Patient Education and Counseling xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Key elements of optimal treatment decision-making for surgeons and older patients with colorectal or pancreatic cancer: A qualitative study

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ARTICLE INFO

Article history:
Received 29 April 2016
Received in revised form 21 September 2016
Accepted 14 October 2016

Keywords:
Shared decision-making
Cancer
Elderly
Abdominal surgery

ABSTRACT

Objective: To identify key elements of optimal treatment decision-making for surgeons and older patients with colorectal (CRC) or pancreatic cancer (PC).
Methods: Six focus groups with different participants were performed: three with older CRC/PC patients and relatives, and three with physicians. Supplementary in-depth interviews were conducted in another seven patients. Framework analysis was used to identify key elements in decision-making.
Results: 23 physicians, 22 patients and 14 relatives participated. Three interacting components were revealed: preconditions, content and facilitators of decision-making. To provide optimal information about treatments' impact on an older patient's daily life, physicians should obtain an overall picture and take into account patients' frailty. Depending on patients' preferences and capacities, dividing decision-making into more sessions will be helpful and simultaneously emphasize patients' own responsibility. GPs may have a valuable contribution because of their background knowledge and supportive role.
Conclusion: Stakeholders identified several crucial elements in the complex surgical decision-making of older CRC/PC patients. Structured qualitative research may also be of great help in optimizing other treatment directed decision-making processes.
Practice implications: Surgeons should be trained in examining preconditions and useful facilitators in decision-making in older CRC/PC patients to optimize its content and to improve the quality of shared care.

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1. Introduction

The number of cancer patients aged 65 years or older presenting for major abdominal surgery is rising. Due to increasing multimorbidity, the surgical evaluation of these patients becomes more complex [1]. Negative outcomes postoperative may threaten patients' quality of life and functioning [2]. Colorectal (CRC) and pancreatic cancer (PC) resections in older patients are such high-risk procedures and treatment decision-making needs careful attention. Tolerance for adverse effects and preference for quality or quantity of life need to be considered [3–8]. Shared decision-making (SDM) and goal-oriented communication are widely recommended to improve treatment decision-making and deliver patient-preferred care [1,9–12]. Recent studies showed that SDM increases patient satisfaction and knowledge with improved long-term health-related quality of life [13–16]. Therefore, SDM is considered an important step in improving quality of care [17–19]. SDM is particularly applicable for surgical disorders such as rectal and pancreatic cancer where alternatives for major surgery are available. However, SDM before elective surgery often shows several deficits [20,21]. Additionally, existing models for SDM are described not to be sufficient for older patients [9] and tools to encourage patient participation in decision-making lack focus on older patients [22–24]. Among older CRC/PC patients, SDM is not easily achieved due to the complexity of the decision-making process including time pressure for initiating treatment. Consequently, treatment decisions up till now have been largely driven by physicians [25]. Friction between the complex decision-making processes and the importance of patient involvement in health

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http://dx.doi.org/10.1016/j.pec.2016.10.013
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Please cite this article in press as: N.H. Geessink, et al., Key elements of optimal treatment decision-making for surgeons and older patients with colorectal or pancreatic cancer: A qualitative study, Patient Educ Couns (2016), http://dx.doi.org/10.1016/j.pec.2016.10.013

care decisions emphasizes the need to clarify the role and possibilities of SDM in older CRC/PC patients. Therefore, this study aimed to identify key elements that may help to improve treatment decision-making involving surgeons, older CRC/PC patients and relatives.

2. Methods

2.1. Design and participants

A qualitative design was used to explore the views on key elements in treatment decision-making of older CRC/PC patients and physicians involved in the cancer pathway. Six focus groups with different participants were performed: three with older patients and relatives and three with physicians including GPs. Moreover, seven additional patients participated in supplementary semi-structured in-depth interviews. A purposive sampling method was used to recruit participants. Physicians, consisting of surgeons, geriatricians, general practitioners (GPs) and residents, were contacted by e-mail. Patients and relatives for the first and second focus group were recruited by professionals. For the third focus group and interviews, patients were selected by using a comprehensive list of patients of the onco-surgical outpatient clinic from 2014 to 2015 to create a more general sample. Every third and fifth person from the list that met the inclusion criteria was invited to participate if their current health allowed participation as determined by nursing specialists. Patients were ≥65 years and diagnosed with CRC/PC in the previous five years. To complement the focus groups, three patients with different types of cancer were included. These patients did not show strongly deviating views concerning the discussed topics during data analysis. Because the mean age in the focus groups was rather low, patients' ages were intentionally taken into account during recruitment for the interviews. Participation in the study was voluntary. All participants gave written informed consent. The study was approved by the local ethics committee (CMO Arnhem-Nijmegen, #2014–1400).

Table 1
Characteristics of participants.

	Patients (Focus groups)	Patients (Interviews)	Physicians (Focus groups)
Total number of participants	15 patients 10 relatives	7 patients 4 relatives	23 physicians - 5 surgeons 3 residents - 3 geriatricians 6 residents - 4 general practitioners - 1 internist (palliative care) 1 resident
Mean age in years (SD)	Patients: 73.5 (6.7) Relatives: 63.3 (7.1)	Patients: 80.6 (5.0) Relatives: 79.3 (8.4)	- Surgeons 42.4 (7.8) Residents 30.0 (2.6) - Geriatricians 39.7 (11.0) Residents 27.5 (2.3) - General practitioners 42.5 (9.0) - Internist 44.0 Resident 25.0
Diagnoses	6 colorectal cancer 6 pancreatic cancer 1 gastric cancer 1 oesophageal cancer 1 Non-Hodgkin lymphoma	4 colorectal cancer 3 pancreatic cancer	
Percentage of participating patients diagnosed in prior year	Total: 47% Colorectal cancer: 57% Pancreatic cancer: 50%	Total: 43% Colorectal cancer: 25% Pancreatic cancer: 67%	

2.2. Focus groups and semi-structured in-depth interviews

Focus groups were used to encourage group interaction allowing participants to extensively explore and clarify their views [26]. Supplementary in-depth interviews were performed in the patient's home situation to verify whether the same results would be found, to be able to deepen some topics and to recruit the oldest old (possibly more frail) patients or those who are not interested or comfortable in group discussions. Moderators of the focus groups were two geriatricians. One researcher (NG) observed all focus groups and made field notes. A topic list (Appendix A) was used and adjusted during data analysis.

2.3. Framework analysis

All focus groups and interviews were audio taped and transcribed verbatim. Afterwards, the transcripts were analysed by two researchers (NG, HH) using framework analysis [27]. Initially, a grounded theory approach was used to identify new themes [28]. Therefore, the researchers familiarized themselves with the data. Subsequently, open, axial and selective coding were applied to conceptualize, categorize, and abstract data. After the first two focus groups in both participant groups (patients/relatives versus physicians), the two researchers discussed initial coding per participant group: if disagreements arose, a third researcher (YS) was consulted. A coding framework was made by subdividing all codes into (sub)themes on a matrix-based method. Afterwards, the framework was used to code the remaining focus groups and the supplementary interviews with patients. Data collection proceeded until no new themes were identified in the analysis and saturation was reached. Analysis processing was supported by the Atlas.ti version 7.1.5 software.

2.4. Accuracy check

To ensure accuracy of our interpretations, results of the analyses were sent to all the participants. We asked the participants to provide feedback on misinterpretations. In the final focus groups and interviews previous opinions and themes were discussed and agreed upon with participants.

3. Results

In total, 23 physicians, 22 older patients and 14 relatives participated in this study (Table 1 and Appendix B). Physicians, older patients and relatives discussed similar topics but provided various emphases. Discussed key elements can be subdivided into three interacting components: preconditions, content and facilitators of the decision-making process (Figs. 1 and 2). Perspectives of the different participant groups regarding key elements per component are presented below in more detail with quotes to support the findings (see Appendix C for additional quotes). To make them more readable, quotes are shortened without changing the content.

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