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# Supporting doctor-patient communication: Providing a question prompt list and audio recording of the consultation as communication aids to outpatients in a cancer clinic

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### ABSTRACT

**Objective:** To document the effect of a cancer specific question prompt list (QPL) on patients question asking and shared decision-making (SDM), and to evaluate the combined effect of the QPL and consultation audio recording (CAR) on patient outcomes.

**Method:** This exploratory study compared two groups of patients receiving either a QPL or combined QPL/CAR, to a control group. Measurements included number/types of questions asked, and physician SDM behavior (OPTION score). Questionnaire data included anxiety/depression and quality of life (QoL).

**Results:** A total of 93 patients participated (31 Control, 30 QPL and 32 Combined). Patients in the intervention groups asked more questions concerning prognosis ( $p < .0001$ ), the disease ( $p = .006$ ) and quality of treatment ( $p < .001$ ) than patients in the control group, but no impact was found on the OPTION score. An increase in mean consultation length was observed in the intervention groups compared to the control group (44 vs. 36 min;  $p = .028$ ). Patients rated both interventions positively.

**Conclusion:** Provision of the QPL facilitates patients to ask a broader range of questions, but does not increase physician SDM behavior.

**Practical implementation:** The combination of QPL and CAR seems feasible and should be tested in an implementation study following the disease trajectory.

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## 1. Introduction

Evidence based medicine is the cornerstone of medical treatment and it is argued that real evidence based medicine should include sharing decisions with patients through meaningful conversation [1]. Shared decision making (SDM) is defined by Charles et al. as involving at least two participants (the physician and patient) that both share information, take steps to build a consensus about the preferred treatment, and agree on the treatment to be implemented [2]. One of the assumptions underlying SDM is that the information is provided in a way that is understandable and adapted to the individual

patients' need [3]. The Norwegian health care legislation ensures patients the right to receive necessary information and to participate in SDM [4].

In a UK study of 2331 cancer patients, the vast majority wanted as much information as possible [5]. Patients' strong preference for information is a consistent finding in over 25 years of communication research [6]. Asking questions during medical consultations may facilitate physicians to provide information, and it helps patients obtain the specific information that is most important to them. Furthermore, patients who actively participate in the medical encounter receive more facilitating communication from their physicians [7]. Question prompt lists (QPLs) and consultation audio-recordings (CARs) are communication aids that may facilitate question asking and information recall.

A QPL is a structured list of questions patients may want to ask their physician during the medical encounter and has been

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developed for various areas of cancer care [8–10]. QPLs can increase patients' question asking [11], especially regarding specific topics such as diagnosis and prognosis [12]. Furthermore, a shortened consultation length, reduced anxiety and improved information recall are found when the oncologist explicitly addresses the QPL [13]. Implementing QPLs in routine oncology practice is feasible, and in a study from 2012, 44% of patients provided with a QPL reported to have used it during their medical encounter [14]. There is some evidence suggesting that patients asking target questions may influence physicians towards more SDM behavior [15]. To our knowledge, the direct effect of QPLs on SDM has not been previously investigated.

CARs are audio recordings of consultations for the patient to keep. A Cochrane review found that most cancer patients provided with an audio file of the consultation listened to the audiotape, found it valuable and reported that it helped them inform their family and friends [16]. In a randomized control trial (RCT) by Hack et al. [17], men with prostate cancer given a CAR of their initial treatment consultation, reported being significantly better informed about aspects of their illness and treatment. Similar results were reported from a RCT of patients with oesophageal cancer [18], where patients provided with a CAR from the diagnostic consultation, demonstrated significantly better information retention without experiencing adverse psychological outcomes.

Even though both communication aids are highly valued by patients, the combination of QPL and CAR is sparsely explored except for a recent study of consultations in four different (non-cancer) outpatient clinics. In this study, providing the combination of a QPL and CAR, positively affected the patients' perception of being adequately informed [19].

To date, the effect of QPLs on patients' question asking has mainly been investigated in countries where English is the first language. However, based on literature review, this has not been done in Norway.

Thus, the aim of this study was to investigate the effect of a culturally adapted Norwegian QPL [20] separately and in combination with a CAR in consultations with newly admitted patients to an outpatient cancer clinic. Our study was designed to test whether the QPL increased the number of questions asked by patients/caregiver in a Norwegian setting. Furthermore, we explored if and how the QPL affected the degree to which physicians included patients in SDM. We also examined to what extent the QPL, and the combined QPL and CAR, affected patients' satisfaction, their anxiety/depression and quality of life (QoL) compared with cancer patients receiving consultations without these tools.

## 2. Method

### 2.1. Setting

The study was conducted at the Cancer Outpatient Clinic at the University Hospital of North Norway (UNN), serving patients with a wide range of cancer diagnoses from the three northernmost counties in Norway.

### 2.2. Participants

#### 2.2.1. Physicians

Physicians in the Oncology Department receive a minimum of one year of clinical training before seeing newly admitted patients at the Outpatient Clinic. The physicians fulfilling this requirement were invited to participate in the study and written informed consent was obtained. Physicians involved in planning the project were excluded (four senior physicians).

#### 2.2.2. Patients

Patients were recruited from the Cancer Outpatient Clinic at UNN in three different time periods (assuming no seasonal variation in the admitted patients). We aimed to have one group of patients as a historic control group (Control group), one group of patients receiving the QPL only (QPL group) and one group receiving both QPL and CAR (Combined group). The recruitment occurred in the periods of April to June 2014 (Control group), April to June 2015 (QPL group) and November to January 2015/2016 (Combined group). Eligibility criteria included age 18 to 75, newly admitted to the Cancer department, Norwegian speaking and no cognitive dysfunction. The combined group also had to have access to a computer to play the audio recording.

Author AA identified patients from the participating physicians' outpatient lists. Eligible patients received a letter of invitation one week prior to their appointment. All participating patients signed an informed consent form and completed the first questionnaire prior to the consultation, which was audio recorded. Patients in the QPL and Combined group received the QPL by mail prior to the consultation. Patients in the Combined group received the CAR on a memory stick immediately after the consultation. One week after the consultation, all patients received a second questionnaire by mail.

### 2.3. Study design

This exploratory study was carried out with a quasi-experimental design. The data collection from the control group receiving regular care was completed prior to the recruitment of the intervention groups to minimize any learning effect on the physicians. In the first intervention group (QPL group) patients received the QPL prior to the consultation and in the second intervention group (Combined group) they received the QPL before consultation and a CAR after the consultation. Neither the patients nor the physicians were blinded to the interventions. Fig. 1 shows the study design.

### 2.4. Interventions

#### 2.4.1. QPL

The Norwegian QPL is a 4-page A5 booklet (Appendix A) that applies to most oncology consultations, and was previously shown to have face validity and high patient acceptability [20]. The physicians were asked to address the QPL as early as possible in the consultation and to encourage the use of the QPL and question asking in general.

#### 2.4.2. Consultation audio record (CAR)

A CAR was provided to patients in the Combined group only. The research nurse copied the CAR from a handheld audio recorder onto a memory stick. The memory stick was handed directly to the patient, and a copy was stored in the research database.

### 2.5. Analysis of the audio files (Immediate results)

Medical transcription staff at UNN transcribed all the audio files verbatim. Two trained psychology students at the masters level coded the consultations.

#### 2.5.1. Questions asked by patients/caregivers

A manual for coding the questions was developed to ensure reliable coding. The physicians' verbal attempt to invite patients to ask questions was coded either as absent, basic or extended and in what part of the consultation it occurred (beginning, middle, end). Extended invitation was coded if the physician emphasized the importance of asking questions. The patient and caregiver questions were coded separately into one of 14 categories.

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