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Deaf patient-provider communication and lung cancer screening: Health Information National Trends survey in American Sign Language (HINTS-ASL)

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ABSTRACT

Objective: To assess whether mode of communication and patient centered communication (PCC) with physicians were associated with the likelihood of deaf smokers inquiring about lung cancer screening. **Methods:** An accessible health survey including questions about PCC, modes of communication, smoking status and lung cancer screening was administered in American Sign Language (HINTS-ASL) to a nationwide sample of deaf adults from February to August 2017. Of 703 deaf adults who answered the lung screening question, 188 were 55–80 years old.

Results: The odds ratio of asking about a lung cancer screening test was higher for people with lung disease or used ASL (directly or through an interpreter) to communicate with their physicians. PCC was not associated with asking about a lung cancer screening test.

Conclusion: Current or former smokers who are deaf and use ASL are at greater risk for poorer health outcomes if they do not have accessible communication with their physicians.

Practice implications: Optimal language access through interpreters or directly in ASL is critical when discussing smoking cessation or lung cancer screening tests. Counseling and shared decision-making will help improve high-risk deaf patients' understanding and decision-making about lung cancer screening.

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1. Background

1.1. Introduction

In the U.S., tobacco products inhaled into the lungs are the greatest preventable cause of death. Smoking causes almost nine out of ten lung cancer deaths [1]. Using data from a 2015 national survey, it was estimated that over 50% of cigarette smokers were motivated to quit, but less than ten percent followed through, leaving a sizable group that may benefit from adhering to lung cancer screening recommendations [2].

Low-dose computed tomography (LDCT) screening has been proposed as an early detection tool for those at high risk [3]. The U. S. Preventive Services Task Force (USPSTF) recommends that former and current smokers between the ages of 55 and 80 who have a 30 pack-year history and currently smoke or have quit within the past 15 years, receive an annual CT scan for early lung

cancer detection. Limiting screening to these criteria was deemed by USPSTF to have a reasonable balance of benefits (early detection and treatment) and harms (incidental findings and over-diagnosis). Given the existence of these harms, patients must be involved in an informed discussion of the possible benefits, limitations, and known and uncertain harms before a decision is made to begin screening.

In a recent study of 3677 adults who participated in the 2014 Health Information National Trends survey, 795 adults aged 55 to 80 were former or current smokers. Among smokers, only 10% had asked their healthcare providers about lung cancer screening within the past year [4]. In other studies, focusing on care after lung cancer screening tests, patient-physician discussions about the lung cancer treatment and follow-up smoking cessation sessions through telephone-based communication were found to be associated with greater compliance to lung cancer-directed therapy among diagnosed patients [5] and smoking cessation among individuals who were not diagnosed with lung cancer after LDCT screening test [6]. Physicians' recommendations influence screening and patient-physician communication influences post-LDCT care, making it reasonable to hypothesize that physicians

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who provide accessible, patient-centered communication (PCC) techniques will facilitate access to lung cancer screening in the deaf population.

1.2. Smoking prevalence among deaf adults who use American Sign Language

Among deaf adults who use American Sign Language (ASL), little is known about their smoking prevalence and predicted risk factors. Nearly two decades ago, a study that used a secondary analysis of a national dataset found that the smoking prevalence among deaf adults was lower than for hearing adults [7]. While the smoking prevalence did not vary across education and income levels in their deaf adult sample, the lower smoking rate may either be a result of under-reporting or inaccessibility of orally delivered tobacco-related advertising.

In a 2008 Deaf Health Survey with Rochester, NY-based adult sample (n = 339) and 2013 (n = 211), 9.1% and 8.1% respectively self-identified as current smokers [8]. Another study in Chicago reported an even higher smoking rate among 203 deaf signers, with over half (52.5%) being current or former smokers [9]. It should be noted that the Rochester study had adults with higher levels of education compared to their counterparts in the Chicago study.

In health care, there is a stigma associated with disclosure of smoking status. Although patients can be highly motivated to quit smoking, they do not necessarily engage their providers in discussions about lifestyle changes, mainly due to fear of judgment, and refusal of continued treatment by the physician [10]. If a patient with a smoking history is also deaf and simultaneously experiences communication difficulties with healthcare providers, this can potentially increase the likelihood

of the patient *failing to share* their smoking history or asking lung cancer-related questions.

1.3. Patient centered communication

PCC might affect the lung cancer screening test inquiry by deaf patients who are current or former smokers. PCC is critical in that it can significantly improve health outcomes [11], while reducing the cost of health care [12]. Higher perceived PCC scores have been correlated with a greater likelihood of patients asking their doctors questions. Furthermore, Street et al. [11] found that effective doctor-patient communication led to “increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and patient empowerment.” Clear communication is key to promoting disease prevention and early detection behaviors, such as smoking cessation and lung cancer screening (Fig. 1).

Research suggests that communication between deaf patients and physicians is suboptimal, which could lower the likelihood of a deaf patient being informed about lung cancer screening, particularly if deaf patients withhold their history of smoking. The deaf population, by virtue of communication and linguistic differences within the mainstream culture, has an increased likelihood of poor doctor-patient communication and reduced satisfaction with care. Bartlett et al. [13] found that patients with communication problems were three times more likely to experience a preventable adverse event than patients without communication problems.

Patient safety has been severely compromised in cases where communication was inadequate [14]. Patients reported not understanding their doctor's advice, receiving insufficient medication

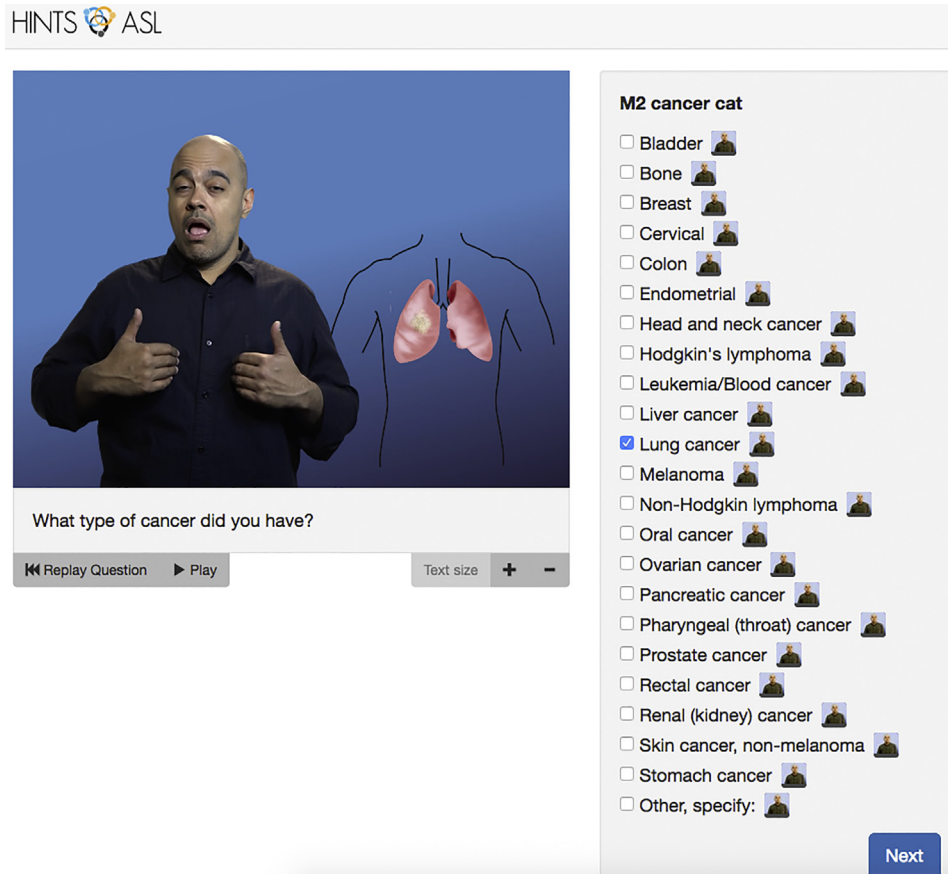


Fig. 1. Lung cancer answer option with medical illustration.

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