ACT) after resection of early non-small cell lung cancer (NSCLC).

Methods: Patients considering ACT for NSCLC were asked to complete a self-administered questionnaire at baseline and 6 months. Preferred and perceived decision-making roles were assessed by the Control Preferences Scale (CPS). We examined differences between preferred and perceived roles, differences in preferred roles over time, determinants of preferences, and differences in treatment preferences between patients preferring active and less active roles.

Results: 98 patients completed the baseline questionnaire; 75 completed the 6 month questionnaire. Most patients were male (55%) with a median age of 64 years (range, 43–79 years). Preferred role in decision-making at baseline ($n = 98$) was active in 27%, collaborative in 47%, and passive in 27%. Perceived decision-making roles matched the preferred role in 79% of patients. Individuals' role preferences often varied between baseline and 6 months, but there was no consistent direction to the change (25% changed preference to more active involvement, 22% to less active). Preferring a more active role was associated with university education (OR 2.9, $p = 0.02$), deciding not to have ACT (OR 5.0, $p < 0.01$), and worse health-related quality of life (HRQL) during ACT: physical well-being (OR 4.4, $p = 0.05$), overall well-being (OR 5.5, $p = 0.02$), sleep (OR 8.4, $p < 0.01$) and shortness of breath (OR 7.6, $p = 0.01$). Patients who preferred an active decision-making role judged larger survival benefits necessary to make ACT worthwhile than those preferring a passive role.

Conclusion: Most patients with resected NSCLC preferred and perceived a collaborative role in decision-making about ACT. Clinicians should elicit and consider patients' preferences for involvement in decision-making when discussing ACT for NSCLC.

© 2016 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

People with cancer have widely varying preferences for involvement in decision-making between active, collaborative and passive roles. [1] Understanding these preferences is important in order

Abbreviations: NSCLC, non-small-cell lung cancer; ACT, adjuvant chemotherapy; CPS, control preferences scale; HRQL, health-related quality of life.

* Corresponding author at: Concord Cancer Centre, Concord Repatriation General Hospital, Hospital Rd, Concord, NSW 2139, Australia.

E-mail address: erin.moth@sswahs.nsw.gov.au (E. Moth).

<http://dx.doi.org/10.1016/j.lungcan.2016.02.009>

0169-5002/© 2016 Elsevier Ireland Ltd. All rights reserved.

to meet patients' decision-making expectations, navigate discussions about treatment recommendations, and to increase patient satisfaction with the decision-making process. [2–4] This is even more pertinent for preference-sensitive treatment decisions, such as the consideration of adjuvant chemotherapy (ACT) for resected non-small cell lung cancer (NSCLC).

ACT for resected stage II and IIIA NSCLC confers an 11% relative reduction in the hazard of death (95% CI 4%–18%, $p = 0.005$) with an absolute benefit in overall survival at 5 years of 5% (from 44% to 49%) [5]. The poor prognosis of patients considering ACT for NSCLC makes this treatment decision scenario quite distinct from adjuvant (or curative) treatment decisions for other cancer types,

for example early breast or prostate cancers, where 5 year survival rates are significantly better (>90% and nearly 100% respectively). ACT for resected NSCLC can be considered a preference-sensitive treatment, as patients must trade-off its possible benefits against its potential harms and inconveniences. We have previously studied patients' treatment preferences for ACT in NSCLC and found that patients generally judge moderate survival benefits sufficient to make ACT worthwhile (for example an extra 9 months in survival times, or 5% in survival rate) [6]. A final treatment decision about ACT, however, should reflect a patient's preferences for the treatment and their preferred level of involvement in the decision-making process.

Preferred level of involvement in decision-making has been most studied in the setting of breast and prostate cancers, with most patients preferring a collaborative role [1]. Where preferred and perceived decision-making roles have been compared, patients with a discordance between their preferred and perceived roles generally preferred a more active role than was achieved [7]. Only two studies have described decision-making role preferences in patients with lung cancer, one in patients with lung cancer of unspecified stage [8] and one in patients with advanced disease [9]. The majority of patients preferred a passive role [8,9] and there was discordance between preferred and perceived role for a significant minority (29%) [8]. In keeping with studies in other cancer types [10–12], preferences for involvement generally changed to a more active role over time. [8,9]

The aims of this study were to determine the preferences for involvement in decision-making of patients with early stage NSCLC, their perceived experience of involvement, and predictors of preferences for decision-making role. We hypothesized that most patients with early stage NSCLC would prefer a collaborative role in decision-making at baseline; that preferences would change over time to a more active role; that preferred and perceived roles would be discordant with a more active role preferred than was experienced; and that younger age, female sex and higher educational attainment would be associated with preference for an active role.

2. Methods

2.1. Study design and setting

This study was part of a previously published multi-centre, observational cohort study of patients' preferences for ACT in NSCLC at 16 sites in Australia and New Zealand [6].

2.2. Participants

Patients were included if they had resected stage I to stage III NSCLC, were referred to a medical oncologist for consideration of adjuvant chemotherapy, and were willing and able to complete the study questionnaire. Information about ACT, including the provision of any supporting material, was given according to the local practices of each centre. Patients were excluded if they had evidence of metastatic disease or if they had received prior chemotherapy for NSCLC. All patients provided signed, written, informed consent. Ethics approval was obtained by the relevant ethics committees of each participating centre.

2.3. Study questionnaire

Participants completed a self-administered questionnaire at baseline and at 6 months, the latter being about 2 months after ACT was completed in those who had it. Patient characteristics at baseline were recorded on a study specific questionnaire. Aspects of health-related quality of life (HRQL) were assessed at baseline and at 6 months using the Patient Disease and Treatment Assessment

Form (Patient DATA Form) [13]. At baseline, patients were asked to record their expected HRQL during chemotherapy, and at 6 months were asked to record their experienced HRQL during chemotherapy. Tumour and treatment characteristics were obtained from medical records.

2.4. Assessment of preferred and actual decision-making role

Patients' preferences for involvement in decision-making were assessed using the validated and widely used Control Preferences Scale (CPS) [14,15]. This scale asks patients to select one of five statements that best describes their preferred role in decision-making. Response options, as outlined in Table 1, range from an active role ("I prefer to make the final selection about which treatment I will receive") to a passive role ("I prefer to leave all decisions regarding treatment to my doctor"). A patient's *perceived* role was obtained by asking them to select the response that best described the role they had been playing in dealing with their cancer diagnosis, and their *preferred* role by selecting the response that best described the role they preferred.

2.5. Statistical analysis

The 5 possible responses on the CPS were categorised into three decision-making roles: active (responses A and B), collaborative (response C), and passive (responses D and E) (Table 1). Proportions of patients within these categories were described for preferred and perceived roles at baseline, and for preferred role at 6 months.

The five possible responses on the CPS were assigned ordinal scores from 1 to 5 (1 = most active, 2 = active, 3 = collaborative, 4 = passive, 5 = most passive) to measure the change in preferred role over time, and the difference between preferred and perceived role. Differences between roles were then assigned a value (discrepancy score), with 0 indicating no difference and ± 4 indicating maximal change (from most passive or active to most active or passive). Differences in the preferred decision-making roles at baseline and at 6 months, and between patients' preferred and perceived roles, were then assessed using the Wilcoxon signed-rank and rank sum tests. Determinants of preferences were assessed using chi-squared tests of association and summarised by odds ratios. Wilcoxon rank-sum tests were used to assess differences in the survival benefits judged sufficient to make ACT worthwhile by patients preferring active and less active decision-making roles.

A sample size of 100 patients was sufficient to allow for description of the modal preferred and perceived decision-making roles with 95% confidence intervals of ± 10 percentage points.

3. Results

3.1. Patient characteristics

Patient, disease and treatment characteristics are summarised in Table 2. From 2010 to 2012, 98 patients with resected stage I to III NSCLC consented to the study and completed the baseline questionnaire and 75 (77%) patients completed the 6 month questionnaire. Patient characteristics were as expected for this study population. The majority were male (55%), with a median age of 64 years (range 43–79 years) and were previous smokers (82%). Patients most commonly had adenocarcinoma (63%), had undergone a lobectomy (85%), and almost half (46%) had stage II disease. 82 patients (84%) had ACT which was most commonly cisplatin and vinorelbine (74%). Reasons for not completing the 6 month questionnaire (available for $n=9$) included study withdrawal ($n=1$), cancer recurrence ($n=5$), death ($n=2$), and illness ($n=1$). Patients who completed the 6 month questionnaire, compared with those

Download English Version:

<https://daneshyari.com/en/article/2140415>

Download Persian Version:

<https://daneshyari.com/article/2140415>

[Daneshyari.com](https://daneshyari.com)