

# Specialty-Specific Values Affecting the Management of Symptomatic Uterine Fibroids

Eric J. Keller, MA, Megan Crowley-Matoka, PhD, Jeremy D. Collins, MD, Howard B. Chrisman, MD, MBA, Magdy P. Milad, MD, MPH, and Robert L. Vogelzang, MD

## ABSTRACT

**Purpose:** To better understand why interventional radiologists and gynecologists differ in their approaches to symptomatic uterine fibroids.

**Methods:** Conversational interviews were conducted with 26 interventional radiologists and gynecologists about their professional roles, clinical reasoning, and practice variation within and outside their specialty. Interview transcripts were systematically analyzed using NVivo 10 software (QSR International, Burlington, Massachusetts) according to grounded theory and content analysis to identify key themes and compare themes across specialties and practice environments. Data were supplemented with retrospective analysis of 7,659 patients with symptomatic uterine fibroids treated at a large academic center over 11 years.

**Results:** Interventional radiologists' shares of symptomatic uterine fibroid treatment and endovascular stent treatments have remained constant ( $P > .05$ ) for 11 y at a large medical center, whereas minimally invasive gynecologic fibroid treatments and the percentage of interventional radiology (IR) procedures reimbursed by Medicaid/Medicare have increased significantly ( $r > .90$ ,  $P < .001$  and  $r = .93$ ,  $P < .001$ ). Interventional radiologists and gynecologists shared a commitment to do "the right thing" for patients, but each group possessed distinct professional values affecting how they viewed medical evidence, outcomes, and their colleagues. When differences were apparent and concerning, physicians tended to suspect ulterior motives not in patients' best interests.

**Conclusions:** Interventional radiologists and gynecologists demonstrated wide-ranging perspectives regarding their role in caring for patients with symptomatic uterine fibroids. To promote genuine collaboration and adoption of shared goals, stakeholders should seek and promote a deeper understanding of specialty-specific values and culture.

## ABBREVIATIONS

GT = grounded theory, UFE = uterine fibroid embolization

From the Departments of Radiology (E.J.K., J.D.C., H.B.C., R.L.V.), Obstetrics and Gynecology-Reproductive Endocrinology & Infertility (M.P.M.), and Medical Humanities & Bioethics Program (E.J.K., M.C.-M.), Northwestern University Feinberg School of Medicine, 251 East Huron Street, Feinberg Room 4-7105, Chicago, IL 60611. Received August 15, 2016; final revision received November 3, 2016; accepted November 7, 2016. Address correspondence to R.L.V.; E-mail: [vogelzang@northwestern.edu](mailto:vogelzang@northwestern.edu)

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Uterine fibroid embolization (UFE) has been performed as a minimally invasive alternative to gynecologic surgery for symptomatic uterine fibroids since 1995 (1). Many subsequent studies have illustrated the efficacy and safety of UFE (2-4), leading the American College of Obstetrics and Gynecology to recommend it as a first-line alternative to hysterectomy for symptomatic uterine fibroids (5). Nevertheless, many women with symptomatic uterine fibroids are not offered UFE as a treatment option. For example, a statewide study found no evidence of discussion of alternative treatments for 38% of women who underwent a hysterectomy, and nearly 20% of these procedures may not have been indicated based on surgical pathology (6,7).

Although there are good reasons why women may choose to undergo gynecologic surgery instead of UFE (8,9), interventional radiologists have long criticized the underuse of UFE, questioning whether the prioritization of gynecologic procedures is economically motivated (10). Numerous studies and conference presentations have presented quantitative data suggesting UFE is underrecommended by gynecologists, but these investigations have been unable to answer why practice variation exists. This is because “why” is more of a qualitative question, requiring a qualitative method sensitive enough to characterize values and motivations affecting clinical decision making.

In light of this, in the present study, grounded theory (GT), a well-validated method from the social sciences, was used to systematically characterize professional values and clinical reasoning of interventional radiologists and gynecologists related to symptomatic uterine fibroids. GT has been used since the 1960s to understand values of patients and physicians through the systematic analysis of observations and interviews (11–15). The method’s founders “argued that scientific truth results from both the act of observation and the emerging consensus within a community of observers as they make sense of what they have observed” (16). As such, “empirical ‘reality’ is seen as the ongoing interpretation of meaning produced by individuals engaged in a common project of observation” (16). One problem with this method is the verbose nonquantitative results it yields, limiting its acceptance among many clinician audiences. Therefore, the GT analysis in this study was supplemented with a quantitative analysis of practice patterns and concept/word frequencies among study subjects.

## MATERIALS AND METHODS

### Ethics Approval

This study was reviewed and approved by an institutional review board (STU: 00105347). Informed consent was obtained and documented from all participants after ensuring that their confidentiality would be strictly protected.

### Interview Participants

Interviews were conducted with 13 physicians from each specialty (interventional radiology [IR] and

obstetrics-gynecology) based on previous work, which suggested most key interview themes from relatively homogeneous groups can be obtained from the first 6 interviews owing to the method’s sensitivity (17,18). As directed by a medical anthropologist (M.C.-M.), a single physician was selected in each specialty for the first interview, and subsequent interviews were generated by asking the interviewee to recommend colleagues with valuable perspectives. However, to ensure that the sample included a range of practice lengths and environments (academic vs private) as well as a gender ratio similar to the entire specialty, interviewees occasionally were asked to recommend colleagues with a particular gender or practice environment. Interviews were initially limited to our hospital system to ensure that consistent interview themes would emerge before allowing interviewees to recommend colleagues from anywhere in the United States. **Table 1** lists physicians’ demographics.

### Interview Technique

Interviews were conducted in a conversational style by a medical student (E.J.K.) mentored by the medical anthropologist. This approach was intended to reduced filtered answers, while ensuring all topics of interest were discussed (19). A medical student interviewer was used because of his status as a nonthreatening, more neutral member of the interviewees’ medical community. Each physician was asked about his or her professional role, clinical reasoning related to symptomatic uterine fibroids, and views of how others within and outside his or her specialty approached patients. Further views and context were elucidated with follow-up questions (eg, “why”; “can you give me an example”). The interview outline is provided in **Table 2**.

### GT Analysis

Interviews were recorded, transcribed verbatim, and analyzed according to GT (11) using NVivo 10 software (QSR International, Burlington, Massachusetts). Core concepts were identified based on interviewees’ emphasis and frequency of ideas. Concepts were compared across interviews to discover themes, such as “definitive treatment,” “ulterior motives,” and “influence of one’s environment.” These concepts and themes were continually revised and refined as additional interviews were performed. For example, at the end of each interview, the interviewer summarized core themes back to interviewees to assess

**Table 1.** Physician Interview Demographics

	Interventional Radiologists (n = 13)	Gynecologists (n = 13)	P Value
Gender (male/female)	11/2	7/6	.09
Environment (academic/private practice)	7/6	6/7	.70
Median years after training (range)	11 (1–31)	21 (5–36)	.08
Chicago/non-Chicago*	9/4	10/3	.66

\*Physicians were included from California, Arkansas, and Ohio.

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