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Dumping the information bucket: A qualitative study of clinicians caring for patients with early stage non-small cell lung cancer

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ABSTRACT

Objective: To evaluate the quality of patient-clinician communication and shared decision making (SDM) when two disparate treatments for early stage non-small cell lung cancer (NSCLC) are discussed.

Methods: We conducted a qualitative study to evaluate the experiences of 20 clinicians caring for patients with clinical Stage I NSCLC prior to treatment, focusing on communication practices. We used directed content analysis and a patient-centered communication theoretical model to guide understanding of communication strategies.

Results: All clinicians expressed the importance of providing information, especially for mitigating patient worry, despite recognition that patients recall only a small amount of the information given. When patients expressed distress, clinicians exhibited empathy but preferred to provide more information in order to address patient concerns. Most clinicians reported practicing SDM, however, they also reported not clearly eliciting patient preferences and values, a key part of SDM.

Conclusion: Communication with patients about treatment options for early stage NSCLC primary includes information giving. We found that only a few communication domains associated with SDM occurred regularly, and SDM may not be necessary in this clinical context.

Practice implications: Clinicians may need to incorporate nurse navigators or more written materials for effectively discussing potentially equivalent treatment options with their patients.

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1. Introduction

Surgical resection for early stage non-small cell lung cancer (NSCLC) is currently considered the most appropriate treatment [1,2], and stereotactic body radiotherapy (SBRT) is reserved for patients who decline or cannot safely tolerate surgery [3,4]. These treatments have not been directly compared in high quality studies but SBRT may be associated with similar, or even better, oncologic outcomes [5–11]. There are also no high quality comparative

quality of life (QOL) data, but SBRT likely results in less decreased QOL measures than surgical resection [12] [13].

It is unknown how clinicians discuss these uncertainties about the likely oncologic and QOL outcomes, and how they discuss these competing goals when making treatment decisions with their patients. However, clinicians seem to be recommending SBRT more frequently [14]. Providing accurate information about these concepts through a process of shared decision making (SDM) is recommended by many organizations [15–18]. High quality communication is associated with improvement in several patient-centered and clinical outcomes [19–22], although results are mixed in some clinical settings [23,24]. Accordingly, clinicians who care for patients with early stage NSCLC are faced with considering how, and with whom, they discuss these two treatment options, [12]. Since the clinical evidence regarding treatment will remain indeterminate for the foreseeable future,

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¹ See Appendix A.

communication surrounding this uncertainty and decision making remains central to providing high quality patient-centered care.

The current analysis is part of a larger mixed-methods study to study the association of patient-clinician communication with patient-centered outcomes. Our previous work found that patients were satisfied with their lung cancer care, despite reporting little knowledge about risks or other treatment options. Patients also described a lack of SDM and did not recall providers directly eliciting distress [25]. We wanted to understand how clinicians communicate with patients with early stage NSCLC about treatment decisions and this potentially distressful process.

2. Methods

We included clinicians from seven medical centers in the Pacific Northwest: the VA Portland Health Care System (VAPORHCS); Oregon Health & Science University (OHSU), an employee-based academic, quaternary health center; Legacy Health, a private nonprofit, tertiary health organization incorporating both private-practice and employed physicians; Providence Health & Services, a majority employee-based not-for-profit organization; PeaceHealth, a not-for-profit health care system with private-practice and employed physicians; Tuality Healthcare, a not-for-profit community-based health care system with both employed and community physicians; and Kaiser Permanente, a nonprofit employee-based health plan organization. We enrolled providers who care for patients with suspected or confirmed Stage I NSCLC and were being considered for curative treatment. The Joint Internal Review Board (IRB) of the VAPORHCS and OHSU (#10340), the Providence (#15-031A), and Legacy IRBs, approved this study. All participants completed written informed consent. We completed recruitment after 20 participants as we had reached saturation at each study site [26,27], based on the level of contribution of new knowledge gleaned from the analysis [28,29]. We conducted 2–4 interviews at each site to include at least one radiation oncologist, one surgeon, and one pulmonologist (if applicable). Often sites only had one or two of each provider type. We conducted approximately 45-min interviews in a private space

at the provider’s location during non-clinical time. Participants were not compensated and all except one provider who was approached agreed to be in the study.

SEG (qualitative research analyst) and/or CGS (pulmonologist) interviewed the clinicians and we digitally recorded and transcribed the interviews. Neither researcher practices surgery or radiation oncology. We used a patient-centered communication (PCC) theoretical model emphasizing five domains to guide our understanding of the communication strategies [30], but the flexibility of the interview guide (Supplementary Appendix A) allowed other themes to emerge. While the PCC model includes five domains (Fig. 1 [19]), we focused on the following three: information exchange; patient as person (consideration of patients’ feelings, preferences, and values); and sharing power and responsibility (shared decision making) [19]. The PCC theoretical model incorporates multiple indirect methods of communication [19] to evaluate influence on patient-centered outcomes. Therefore, by using this framework, we evaluated how and if clinicians incorporate each domain into practice, and what barriers or facilitators are involved in the communication process. Each clinician was identified by a randomly assigned letter not related to his or her name and a letter following a hyphen for the type of provider (N=thoracic oncology Nurse; P=Pulmonologist; S=Surgeon; R= Radiation Oncologist).

2.1. Analysis

We used directed content analysis [26,31], which uses existing theory to first identify key concepts as initial coding categories before defining them operationally. First, SEG and CGS reviewed together three completed transcripts to develop a codebook. Following discussions about the codebook, we then independently coded an additional three transcripts. Collaboratively, we refined the codebook, reviewed, coded, and discussed discrepancies in the original transcripts. SEG independently reviewed and coded the remaining transcripts, with CGS separately reviewing and coding three randomly selected transcripts to ensure consistency. We used ATLAS.ti 7.1.7 (ATLAS.ti GmbH, Berlin, Germany) for analysis.

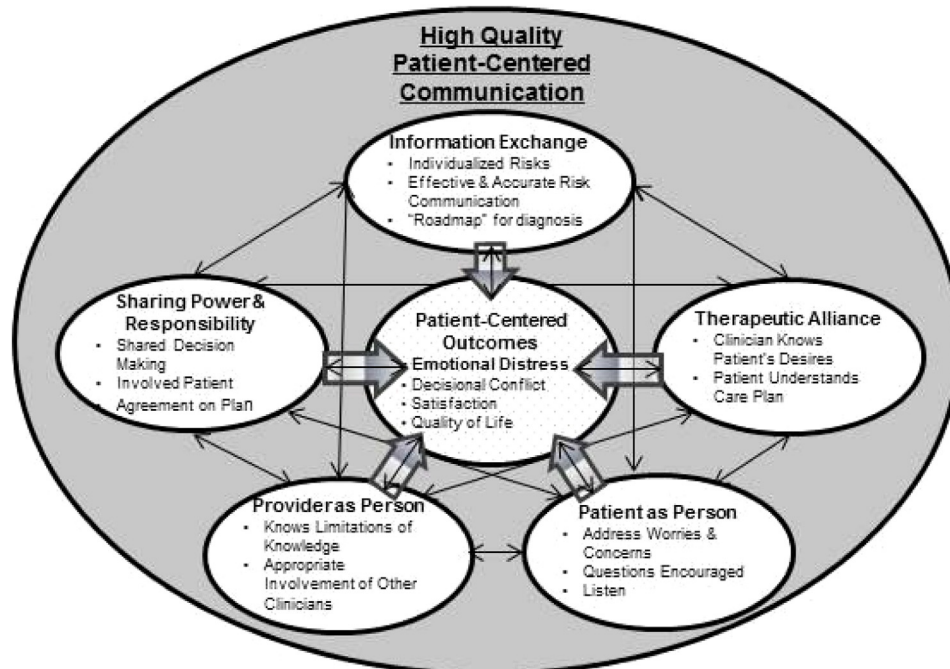


Fig. 1. Patient-Centered Communication Model.

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