Clinician Perspectives on Factors Affecting Shared Decision Making in Lung Cancer Screening

Abubaker-Sharif M, DiCarlo M, Myers, R
Sidney Kimmel Medical College, Department of Medical Oncology, Division of Population Science

Background

The results of the National Lung Screening Trial (NLST) revealed a 20% risk reduction of lung cancer mortality subsequent to annual screening with low dose CT (LDCT) in individuals at high risk for lung cancer. This has translated to annual LDCT receiving a grade B recommendation from the United States Preventive Services Task Force (USPSTF). In 2015, the Centers for Medicare and Medicaid Services (CMS) announced coverage for annual lung cancer screening (LCS) with low dose computed tomography (LDCT) for individuals who are 55 to 77 years of age, have > 30 pack years of smoking history, and undergo shared decision making (SDM) prior to screening.

Although a variety of definitions of SDM exist in the literature, many share the following three components: patient education, patient preference clarification, and the explicit making of a shared decision. SDM, through some type of decision aid (DA), has become promoted both within the United States and abroad as a tool to increase patient knowledge, lower decisional conflict, and improve risk perception. A wealth of evidence continues to show that DAs fulfill an ethical imperative to actively engage patients in their own healthcare and provide a wide range of benefits to patients and the healthcare system. Adoption and implementation of SDM in clinical practice has lagged behind.

DA use among physicians is minimal. A population-based survey of 739 physicians revealed that only 24% were currently using a decision aid in the context of cancer management. The fundamental reasons behind poor DA adoption are due to several clinician perceived barriers including lack of time, competing responsibilities such as workload and clinical documentation, and limited patient comprehension. Significant clinician concerns exist on how to effectively integrate SDM into the clinical workflow. Additionally, there are gaps in research on meaningful SDM and particularly sparse evidence and experience of SDM in lung cancer.

Methods

Interview Guide

- An interview guide, which included a total of two main sections: understanding of SDM, perceptions about SDM in LCS, and receptivity to an online decision support intervention (DSI), specifically the Decision Counseling Program (DCP) in development at TJJU. (Supplement 1). Interviewers found the interview guide to be helpful in guiding discussions.

- Working with senior leadership in the Department of Internal Medicine at TUU, a pool of twenty-three physicians was generated.

- An email was sent to the physician pool to request their permission to participate in an interview about SDM in LCS.

- In-person audio recorded interviews were conducted. Interviews were transcribed for analysis. A codebook was generated and used to analyze the interview transcripts with Nvivo qualitative analysis software.

- An interview and selection guide included an introduction to the interview and a list of interview questions organized into three main sections: understanding of SDM, perceptions about SDM in LCS, and receptivity to an online DSI in LCS.

- Clinicians agreed to participate in the interview with their permission to participate in an interview about SDM in LCS.

Objective

Most referrals for LCS are initiated in primary care. Currently, little is known about how primary care physicians view SDM and barriers in practice to SDM about LCS. This study aimed to gather information to help fill these knowledge gaps.

Results

Out of a total pool of twenty-three internal medicine physicians who were solicited to participate in an interview about SDM in LCS, nine physicians responded and nine interviews were subsequently conducted over the course of three weeks. Preliminary observations are as follows:

Understanding of SDM

- Physicians were generally in agreement that SDM is a joint decision based on a discussion about the risks and benefits of a particular intervention that considers patient values and medical status.

- Patient education was often highlighted as an essential component to the SDM process.

- Many were familiar with DAs and had utilized them in the past.

Perceptions about SDM in LCS

- Perceptions that LCS is a more controversial and complex screening process for patients specifically in comparison to screening for breast cancer and colon cancer influenced physicians’ perception of SDM in LCS.

- In addition, the time consuming nature of having a thorough conversation about the risks and benefits of LCS was a limiting factor for meaningful SDM.

- Some physicians noted that given patients eligible for LCS may typically also have several comorbidities, LCS was not prioritized.

- When navigating patient preference for LCS, physicians often relied on their assessment of a patient’s adherence and general attitude towards other screening or treatment goals and patient health literacy.

Receptivity to use of an online DSI in LCS

- Physicians were supportive of the DCP noting its patient education component, offloading of physician work, and the appropriate time spent with patients by a trained counselor.

- Concerns were raised about patient adherence to referral to a LCS program and follow up related to incidental findings.

Discussion

- Observations from this study highlight a common general understanding of SDM, yet mixed approaches to SDM in LCS.

- Physicians’ perception of SDM in LCS was influenced by patient comorbidities, LCS controversy and complexity, and limited office time.

- Strong support also exists for a DSI that educates patients about LCS and saves physicians time.

- Additionally with respect specifically to the DCP, several physicians voiced support for its full integration within EPIC, the electronic health record (EHR) in use.

- Future steps include interviewing a set of family medicine physicians to investigate potential differences in viewpoints compared to internal medicine physicians.

- The major limitation of this study in terms of generalizability is the small sample size of physicians from one medical center, albeit from an academic teaching hospital with access to a patient population at high risk for lung cancer.

References


Acknowledgements

We thank Dr. Gregory Kane, Dr. Barry Ziring, and Dr. Rickie Brawer for their assistance in the interviewee selection process. We also extend gratitude to Aneet Petrich and Emily Lambert for their continual facilitation of study implementation.

Dr. Amy Leader and Pamela Myers deserve thanks for their guidance on use of the NVivo qualitative analysis software for transcript analysis.