

ORIGINAL ARTICLE

Introducing a time out consultation with the general practitioner between diagnosis and start of colorectal cancer treatment: Patient-reported outcomes

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Abstract

Objective: To evaluate the introduction of a “time out consultation” with the general practitioner (GP) recommended to patients following the diagnosis of colorectal carcinoma (CRC) before start of treatment.

Methods: A prospective study using questionnaires to compare the number of GP consultations, with their content and outcomes before and after the introduction of an additional consultation with the GP to improve decision-making and adequate support.

Results: 72 patients before and 98 patients after the introduction of the “time out consultation” participated. Introduction of the consultation increased the number of patients to contact their GP from 67% to 80%, but did not change kind or content of the consultations. Patients felt the consultation was comforting and were more satisfied with the GP after the introduction. There was no difference in outcomes measured by the questionnaires in all patients combined, but men, older patients and patients with palliative treatment options only did improve on specific outcomes after the introduction.

Conclusion: The introduction of the “time out consultation” did not change the kind or content of GP consultations before start of CRC treatment, but patients did feel more comforted and satisfied. Subgroups of patients benefited on specific outcomes.

KEYWORDS

colorectal cancer, general practitioner, patient perspective, primary care involvement, time out consultation, treatment decision

1 | INTRODUCTION

Several initiatives advocate and evaluate a larger role for general practitioners (GPs) in caring for patients with cancer (Eyck et al., 2012; Kievit et al., 2007; Knottnerus & Wijffels, 2011; Rubin et al., 2015). The GP is

thought to be best positioned and trained to provide continuous care, enhance patient participation during decision-making and provide integrated care considering a patient's medical as well as contextual background (Eyck et al., 2012; Henselmans, de Haes, & Smets, 2013; Perfors et al., 2018; Rubin et al., 2015; de Wit, 2017). In the Netherlands,

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however, GPs are currently only mainly involved in the diagnostic and palliative stages of cancer care. For this reason, projects have recently started expanding GP involvement in other stages of cancer care, such as treatment decision-making and survivorship care after treatment (Duineveld et al., 2015; Perfors et al., 2018; de Wit, 2017).

A teaching hospital in the region of Amsterdam recently carried out a project to involve GPs more in their patients' decision-making process. Publications from the Federation of Cancer Patient organisations indicated that 20% of elderly patients retrospectively regretted the treatment they underwent and that patients may feel inadequately informed (Broenland, 2018; de Wit, 2017). This large number of patients who in retrospect regret their decisions is worrying, especially if this can be improved by better information and counselling before start of treatment. A review by van Mossel et al. (2012), however, showed that of all available literature, only 3% dealt with patients' information needs before surgery. To be able to make a considered decision, it is important that patients are well informed, actively involved in the decision-making process, confident to ask questions when needed and able to deliberate on all treatment options against their personal backgrounds. Because of his/her unique position and training, the GP seems to be most suited to discuss treatment options considering the context and personal backgrounds of patients, and provide continuity of care.

With this in mind, the "time out consultation" with a patient's GP following the cancer diagnosis was introduced. The "time out consultation" was intended to be a face-to-face consultation with the GP before start of cancer treatment and to allow patients to discuss the proposed treatment and its possible consequences, to check whether they had understood all relevant information and to consider if they needed additional physical or emotional support. It was decided to introduce the consultation for colorectal cancer (CRC) patients first and examine the results before potentially expanding to other types of cancer.

The aim of this study is to examine the effect that the introduction of this "time out consultation" with CRC patients had on primary care use and on patient-related outcomes. To this end, we performed a prospective study to examine: (a) how the introduction of the "time out consultation" changed the number, kind and content of GP consultations, (b) the difference in several patient-reported outcomes before and after the introduction of the "time out consultation", that is patient activation, patient-physician interactions, shared decision-making, decisional conflict and patient satisfaction and (c) whether any differences in outcomes between patient subgroups could be detected.

2 | METHODS

2.1 | Patients

We included patients aged 18 years or older with a new diagnosis of CRC, either first time or recurring. All tumour stages (1-4) were eligible. Patients who were not able to speak or read Dutch were excluded from participation. Candidates were identified and informed about the study by oncology nurses at the outpatient clinics of the

OLVG, a teaching hospital in Amsterdam, and came from Amsterdam or surrounding regions. When patients agreed to participate, they were contacted by telephone by a researcher to confirm participation and make arrangements concerning the surveys. The inclusion period was from October 2016 until October 2017, with the "time out consultation" starting in January 2017.

Before the introduction of the time out consultation with their GP, patients were asked to participate in a questionnaire survey. No extra recommendation was made for patients to consult their GP.

2.2 | Intervention

A discussion panel consisting of medical specialist, GPs and patients combining existing literature and personal experiences composed six proposed topics of discussion for the "time out consultation": (a) Do I really want to be treated? (b) Is this the right hospital for me? (c) Did I understand all information correctly? (d) What are the consequences of the proposed treatment? (e) Can I continue working? (f) Do I need support at home?

By means of a hospital newsletter, several presentations and symposia, all GPs working in the region of the hospital (just under five hundred) were informed on the study.

Subsequently, the introduction of the time out consultation started. This meant that physicians and nurses at the outpatient clinics recommended patients to consult their GP the week following the diagnosis of CRC and before start of treatment to discuss a number of possible subjects. Both patient and GP received the same written information and were encouraged to plan the time out consultation, but actually making the appointment was left to patients and GPs.

2.3 | Questionnaires

Information on patient and disease characteristics was obtained from patients' medical files after patients agreed to participate. The survey used in patients both before and after the introduction of the time out consultation was identical and provided information on patient-GP relations, and specifics of any GP consultations. Furthermore, it consisted of validated questionnaires to measure the outcomes of shared decision-making mentioned in the introduction: Patient Activation Measure (PAM-13; Hibbard, Stockard, Mahoney, & Tusler, 2004), Perceived Efficacy in Patient-Physician Interactions (PEPPI-5; Maly, Frank, Marshall, DiMatteo, & Reuben, 1998), Shared Decision Making Questionnaire (SDM-Q-9; Rodenburg-Vandenbussche et al., 2015), Decisional Conflict Scale (DCS-16; Koedoot et al., 2001; O'Connor, 1995) and European Organization for Research and Treatment of Cancer in patient satisfaction score (EORTC IN-PATSAT-32; Bredart et al., 2005). Appendix S1 contains the entire composite questionnaire.

2.4 | Statistics

The data were collected using an online survey programme (SurveyMonkey Inc.) and analysed using SPSS Statistics 25 (SPSS).

Surveys with less than fifty per cent response were deleted from further analysis. We performed the independent samples *t* test, the chi-squared test and the one-way ANOVA test to compare differences between groups of patients. A *p*-value < .05 (two-sided) was considered statistically significant. Thematic analysis was performed according to Braun and Clarke for responses to open questions by two researchers (TW and SW) and checked by a third researcher (JW) (Braun & Clarke, 2006).

A comparison was made between groups of patients before and after the introduction of the time out consultation, regardless of whether patients actually *had* a consultation with their GP, to measure the effect that introducing the consultation had on our patient-reported outcomes.

2.5 | Ethical statement

The Medical Ethics Committee of the Amsterdam University Medical Centres reviewed the protocol and judged that a formal evaluation by the committee was not required. Nevertheless, all participants received written study information and provided verbal consent.

3 | RESULTS

We identified 251 eligible patients, 170 participated in the study and completed the survey (response rate 68%). Reasons for not participating were as follows: patient was too weak to participate (*N* = 23), patient could not be contacted (*N* = 19), patient was too preoccupied at the moment (*N* = 18), patient was not interested (*N* = 9), other or undisclosed reason (*N* = 12).

Characteristics of all participating patients are shown in Table 1. Seventy-two patients completed the survey before introduction of the “time out consultation” and 98 patients after the introduction of the consultation. Twelve patients (7% of respondents) completed less than fifty per cent of the questionnaire and were excluded from further analysis: five before and seven after introduction of the consultation. The patients who completed the survey after the introduction of the consultation were slightly older (average 66 vs. 63 years, *p* = .039), but otherwise their characteristics were similar to the patients who completed the survey before introduction of the consultation.

Table 2 shows specifics of the GP consultations and compares these specifics before and after the introduction of the “time out consultation”. The mean appreciation for the GP in both groups was 7.7 out of 10 and 7.6 out of 10 respectively. After the introduction of the “time out consultation”, the number of patients that contacted their GP rose from 67% to 80%. The consulted GP and kind of contact (telephone, practice visit or home visit) were the same for both groups, *as were the reported topics of conversation* during these consultations. Around 80% of patients indicated they had no real choice between different treatment options, and that their GP did not help in reaching a treatment decision. However, patients *did* feel the consultation with their GP was comforting, and this feeling increased

after the introduction of the “time out consultation” (*p* = .016). Likewise, patients were more satisfied with the GP consultation after the introduction of the “time out consultation” (*p* = .042).

Table 3 shows the mean total results for each questionnaire used in our survey. For all patients combined, all questionnaires showed a tendency to improvement after introduction of the “time out consultation”, but none improved significantly.

However, some patient groups that did improve significantly could be identified (Table 4). Men were more satisfied with the technical and interpersonal skills of their GP, and with the patient-GP relations. Patients aged 65 years or older scored better on the Patient Activation Measurement (PAM-13) questionnaire, and also better on satisfaction with their GP's technical skills, interpersonal skills, information provision and availability. Lastly, after introduction of the consultation, patients with palliative treatment options only scored significantly lower on the Decisional Conflict Scale (DCS-16), indicating that they felt less conflicted on treatment decision, and more supported by their healthcare providers regarding decisions.

4 | DISCUSSION

This paper describes the effect of introducing a “time out consultation” with the GP for patients recently diagnosed with (recurrence of) colorectal carcinoma (CRC). We found that the introduction resulted in only a modest increase in the number of actual consultations with the GP and did not change the kind and content of the consultations. Patients did feel the “time out consultation” was comforting and were more satisfied with the GP after the introduction. There was no difference in outcomes measured by the questionnaires in all patients combined, but men, older patients and patients with only palliative treatment options did improve on specific outcomes after the introduction of the consultation.

In line with previous findings (Wieldraaijer et al., 2018, 2017), patients in general reported to be content with their GP. Even before the introduction of the “time out consultation”, two-thirds of all CRC patients were in contact with their GP between diagnosis and start of treatment. Because so many patients were already in contact with their GP before the introduction of the “time out consultation”, we found only a modest increase to 80% in the proportion of patients to contact their GP after the introduction. Half of the “time out consultations” were by phone, while the other half mostly were consultations at the GP's practice, leaving a small percentage home visits. Nearly always, the consultation was with the patient's regular GP. With the introduction of the “time out consultation”, both patient and GP received recommendations on possible topics of discussion. However, we found that this way of introducing the consultation did not change discussed topics. Most patients in our study did not feel they had an actual choice to make regarding treatment, either when treatment was curative or palliative in intent. As such, the consultation with the GP did not change the patients' decision to start the proposed treatment; the “time out consultations” typically

TABLE 1 Patient and disease characteristics

	All patients (N = 170)		Before introduction of time out consultation (N = 72)		After introduction of time out consultation (N = 98)		p-value
Age (mean years, range)	65	(35–88)	63	(35–88)	66	(36–85)	.039*
Gender—male (%)	107	(63%)	43	(60%)	64	(65%)	.456
Tumour stage							.361
I	41	(24%)	14	(19%)	27	(28%)	
II	39	(23%)	19	(26%)	20	(20%)	
III	46	(27%)	18	(25%)	28	(29%)	
IV	44	(26%)	21	(29%)	23	(24%)	
Location of tumour							.376
Colon	98	(58%)	44	(61%)	54	(55%)	
Caecum	11	(7%)	5	(7%)	6	(6%)	
Ascending	26	(15%)	14	(19%)	12	(12%)	
Transverse	8	(5%)	3	(4%)	5	(5%)	
Descending	5	(3%)	1	(1%)	4	(4%)	
Sigmoid	48	(28%)	21	(29%)	27	(28%)	
Recto-sigmoid	3	(2%)	3	(4%)	0		
Rectum	65	(38%)	24	(33%)	41	(42%)	
Multiple tumours	4	(2%)	1	(1%)	3	(3%)	
Recurrent disease	24	(14%)	8	(11%)	16	(16%)	.335
Initial treatment proposed							.768
Surgery	122	(72%)	53	(74%)	69	(70%)	
Radiotherapy	14	(8%)	5	(7%)	9	(9%)	
Chemoradiotherapy	11	(7%)	5	(7%)	6	(6%)	
Chemotherapy	21	(12%)	9	(13%)	12	(12%)	
None	2	(1%)	0		2	(2%)	
Treatment intent							.413
Curative	146	(86%)	60	(83%)	86	(88%)	
Palliative	24	(14%)	12	(17%)	12	(12%)	
Chronic comorbid condition							.058
None	55	(32%)	29	(40%)	26	(27%)	
Cardiovascular disease	73	(43%)	27	(38%)	46	(47%)	
Severe arthrosis	28	(17%)	11	(15%)	17	(17%)	
Asthma/COPD	22	(13%)	9	(13%)	13	(13%)	
Diabetes mellitus	18	(11%)	9	(13%)	9	(9%)	
Central nervous system disorders	9	(5%)	1	(1%)	8	(8%)	
Depression	6	(4%)	2	(3%)	4	(4%)	
Other	58	(34%)	20	(28%)	38	(39%)	
Educational attainment							.850
Primary or none	17	(10%)	6	(8%)	11	(11%)	
Secondary or lower vocational	72	(42%)	33	(46%)	39	(40%)	
Higher vocational	52	(31%)	21	(29%)	31	(32%)	
University	29	(17%)	12	(17%)	17	(17%)	

*Significant difference between groups.

covered the patient's support structure and mental health more than any possible decisional conflict concerning the treatment that would follow. Because of the short follow-up period in this study, it

is uncertain whether the "time out consultation" will have any effect on the percentage of patients who retrospectively regretted the decision they made before start of treatment (Broenland, 2018; de

TABLE 2 GP consultations: number of contacts, kind and content of contact

	Before introduction of time out consultation (N = 72)		After introduction of time out consultation (N = 98)		p-value
General appreciation for GP (scale 1–10, mean)	7.7	(SD 1.6)	7.6	(SD 1.7)	.850
Patient had contact with GP after diagnosis	48	(67%)	78	(80%)	.057
Kind of contact					.844
Telephone only	19	(40%)	35	(45%)	
Consultation	25	(52%)	37	(47%)	
Home visit	4	(8%)	6	(8%)	
Caregiver					.169
Own GP	45	(94%)	75	(96%)	
Replacement GP	1	(2%)	3	(3%)	
GP in training	2	(4%)	0		
Reported topics of discussion					
Recent diagnosis	19	(40%)	28	(36%)	.678
Proposed treatment	17	(35%)	33	(42%)	.443
Support structure	7	(15%)	21	(27%)	.106
Information checking	4	(8%)	8	(10%)	.721
Physical health	4	(8%)	6	(8%)	.897
Mental health	4	(8%)	15	(19%)	.097
Other	11	(23%)	10	(13%)	.140
Patient reported having different treatment options	13	(18%)	24	(25%)	.315
Patient felt GP helped in reaching a decision (scale 1–5)	1.94	(SD 1.4)	2.23	(SD 1.6)	.308
Patient felt GP consultation comforting (scale 1–5)	3.00	(SD 1.0)	3.53	(SD 1.2)	.016*
Patient was satisfied with GP consultation (scale 1–5)	3.79	(SD 1.1)	4.18	(SD 0.9)	.042*

*Significant difference between groups.

TABLE 3 Mean total scores for the questionnaires with group comparison

Questionnaires ^a	Before introduction of time out consultation (N = 72) Mean (SD; SE)	After introduction of time out consultation (N = 98) Mean (SD; SE)	p-value
PAM-13 (range 0–100, optimal score 100)	71.93 (8.0; 0.9)	74.02 (8.7; 0.8)	.113
PEPPI-5 (range 0–100, optimal score 100)	68.89 (13.6; 1.6)	71.22 (12.9; 1.3)	.257
SDM-Q-9 (range 0–100, optimal score 100)	52.87 (24.6; 2.9)	53.51 (27.6; 2.7)	.875
DCS-16 (range 0–100, optimal score 0)	32.98 (19.1; 2.2)	28.71 (15.7; 1.5)	.112
EORTC IN-PATSAT-32 (range 0–100, optimal score 100)	56.71 (13.9; 1.6)	59.90 (17.7; 1.7)	.208

^aDCS-16 (Decisional Conflict Scale); EORTC IN-PATSAT-32 (Patient Satisfaction); PAM-13 (Patient Activation Measurement); PEPPI-5 (Perceived Efficacy in Patient–Physician Interactions); SDM-Q-9 (Shared Decision-Making).

Wit, 2017). Patients with palliative treatment options only, however, did have lower scores of decisional conflict before treatment, so we might hope for reduced feelings of regret in this specific group of patients.

Despite not covering the subjects originally intended, the introduction of the “time out consultation” did significantly improve the feeling of support all patients experienced. This implies that patients benefit from the “time out consultation” in a different way than

TABLE 4 Significant differences between subgroups

Subgroup	Before introduction of time out consultation Mean (SD; SE)	After introduction of time out consultation Mean (SD; SE)	p-value
Male (N = 107)	(N = 43)	(N = 64)	
PATSAT ^a —Technical skills GP	52.97 (16.1; 3.2)	65.29 (23.5; 3.6)	.027
PATSAT—Interpersonal skills GP	60.99 (19.3; 3.5)	74.95 (20.7; 3.2)	.006
PATSAT—Relation with GP	57.55 (22.1; 3.3)	69.44 (28.9; 3.6)	.025
65 years or older (N = 88)	(N = 29)	(N = 59)	
PAM-13 ^b	69.82 (7.7; 1.4)	75.09 (9.6; 1.2)	.012
PATSAT ^a —Technical skills GP	47.05 (18.6; 4.5)	62.01 (24.6; 3.8)	.029
PATSAT—Interpersonal skills GP	52.20 (14.9; 3.6)	71.35 (23.7; 3.7)	.003
PATSAT—Information provision GP	41.66 (20.6; 5.5)	58.48 (24.3; 4.4)	.031
PATSAT—Availability GP	52.94 (17.4; 4.2)	68.58 (29.0; 4.6)	.045
Palliative treatment options only (N = 24)	(N = 12)	(N = 12)	
DCS ^c -16	41.66 (17.2; 4.9)	27.21 (15.0; 4.3)	.039
DCS Support	41.66 (18.1; 5.2)	21.52 (13.5; 3.9)	.005

^aEORTC IN-PATSAT-32 (Patient Satisfaction; range 0–100, optimal score 100).

^bPAM-13 (Patient Activation Measurement; range 0–100, optimal score 100).

^cDCS-16 (Decisional Conflict Scale; range 0–100, optimal score 0).

previously thought and are likely to appreciate a proactive approach by their GP preferably with a face-to-face consultation.

The second aim of this study was to examine whether the introduction of the “time out consultation” resulted in an improved score on some important patient-reported outcomes. We could not demonstrate a significant improvement in general, but specific groups of patients showed marked improvements. Men were significantly more satisfied with their GP's care after the introduction of the consultation. This observation was made in an earlier study (Wieldraaijer et al., 2018), and part of the explanation may be offered by Christen et al. (2016), who report that women prefer cancer survivorship care to be organised in a hospital setting over a primary care setting, and speculate this may be because women expect more supportive care in a secondary care setting.

Older patients were also more satisfied with their GP's care after the introduction of the consultation and specifically about the availability and information provision by their GP. A systematic review by Henselmans et al. (2013) showed the beneficial effect of initial treatment-planning consultations on observed patient participation in general. Older patients, especially those with comorbid conditions, are generally better acquainted with their GPs, which is likely to benefit constructive GP consultation and agreement on supportive care during and after treatment (Berendsen et al., 2010; Heins et al., 2016; Wieldraaijer et al., 2018). Consequently, GPs should realise that older patients in particular could benefit from a “time out consultation” of sorts before start of treatment, because of their often more complex medical histories and fragile living situations.

The small group of patients with only palliative treatment options reported feeling less conflicted regarding treatment decisions and more supported in making a decision after the “time out

consultation” had been introduced. As opposed to curative treatment proposals, the decision to start a palliative treatment with limited benefits and possibly far-reaching side effects probably is a more difficult decision to make. In this regard, it is not surprising that the “time out consultation” with the GP can help in supporting patients with only palliative treatment options make well-considered decisions.

4.1 | Strengths and limitations

This paper describes the actual introduction of an initiative that is intended to enhance care for CRC patients. It includes all stages of CRC and provides results that are generalisable to the Netherlands, and possibly to any country where a patient can contact a primary care provider for a “time out consultation” of sorts. Therefore, it offers points of interest to both researchers and healthcare providers.

The researchers are well aware that we did not use the preferred research design to show effectiveness. The decision by the OLVG hospital to simultaneously inform all GPs in the region about the “time out consultation” by various means (as described in the Section 2) urged the researchers to use a before–after design and limited the sample size and consequent power of the study. To approximate the effect that the recommendation of the “time out consultation” actually had on current practice, the researchers tried to minimise interference, but this possibly limited the response rate and any difference in effect. Furthermore, we evaluated only one specific type of cancer and therefore, our results are not generalisable to other cancer types. Most patients in our study reported not having different treatment options, which is different for some other cancer types (Henselmans, Van Laarhoven, Van der Vloodt,

De Haes, & Smets, 2017; Wallner et al., 2016). Lastly, all results presented in this paper constitute the patients' perspective of the "time out consultation", but do not discuss the opinions and results from the point of view of GPs. We are currently surveying GPs on their views of the "time out consultation" and hope to report our findings in the near future.

4.2 | Conclusion

This study showed some promising results of the introduction of a "time out consultation" for patients with colorectal cancer. Especially men, older patients and patients with palliative treatment options seem to profit and experience comfort and support, and indicate to be more confident about their decisions. These findings, however, are provisional and need to be confirmed in further studies with sufficient power. In general, the increased comfort and satisfaction that *all* patients report with their GP after the consultation could be considered a starting point for structured care by the GP during and after treatment, while in particular the older patients and those with only palliative treatment options seem to benefit from proactive support by the GP before start of treatment.

CONFLICT OF INTEREST

The authors declare to have no conflict of interest.

ETHICAL APPROVAL

All authors have contributed to the writing of this manuscript and approved publication of its content.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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