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Impact of Patient Comorbidities on Shared Decision-Making Practices in Lung Cancer Screening

The United States Preventive Services Task Force (USPSTF) recommends annual low dose–computed tomography (LDCT) scans for lung cancer screening (LCS) for eligible individuals based on age and smoking history. Despite this recommendation, LCS uptake is low compared to other screenings, like breast cancer. Medicare policy mandates shared decision-making for LCS but its impact on adherence rates is unclear. Shared decision-making involves clinicians and patients discussing screening options, benefits, and risks to align with patient preferences, often aided by decision aids. Many LCS-eligible individuals have comorbid conditions due to shared risk factors with lung cancer from tobacco exposure. These conditions can affect the risk-benefit ratio of LCS by influencing diagnostic and treatment complications, eligibility, and quality of life. Guidelines suggest considering comorbidities in LCS decisions, but how primary care physicians (PCPs) navigate shared decision-making with complex patients remains unclear. A recent study published in the Annals of Family Medicine aims to explore PCPs' reasoning in LCS decision-making with patients having comorbidities.

Exploring PCPs' Views on Comorbidities in Lung Cancer Screening

Between October 2020 and February 2021, a qualitative study was conducted with primary care physicians (PCPs) to explore their perspectives on how patient comorbidities affect shared decision-making conversations regarding lung cancer screening (LCS). PCPs from four internal medicine practices affiliated with the Mount Sinai Health System in New York City were recruited for interviews. The study, approved by the institutional review board at the Icahn School of Medicine at Mount Sinai, involved 45-minute recorded Zoom interviews with experienced qualitative researchers. The interviews focused on various domains of the theoretical domains framework (TDF), a tool for understanding behavioural change in healthcare settings. Questions aimed to elicit PCPs' understanding of how comorbidities influence LCS decisions and the extent of shared decision-making discussions in this context. Thematic analysis of interview transcripts was conducted independently by three investigators, with consensus achieved on identified themes. Saturation was reached after 15 interviews, indicating that no new themes emerged. A fourth team member reviewed themes relevant to comorbidity considerations for confirmation of uniqueness and internal consistency.

Key Themes from PCPs' Approach to Comorbidities in Lung Cancer Screening

The study involved 15 PCPs from 4 academic-affiliated primary care practices, with an average of 15 years of experience and 70 low-dose computed tomography (LDCT) scans ordered. Analysis revealed three main themes regarding the impact of patient comorbidities on LCS shared decision-making practices:

Theme 1: PCPs used subjective clinical judgement to decide whether to discuss LCS with patients with comorbidities, conducting a mental cost-benefit analysis considering factors like patient health, life expectancy, and quality of life. This often led to overriding USPSTF guidelines, with some patients not informed about LCS due to PCPs' internal heuristic assessments.

Subthemes under Theme 1 included assessing patient health, estimating life expectancy, predicting follow-up likelihood, and considering quality of life

Theme 2: Shared Decision Making Is Not a Simple Discussion. PCPs struggled with how to balance honesty with influencing patients during LCS discussions.

Theme 3: Ultimately, the Decision Is Up to the Patient. PCPs believed their role was to advise rather than make the final decision on LCS, emphasising patient autonomy in decision-making.

Impact of Patient Comorbidities on PCPs' Lung Cancer Screening Practices

The study examined how patient comorbidities influence lung cancer screening (LCS) shared decision-making practices among primary care physicians (PCPs). PCPs often relied on clinical judgement, assessing factors like patient health, life expectancy, and quality of life, before initiating LCS discussions. This judgement sometimes led to not discussing LCS with eligible patients with complex comorbidities. PCPs considered patient characteristics and support systems in their decision-making process, often deferring to patients' opinions on LCS. Limitations include the study's focus on internists from a single health system, potentially limiting generalizability. Notably, PCPs did not directly address LCS decision-making in patients with psychiatric comorbidities, highlighting a gap in research. Previous studies have attributed low engagement in LCS discussions to various factors, including time constraints and PCP biases.

PCPs' reliance on subjective judgement reflects the lack of evidence-based guidance on LCS in patients with comorbidities. Conflicting data on LCS outcomes in this population contributes to PCP ambivalence and hesitancy in recommending screening. Efforts are needed to clarify guidelines, provide evidence-based information, and develop decision-support tools to facilitate LCS shared decision-making. Additionally, research should explore the impact of involving other healthcare team members in LCS discussions and address selection bias in patient-clinician conversations.

Source: **The Annals of Family Medicine**

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Published on : Mon, 22 Apr 2024