



Medical decision making

Treatment decision-making in the medical encounter: Comparing the attitudes of French surgeons and their patients in breast cancer care



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ABSTRACT

Objectives: To explore attitudes of French surgeons and their patients towards treatment decision-making (TDM) in the medical encounter.

Methods: Surgeons involved in early stage breast cancer and their patients treated in a French cancer care network received a cross-sectional survey questionnaire containing examples of four different approaches to TDM: paternalistic, “some sharing”, informed TDM and, shared TDM.

Results: Surgeons' interaction styles were clearly distributed among paternalistic, shared and mixed. The paternalistic approach seemed to be associated with private rather than public practice and with less professional experience. Patients reported a rather low level of participation in TDM, varying by socio-demographic characteristics. One third of patients were dissatisfied with the way their treatment decision had been made.

Conclusion: Most surgeons reported adopting the “some sharing” approach. However, one patient out of three reported that they would have liked to participate more in the TDM process.

Practice implications: Surgeons need to ask patients what their preferences for involvement in TDM are and then think about ways to accommodate both their own and patients' preferences regarding the TDM process to be used in each encounter. In addition, decision aids could be offered to surgeons to help them discuss treatment options with their patients.

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1. Introduction

Several types of physician–patient interactions have been proposed in the literature to characterise variations in the physicians' and patients' roles in treatment decision-making (TDM) in the medical encounter [1–3]. Among the most prominently cited [4] is the Charles et al. framework [5,6] which describes three approaches to TDM which vary in terms of (1) the type, amount, direction and flow of information exchanged between physicians and patients, (2) the amount of patient

involvement in the deliberation process and (3) patient involvement in the decision made. In the paternalistic model, the physician provides the minimum amount (legally required) of information to the patient on the potential risks and benefits of a treatment option, but (s)he is the sole decision-maker. In the informed model, the patient is informed by the physician about relevant information needed to make her decision, including the potential risks and benefits of the treatment options, and then the patient makes her decision. The shared model is characterised by (1) a two-way information exchange of relevant information for TDM between physician and patient, (2) deliberation between both parties on treatment options, and (3) involvement of both parties in making the treatment decision. These are pure type models and the framework recognises that, in reality, there are multiple approaches that lie between these three ideal types [6].

Patients' preferences for different models of TDM have been studied [7–19] more extensively than physicians' preferences

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[20,21]. Matching patients' attitudes to the type of treatment decision-making they preferred and think they experienced with comparable views of their own physicians has been less frequently addressed [22–29]. This paper provides information on all these topics in France and to the best of our knowledge this is the first time that these questions have been addressed in a research project from France.

The study explores attitudes towards approaches to TDM in early stage breast cancer (BC) care in a sample of French oncologists (e.g., surgeons, medical oncologists and radiation oncologists) and their patients recruited from a cancer care network (CCN) composed of 47 cancer care organisations located in the Rhone-Alps Region. In this paper, we chose surgeons' and their early stage BC patients because, in the CCN, surgeons play a major role in the entire TDM process for early stage BC patients.

The overall research objective was to explore whether surgeons could be classified into TDM types (clusters) based on their preferred approach to TDM in the medical encounter and whether these preferences are comparable to the preferences of their respective patients. More specifically, we aimed to explore the following questions:

- What do surgeons identify as their typical approach(es) to TDM in the medical encounter?
- What are surgeons' interaction styles based on their self-reported behaviours and their preferences towards TDM? Are there specific characteristics that can be linked to surgeons' interaction styles?
- To what extent do early stage BC patients perceive that they participated in the TDM process with their surgeons?
- Do early stage BC patients perceive that they experienced the TDM approach they preferred?
- Do the demographic characteristics of BC patients' and/or the interaction styles of their surgeons help explain (1) BC patients' reported level of participation in their TDM process? (2) BC patients' preferences for involvement in TDM?

2. Methods

2.1. Design

This study is part of a collaborative research programme between social scientists and clinicians at McMaster University (Hamilton, Ontario, Canada) and at GATE-LSE Research Unit (Lyon, France). The study was approved by the ethical board of the Comprehensive Cancer Centre Léon Bérard where the study was conducted. This project builds on earlier work by the McMaster University research team. This team developed a survey questionnaire with three different versions tailored to surgeons, medical oncologists and radiation oncologists. The Canadian questionnaire was used in a province wide cross-sectional survey of Ontario specialists treating women with early stage BC to explore their definitions of and attitudes towards shared decision-making in the medical encounter [30–32].

In this study we investigate the perceived roles of early stage BC patients and surgeons in the TDM process, in the French CCN. We conducted a cross-sectional survey of both surgeons and patients at the end of the treatment decision-making process. We conducted a retrospective rather than a prospective study to prevent the possibility that surgeons and patients would modify their attitudes if they knew before consultations that they would be asked about these issues.

The Canadian patient and physician questionnaires were modified to fit the French context. The French Clinical Practice

Guidelines [33] used in the CCN recommended that radiotherapy should be performed in all early stages except for mastectomy patients with negative nodes (15% of patients). Because the guidelines mandate only one type of treatment, i.e., radiotherapy for all eligible patients, the radiation oncologist does not have much discretion in offering the patient a choice of alternative treatments. Conversely, surgeons played a major role since they usually met first with patients, made the initial diagnosis, were involved in surgery decision making and provided the patient with information about adjuvant treatments. Given the French practice context, and for feasibility reasons, we decided to enrol patients in radiotherapy wards located in hospitals, thus excluding the 15% of patients not having radiotherapy.

2.2. Questionnaires development and pilot testing

Three different versions of the Canadian physician (e.g., surgeon, medical oncologist and radiation oncologist) and breast cancer patient questionnaires were modified for use in France. The Canadian questionnaires were translated and then pilot-tested with physicians and breast cancer patients respectively in France. A focus group was held with 6 patients (4 post and 2 under treatment) and separate individual interviews were conducted with physicians (2 surgeons, 2 medical oncologists and 2 radiation oncologists). Participants' comments were audio-taped and summarised by the GATE-LSE team. The pilot testing resulted in some rephrasing in the patient questionnaire and in adding a few questions to the physician questionnaire on, for example, the average time duration of surgeon consultations.

The surgeon questionnaire contained 4 primary topics: (1) providing information to newly diagnosed patients; (2) TDM with newly diagnosed patients; (3) perceived facilitators and barriers to TDM; (4) professional characteristics and demographics. The patient questionnaire covered 6 primary topics: (1) information about diagnosis and treatment; (2) personal view of TDM; (3) the doctor/patient relationship; (4) the who and how of TDM; (5) facilitators and barriers to TDM; and (6) patients' demographics.

Both surgeon and patient questionnaires included four examples of different approaches to TDM. The examples were identical in both the surgeon and patient questionnaires (Table 1). One of the scenarios (example 2) reflected an in between approach

Table 1
TDM examples developed by Charles et al. [5,6].

Example 1 (paternalistic): After looking at the patient's medical records and examining the patient, the doctor presents a treatment that he/she thinks is best for the patient. The doctor gives the patient the information about the treatment including the risks and benefits. The patient accepts the treatment that the doctor recommends
Example 2 (some sharing): After looking at the patient's medical records and examining the patient, the doctor presents the treatment choices. Information about the risks and benefits of each option are given and discussed with the patient. The patient asks questions and obtains all the information he/she wants from the doctor. The doctor recommends a treatment that the patient accepts
Example 3 (informed): After looking at the patient's medical records and examining the patient, the doctor presents the treatment choices. Information about the risks and benefits of each option are given and discussed with the patient. The doctor asks the patient to decide on a treatment and states that the patient is the best person to make the decision. The patient decides and informs the doctor of the treatment he/she prefers
Example 4 (shared): After looking at the patient's medical records and examining the patient, the doctor presents the treatment choices. Information about the risks and benefits of each option are given and discussed with the patient. The patient asks questions and obtains all the information he/she wants from the doctor. The doctor asks the patient about his/her preferences for treatment given his/her lifestyle and the issues that are important to the patient. Together the patient and the physician decide on the treatment that is best suited to the patient

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