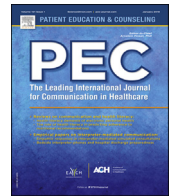




Contents lists available at ScienceDirect

Patient Education and Counseling

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



Coaching to support men in making informed choices about prostate cancer screening: A qualitative study

Dragan Ilic^{a,*}, Kerry Murphy^a, Veronica Collins^b, Carol Holden^{a,b}

^a Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University, Australia

^b Andrology Australia, School of Public Health and Preventive Medicine, Monash University, Australia

ARTICLE INFO

Article history:

Received 15 June 2016

Received in revised form 22 December 2017

Accepted 4 January 2018

Keywords:

Prostate cancer

Decision support model

Decision making

Primary care

ABSTRACT

Objective: The objective of this study was to examine the perceptions of men, practice nurses (PNs) and general practitioners (GPs) on patient decision coaching for prostate cancer screening.

Methods: Seven focus groups were conducted with 47 participants, representing three stakeholder groups – men, GPs and PNs. All focus group discussions were conducted by the same facilitator and guided by a semi-structured interview schedule. Transcriptions were analysed by thematic analysis.

Results: Knowledge about the merits of prostate cancer screening was high amongst GPs, but limited with PNs and men. All groups saw the value in PN-led decision coaching for men considering screening for prostate cancer, but had reservations about its implementation in practice. Barriers to implementing a decision coaching system with PNs included staffing and cost of implementation.

Conclusion: GPs, PNs and men identified benefits for the use of a PN-led decision coaching support intervention to assist men with making an informed choice about screening for prostate cancer. Stakeholders had reservations about how a PN-led intervention would effectively work in clinical practice.

Practice implications: A feasibility study is required to examine barriers and enablers to implementing a PN-led decision coaching process for prostate cancer screening in the Australian primary healthcare setting.

© 2018 Elsevier B.V. All rights reserved.

1. Introduction

Prostate cancer is the second most commonly diagnosed cancer in men globally, and the most frequently diagnosed cancer in men in developed countries [1]. It is the fifth leading cause of cancer deaths worldwide, predominantly in the Caribbean and African countries [1]. Following the introduction of the prostate specific antigen (PSA) test in the early 1990s, a sharp increase in the incidence of prostate cancer was observed, followed by a rapid decline due to the initial detection of non-aggressive, but histologically recognised prostate cancers [2,3]. Mortality rates have been decreasing, although it is uncertain whether this decline can be specifically attributed to the introduction of screening, or improved treatment [2].

Five randomised controlled trials (RCTs) have examined the effectiveness of screening for prostate cancer [4]. A *meta*-analysis of these five RCTs concluded that screening does not significantly

decrease prostate cancer-specific mortality [4]. Only one of the studies included in the *meta*-analysis reported a significant reduction [5]. Combined with the possible harms associated with over-diagnosis and over-treatment, PSA testing remains controversial and most guidelines state that testing should not take place unless the man is properly informed [4].

Even though guidelines are unanimous on the point of informed decision making, the majority of men have limited knowledge about the benefits and harms associated with screening for prostate cancer [6]. Moreover, despite this lack of knowledge, a significant majority choose to be tested, or simply defer their choice to their general practitioner (GP) without informed discussion [6,7]. Alternatively, clinicians may administer the PSA test without discussing its benefits and harms if specifically requested by the patient, or when the clinician has a strong preference for it [8–10].

Integration of evidence with a clinician's experience and patient values underpins shared decision making and evidence based practice [11]. Although patients may discuss the possibility of screening for prostate cancer with their doctor, evidence suggests that few patients can recall clear discussion about harms associated with screening [12]. Decision aids may facilitate the

* Corresponding author at: Level 6, The Alfred Centre, 99 Commercial Rd, Monash University, Melbourne, VIC, Australia.

E-mail address: dragan.ilic@monash.edu (D. Ilic).

patient–clinician interaction by providing a medium in which benefits, harms and uncertainty are discussed [13]. Evidence from recent systematic reviews indicate that decision aids on PSA testing can increase patient knowledge, decrease decisional conflict, and promote greater involvement in decision making [13,14].

Uptake of decision aids by GPs in clinical practice is limited despite the evidence and the most recent Australian clinical guidelines recommending their use [15]. Limited time during consultations and awareness of, and skills in using, decision aids are commonly cited barriers [16–19]. To overcome some of these barriers, recent studies have focused on the development of patient skills and knowledge through an inter-professional, decision coaching approach [20,21]. Decision coaching involves having trained facilitators (most commonly nurses) consult with patients to help them prepare for a consultation with a doctor, deliberate about options, and implement the decision [20]. The coaching may be done in person, or remotely (via telephone/internet), with the goal of providing support, in a non-directive manner, for the decision [21].

Nurse specialists have typically been used to administer decision aids and provide coaching to help patients make informed decisions about health behaviours related to prostate disease [20]. In Australia, the role of nurses in primary health care setting has increased, typically performing a variety of roles including simple clinical procedures, health promotion, implementation of prevention strategies, rehabilitation, clinical research, education and other public health affiliated roles. The only two studies conducted to date have demonstrated that the delivery of decision coaching by a nurse, or health educator, to provide supportive but non-directive information, can enhance patient skills and knowledge when making a decision with their GP with respect to prostate cancer testing [22,23].

Both studies were set in the United States, however no studies to date have been conducted in the context of the Australian health system to examine the reproducibility of these results given different cultural attitudes in screening. For example, recommendations from professional bodies such as the American Cancer Society and American Urological Association recommend screening for prostate cancer in men within a certain age bracket, whereas recommendations from similar professional bodies in Australia recommend a shared decision making approach between patient and GP [4].

The aim of this study was to explore the perceptions of Australian men, practice nurses (PNs) and GPs with respect to the potential of decision coaching for prostate cancer screening, specifically to identify possible benefits and barriers to implementing such an approach.

2. Methods

2.1. Participant selection

Participants were recruited using purposive sampling techniques through advertisements and call for volunteers in health professional networks (for GPs and PNs), and consumer interest groups (for men). The use of a commercial recruitment agency was also used to recruit GPs and PNs, as only two GPs were recruited through the health professional networks. All consumers were recruited through the general advertisement.

GPs and PNs were eligible to participate if they were engaged in clinical practice during the time of the study and regularly consulted with male patients aged over 45 (for GPs), and regularly provided medical services to males over 45 years of age (for PNs). Men were eligible for participation if they were male, aged over 40 and had not been diagnosed with prostate cancer. Interested

respondents were asked to contact the study coordinator, who gave a verbal explanation of the study. Each participant was provided with an explanatory statement, and were asked to provide written consent prior to participation in the focus group discussion.

2.2. Setting

Each focus group was homogeneous with respect to the stakeholder group. GPs and PNs attended focus groups at the offices of the research institute. Focus groups with men were conducted in community halls across metropolitan Melbourne, Australia. All participants were given an honorarium to cover the costs associated with their participation in the study. This study was approved by the Monash University Human Research Ethics Committee (MUHREC).

2.3. Data collection

A total of seven focus groups were conducted with GPs ($n = 2$), PNs ($n = 2$) and men ($n = 3$). Focus groups were chosen as the form of data collection as it is a cost-effective method of collecting data from a variety of stakeholders within a short time frame, when compared to other techniques such as individual interviews. It also provided the opportunity to obtain insights from a range of stakeholders, enabling group interaction and discussion on the topic [24]. Questions for the interview schedule were developed from a review of the literature. Key areas of discussion focussed on (i) perceived merits of prostate cancer screening; (ii) decision making processes between patient and healthcare practitioner; (iii) role of shared decision making and decision aids; (iv) merits of a decision coaching approach to facilitate informed discussion; (v) perceived barriers and enablers to current and proposed decision making processes. All focus groups were conducted by the same male facilitator (DI). Focus groups varied in length, between 1 and 1.5 h in duration. All focus group discussions were audio-recorded through the use of a digital recorder. Audio files were transcribed verbatim at the conclusion of the focus group by an independent transcribing service. Copies of the transcripts were available to participants upon request for feedback purposes. Theoretical saturation was reached after the seventh focus group, with discussion generating no new discussion points [25].

2.4. Data analysis

De-identified transcripts were analysed thematically and independently by two investigators (DI, KM). Thematic analysis was performed through a six-step process which involved investigators: (i) reading each transcript to familiarise themselves with the data; (ii) generating initial codes; (iii) searching for themes from the initial codes; (iv) reviewing the themes; (v) defining and naming themes; and (vi) producing the final analysis [26]. Transcripts for each participant group were analysed separately, before common themes were synthesised. The two investigators discussed similarities and differences across their respective analysis before the final set of themes was established. This discussion was informed by comparing the respective coding processes. Where themes differed, further details about the selective and axial coding was compared before consensus on a theme was reached. Verbatim quotes from focus group participants have been included to illustrate key findings for each theme [27].

3. Results

A total of seven focus groups were conducted with 47 participants, across three stakeholder groups. Demographic details

Download English Version:

<https://daneshyari.com/en/article/8764923>

Download Persian Version:

<https://daneshyari.com/article/8764923>

[Daneshyari.com](https://daneshyari.com)