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Research paper

Barriers and facilitators to the implementation of audio-recordings and question prompt lists in cancer care consultations: A qualitative study

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ABSTRACT

Objective: Question prompt lists (QPL**s**) and consultation audio-recordings (CARs) are two communication strategies that can assist cancer patients in understanding and recalling information. We aimed to explore clinician and organisational barriers and facilitators to implementing QPLs and CARs into usual care.

Methods: Semi-structured interviews with twenty clinicians and senior hospital administrators, recruited from four hospitals. Interviews were recorded, transcribed verbatim and thematic descriptive analysis was utilised.

Results: CARs and QPLs are to some degree already being initiated by patients but not embedded in usual care. Systematic use should be driven by patient preference. Successful implementation will depend on minimal burden to clinical environments and feedback about patient use. CARs concerns included: medico-legal issues, ability of the CAR to be shared beyond the consultation, and recording and storage logistics within existing medical record systems. QPLs issues included: applicability of the QPLs, ensuring patients who might benefit from QPL's are able to access them, and limited use when there are other existing communication strategies.

Conclusions: While CARs and QPLs are beneficial for patients, there are important individual, system and medico-legal considerations regarding usual care.

Practice implications: Identifying and addressing practical implications of CARs and QPLs prior to clinical implementation is essential.

1. Introduction

Approximately 130,000 people are diagnosed with cancer in Australia every year [1]. Receiving a cancer diagnosis and medical information is often a shock and treatment decision making may be overwhelming. During consultations, clinicians aim to provide patients with information about their condition and possible treatments and engage patients in treatment decisions [2,3]. Equally, in order for patients to appraise their circumstances and to participate in treatment decisions in an informed manner, they need a sound understanding and recollection of information provided [4]. Therefore, effective communication involves engagement of both parties and includes the following components: build a patient-doctor relationship, listen to the patient, gather information, understand the patient's perspective, share information, reach agreement on plans and provide disclosure [5].

Cancer patients do not always achieve their preferred level of participation [4]. Communication strategies which focus on patient participation can enhance patient engagement in decision making, satisfaction, preparedness and emotional outcomes [6–8]. Two examples are consultation audio–recordings (CARs) and question prompt lists (QPLs).

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CARs are usually made using digital recorders, with a copy provided to the patient after the consultation to take home, and a copy retained for medical records [9]. Patients who receive a CAR, compared to those who do not, generally have a clearer understanding of their cancer treatment, greater information recall and greater involvement in subsequent consultations and decision-making [9]. CARs also support patients to convey medical information and can facilitate treatment discussions with family members [10].

QPLs consist of a structured list of questions that patients may wish to ask about illness, treatment and supportive care. Patients are typically given the QPLs before their consultation so they can identify questions which are important to them [11]. QPLs can prompt patients to ask more questions. Physicians provide more information when cued by questions, particularly about difficult-to- broach topics such as prognosis and treatment costs [12–14].

Despite evidence supporting the use of QPLs and CARs, there is little indication that these strategies are routinely used in clinical practice [9,12]. Additionally, there is little published data regarding provider and organisational concerns related to routine implementation which can influence long-term utilisation [9,11]. Thus, it is important to obtain organisational and clinical perspectives in order to support the systematic uptake of these strategies. The aim of this study was to explore the barriers and facilitators to implementing an integrated communication initiative, consisting of QPLs and CARs, in usual care from the viewpoint of clinicians and hospital administrators.

2. Methods

This qualitative study used interpretive description methodology [15]. The purpose of this approach is to discover themes or patterns and to understand action, based on experiences, in order to inform clinical knowledge.

2.1. Participants

Clinicians and senior hospital administrators were recruited from four Melbourne metropolitan oncology departments. Purposive sampling was used to identify participants for interview, to obtain maximum variation in the experiences of interest. Each recruiting site had a project representative who identified and approached eligible participants. A total of 37 people were approached and 22 (59%) agreed to take part. For the first 15 interviews, participants were sought on the basis of obtaining a variety of clinician and senior hospital administrator views across the four hospitals. A further five participants were approached based on their role and to explore the findings identified in the initial 15 interviews. Recruitment ceased when no new themes were derived from the interview content (data saturation). The study was approved by the Human Research Ethics Committee of the Peter MacCallum Cancer Centre (LNR/15/PMCC/31) and all participants signed a consent form.

2.2. Data collection and analysis

Data were obtained through semi-structured individual interviews. Open-ended questions explored participants' views about implementing the communication strategies (CARs and QPLs) into usual practice. Interview questions included: what is your overall impression of QPLs/CARs, what are your thoughts about implementing QPLs/CARs during initial treatment consultations, and what might be the positive and negative aspects of QPLs/CARs from your perspective? An abbreviated version of an oncology QPL [16] was presented to participants as an example if they had no prior experience with this communication strategy. Interviews were conducted face-to-face or via telephone by an experienced interviewer (JD, LS, NM or PS), recorded and transcribed verbatim.

NVivo10 qualitative data analysis software was used for data management [17]. Thematic descriptive analysis was used to identify important and consistent themes regarding barriers and facilitators to implementing the communication strategies into usual care [18]. An inductive approach was used, that is, findings were generated from the data rather than imposing a predetermined structure for the analysis. Analysis began by listening to and reading all of the interview transcripts. Next, analysis of the text was used to generate the initial categories (open coding) which were then grouped into sub-themes of related categories. Sub-themes were sorted, synthesised and organised to develop broader themes. To ensure the rigour of the findings [11], a subset (10%) of the transcripts were dual coded (NM and PS) and for all data, emerging sub-themes and themes were discussed with researchers (PB and TH) knowledgeable in the area. This was achieved by discussing the analysis during meetings and with email.

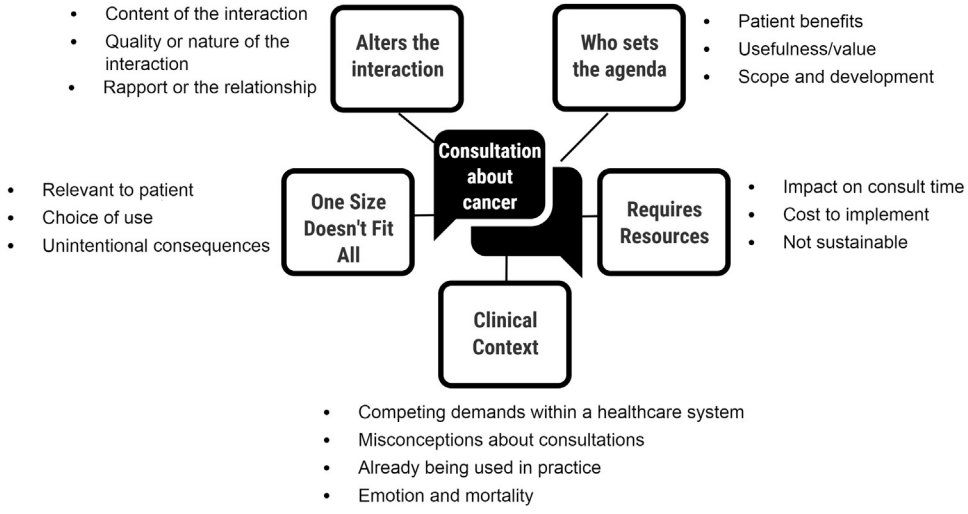

Fig. 1. Overview of themes and sub-themes.

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