



Asking questions during breast cancer consultations: Does being alone or being accompanied make a difference?



L. Del Piccolo^{a,*}, C. Goss^a, A. Bottacini^a, V. Rigoni^a, M.A. Mazzi^a, G. Deledda^a, M. Ballarin^a, A. Molino^b, E. Fiorio^b, C. Zimmermann^a

^a Department of Public Health and Community Medicine, Section of Clinical Psychology, University of Verona, Policlinico G.B. Rossi, Piazzale L.A. Scuro 10, 37134 Verona, Italy

^b O.U. of Oncology d.O., Ospedale Civile Maggiore, Hospital Trust of Verona, Italy

A B S T R A C T

Keywords:

Companion
Informal carer
Family
Breast cancer
Question asking
Information needs
Decision making

Purpose: Companions often accompany patients to cancer consultations. The number of questions asked by patients and companions is an indicator of their active participation. The present study aims to provide first descriptive evidence on the characteristics of unaccompanied and accompanied Italian breast cancer patients that attend the first consultation after surgery and to analyse companions contribution to the type and quantity of questions asked during the consultation.

Method: Seventy consultations of female patients with breast cancer were audio taped. Questions were transcribed and coded by content. Companion's questions were also classified in terms of function. Socio-demographic and clinical data, patients' role preference and confidence in decision making measures were gathered for each patient. Post consultation satisfaction with decision and the perceived level of shared decision making were collected either for the patient and the companion.

Results: 69% of patients were accompanied, usually by one close family member, either husband or adult child. Non employed or retired patients and those with a preference for passive role in decision making were more likely to be accompanied. Unaccompanied patients and accompanied patients had comparable levels of anxiety, emotional distress and depression and were equally active in asking questions. These levels were far greater than those reported for other cancer patients in the literature. Companions did not increase significantly the number of questions per consultation.

Conclusion: Accompanied and non accompanied patients differed more in socio-demographic than clinical characteristics. Companions sustained the patient and shared information without reducing the level of patient involvement.

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Introduction

Companions often accompany patients to cancer consultations and participate at the encounter. They provide emotional, informational and logistical support for patients and may also participate at decisions regarding treatment (Laidsaar-Powell et al., 2013; Street and Gordon, 2008). During the consultation companions may contribute significantly in sustaining information needs by helping the patient to ask questions and express concerns (Ishikawa et al., 2005; Clayman et al., 2005). In this way companions can act as a conduit for information, but they may also elicit

information from clinicians so that patients may be more informed (Hubbard et al., 2010).

Triadic consultations have been studied in a variety of medical settings such as general practice, geriatric clinics, outpatient and oncology settings. Findings, reviewed by Laidsaar-Powell et al. (2013) and Wolff and Roter (2011), showed that elder, less educated and less well patients attending geriatric or primary care consultations were more likely to be accompanied and less actively involved. Companions were found to engage more with logistical and informational support. In the oncology context, Eggly et al. (2006) reported high companion attendance for a mixed group of cancer patients, but the level of patient involvement appeared unaffected by the presence of companions, although they asked more questions than the patients; older patients asked fewer questions, while more educated patients asked more questions. In contrast, Street and Gordon (2008) observed a greater activity level

* Corresponding author. Tel.: +39 (0)45 8124441; fax: +39 (0)45 8027498.
E-mail address: lidia.delpiccolo@univr.it (L. Del Piccolo).

of lung cancer patients in terms of questions, assertiveness and concerns when compared to that of their companions, who were present more for emotional than informational support. They found that most companions adopted a passive observer role, a third were highly active advocates and a minority was moderately involved.

Question asking is also an active behaviour that indicates greater participation during the consultation and may be used as a qualitative indicator of the interaction (Street and Millay, 2001; Eggly et al., 2006). Street et al. (2005) showed that patients who were more active participants (i.e. those who asked questions, were assertive, and expressed concerns), were more educated, were more likely to be white than of another ethnicity and received more facilitative communication from physicians. However the strongest predictors of patient participation were the clinical setting and the physician's communicative style with particular reference to the use of partnership-building and supportive talk. Similar studies showed that the frequency of patient questions was associated to the preference for shared control by the patient, whereas age, education and anxiety were unrelated (Street and Millay, 2001; Street et al., 2003; Street and Gordon, 2008). Therefore, patient's personal characteristics seem to be less relevant than situation-specific variables, like the clinical setting, patient preferences for making decisions and the physician's communicative style in contributing to question asking.

In Italy, the assessment of family members' participation, as well as patients' participation, is a matter of recent interest and exploration that still remains to be further investigated. Recently some surveys on Italian patients' informative needs have been published (Tamburini et al., 2000; De Lorenzo et al., 2004; Travado et al., 2005; Giacalone et al., 2005; Piredda et al., 2008; Annunziata et al., 2009) but very little is known on the characteristics of patients and companions and their contribution to question asking in cancer consultations. No study has been published on data obtained directly from audio recordings.

This study starts to fill this gap aiming to answer the following questions:

1. Are there differences between Italian patients with, and without, attending companion in terms of socio-demographic and psychological characteristics, shared decision making preferences, decisional confidence, information requests, perception of shared decision making and satisfaction with decisions?
2. Are there differences between patients with, and without, attending companion in terms of frequencies and topics of question asked, perceived shared decision making and satisfaction with decisions?
3. What is the role played by the companion with question asking during the consultation?

Methods

Patients and setting

This is an observational study of patients with breast cancer at their first consultation with the oncologist after surgical treatment.

The patients were recruited during the first six months of 2010 in the out-patient clinic of the Medical Oncology Unit of the Hospital Trust of Verona in the Veneto region, Italy. Visits for breast cancer patients (four to eight patients a day) were scheduled on a fixed weekday, with a rotation of three senior oncologists. Patients who faced this consultation were already been diagnosed with cancer, had been visited by the surgeon and had undergone breast operation (e.g. lumpectomy). Usually, the aim of the consultation

was to communicate the histological results and to decide further medical treatment (e.g. chemotherapy, hormone therapy). The consultation length could vary from 30 to 60 min.

Inclusion criteria were age between 18 and 75 years and a recent diagnosis of breast cancer at an early stage. Exclusion criteria were the presence of metastasis or relapse; severe mental deterioration and difficulties in comprehending Italian language.

Data collection procedure

All consecutive breast cancer patients, as well as attending companions, gave informed consent to participate in the study. The consenting patients received an envelope containing the questionnaires to complete before the consultation. The consultation was audio recorded. After the consultation patients and companions completed two other questionnaires, supervised by a project member.

The three oncologists (2 females) of the outpatient Unit gave informed consent to participate. The two female oncologists contributed with 54 and 13 consultations respectively, the male oncologists with four consultations only, due to a late team entry.

The local Ethics Committees approved the study.

Pre-consultation measures

1 Sociodemographic data of patients and companions

These were age, education, family status and employment status.

2 Psychological characteristics of patients

- *State Anxiety Inventory* (STAI-X1) (Spielberger, 1970; Lazzari and Pancheri, 1980). STAI-X1 is a self-administered questionnaire of 20 items on a Likert scale from 1 (not at all) to 4 (very much). Higher total scores indicate greater state anxiety. The cut-off score for clinically significant anxiety was set at 55, as suggested by Vedana et al. (2002), for an Italian sample of females.
- *General Health Questionnaire* (GHQ-12) (Goldberg, 1978). GHQ-12 is a 12-item self administered questionnaire for the presence of emotional distress and has a summative score of 12. The cut off score for Italian patients is ≥ 3 (Politi et al., 1994).
- *Patient Health Questionnaire Depression scale* (PHQ-9) (Kroenke et al., 2001; Thekkumpurath et al., 2011). PHQ-9 is a self-assessment questionnaire for detecting the presence of depression and consists of 9 items with response options of 0 (not at all) to 3 (almost every day), and has a summative score range of 0–27. We scored it in the standard way, using the sum of the 0–3 scores for each item, and ≥ 8 as a cut-score for possible cases of depression.

3 Desired role in the decision making process and confidence in taking informed decisions

- *Control Preference Scale* (CPS) (Hahn et al., 1996; Degner et al., 1997). This self-administered instrument measures patients' preference for the role they want to have in the decision making process. The CPS contains 5 vignettes with text, depicting different patient roles (from active to passive). Patients chose the vignette considered as most appropriate for them.
- *Decision Self Efficacy Scale* (DSES) (O'Connor, 1995). This self-administered questionnaire consists of 11 items on a Likert scale from 0 (not at all confident) to 4 (very confident) and measures patient's confidence in making an informed choice.

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