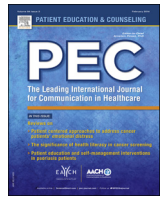




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Research Paper

The role of patient education and physician support in self-efficacy for skin self-examination among patients with melanoma

Z. Czajkowska^{a,*}, N.C. Hall^b, M. Sewitch^c, B. Wang^d, A. Körner^a

^a McGill University, Dept. of Educational and Counselling Psychology, 3700 rue McTavish, Room 614, Montreal, Quebec H3A 1Y2, Canada

^b McGill University, Dept. of Educational and Counselling Psychology, 3700 rue McTavish, Room 543, Montreal, Quebec H3A 1Y2, Canada

^c McGill University Health Centre, Div. of Clinical Epidemiology, V-building Room V2.15, 687, Avenue des Pins Ouest, Montreal, Quebec H3A 1A1, Canada

^d McGill University Health Centre, Melanoma Clinic, Royal Victoria Hospital, 1001 Decarie Boulevard, Montreal, Quebec H4A 3J1, Canada

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ABSTRACT

Objective: This project aims to elucidate the relationships between skin self-examination (SSE), perceived physician support of SSE, and self-efficacy for SSE among melanoma patients.

Methods: A longitudinal study of patients diagnosed with melanoma was conducted over the span of 18 months. Participants filled out questionnaires at four assessment points and participated in an SSE education about the early signs of melanoma.

Results: Among the 242 patients enrolled, the level of self-efficacy for SSE was 23% higher immediately after the educational intervention ($p < .001$) and the increase was retained three months ($p < .001$) and twelve months later ($p < .001$). Additionally, a one-way repeated measures ANOVA revealed that the perceived physician support of SSE positively corresponded to the level of patient self-efficacy with higher patient-reported physician support being related to higher self-efficacy ($p = .001$).

Conclusion: Patient education and perceived physician support of SSE are positively associated with patients' level of self-efficacy.

Practice implications: Physicians caring for melanoma survivors should be aware that, both SSE education and patients' perception of high physician support of SSE may be associated with higher self-efficacy for checking one's own skin for signs of cancer recurrence.

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1. Introduction

1.1. The role of self-efficacy in health behaviours

Self-efficacy has been defined as “people’s judgments of their capabilities to organize and execute courses of action required to attain designated types of performances” (p. 391) [1] and it has been consistently linked with desired behaviours [2]. Although the construct is primarily cognitive in nature by being “concerned not with the skills one has but with judgments of what one can do with whatever skills” (p. 391) [1] a plethora of research confirms the potential of self-efficacy to predict positive health behaviours ranging from dieting and smoking cessation to cancer prevention [2–4]. It can predict both the uptake and the maintenance of health behaviours [5,6], which could be crucial for patients’ health and

longevity, as in the case of cancer prevention and detection behaviours. For instance, self-efficacy positively predicts intention for sun protection as well as sun-protective behaviours above and beyond habit [7,8]. Further, skin self-examination (SSE) practice is much higher among the survivors of melanoma whose self-efficacy for this behaviour is high (OR 14.4) [9]. Similarly, self-efficacy for breast self-examination predicts both the intention to engage in and the practice of self-exams [10,11]. Lower self-efficacy for managing pain and cancer symptoms predicts greater pain and fatigue, more difficulty in adjusting to cancer, symptoms of depression, anxiety, and lower quality of life in addition to worse physical functioning among patients with lung cancer [12]. Not surprisingly then, interventions that aim to increase self-efficacy also typically result in a better adjustment to cancer including an improved mood and higher quality of life [13,14].

1.2. Why does self-efficacy matter for patients with melanoma?

Melanoma represents a prototypical malignancy, in which continuous engagement in tumour-detecting behaviours can lead to an earlier diagnosis and treatment [15,16]. Melanoma survivors

* Corresponding author.

E-mail addresses: zofia.czajkowska@mail.mcgill.ca (Z. Czajkowska), nathan.c.hall@mcgill.ca (N.C. Hall), maida.sewitch@mcgill.ca (M. Sewitch), beatrice.wang@mcgill.ca (B. Wang), annett.korner@mcgill.ca (A. Körner).

are at an increased lifelong risk for developing new primary tumours and recurrences, with subsequent melanomas affecting up to 11% of patients [15,17–19]. Thus, secondary prevention through early detection is particularly important for these individuals [19,20]. Among skin cancer survivors, medical check-ups and regular SSE are recommended by clinical guidelines as a part of melanoma follow-up care [21]. Clinical skin exams for patients with suspicious skin lesions are crucial as the physicians may be able to detect melanomas at earlier stages than patients would, when the tumours are more amenable to treatment [22–24]. However, clinical exams are increasingly less likely to include an examination of the entire body of the patient and thus miss up to 1 in 3 melanomas [25]. In contrast, checking one's own skin for changes can increase the likelihood that an individual will consult a physician before the tumour has developed into an advanced stage [23,26]. Thus, the practice of skin self-examination (SSE) represents an important step toward earlier diagnosis and treatment, and could contribute to a reduction in mortality among melanoma survivors [26–28]. Like many health behaviours, SSE practice following the clinical recommendations may be more likely if patients feel confident about the capacity to conduct a skin self-exam [9,29–31]. Fortunately, self-efficacy specific to SSE can be improved through patient education [29,32–35].

1.3. The importance of medical support

Learning to conduct a skin self-exam is not easy. In order to maximize the likelihood of detecting a potential melanoma, one must check the skin of the entire body including places that are difficult to see such as the upper back, top of the head and soles of the feet; which requires some physical agility and the use of a mirror or help from a partner [36]. Furthermore, to recognize a mole as a potential melanoma, as opposed to a regular nevus, one must know the signs and carefully examine the nevi for asymmetry, border, colour, diameter as well as evolution [37]. Physicians or nurses, who are knowledgeable about the risk for developing subsequent melanomas and the importance of SSE for early prevention, are in a critical position to impart that knowledge to their patients [34]. Dermatology experts also have the authority and the trust of the patients: what they say, matters. For example, in a study of 483 melanoma patients, it was reported both immediately after the diagnosis and at a 10-year follow-up, that the two most frequently endorsed ways of coping were “trusting my doctors” and “following the medical advice exactly” [38]. Teaching SSE to patients has an impact on their SSE performance [29,34,39–43]. However, the reality of many healthcare systems around the world is that the physicians have little time to teach prevention skills to every patient [44,45]. Fortunately, doctors do not necessarily need to teach SSE in detail as interventions carried out by nurses or trained ancillary staff are typically very effective [29,39,46,47]. Moreover, physicians who verbally recommend SSE to patients (even without illustrating how to perform a skin exam) or who simply mention SSE as an option, have the potential to increase the practice of SSE among patients, although to a lesser degree than a full SSE education [48–52]. Consequently, the role of physicians may be to simply encourage and support self-examination, with nurses or trained ancillary staff providing more detailed instructions.

Given how little is known about physician support of SSE and patient self-efficacy for this potentially life-saving practice, the current project will focus on exploring the link between the two. The first study objective is therefore to prospectively assess self-efficacy for SSE among patients diagnosed with melanoma. The second objective is to compare the trajectory of self-efficacy of patients as a function of perceived physician support of SSE practice. Finally, the third objective is to evaluate whether medical

support of SSE, conceptualized as physicians' encouragement of the SSE practice as reported by the patients (“physician support of SSE”) and the education provided to the patients by trained ancillary staff, relates to patients' self-efficacy levels over time.

It is hypothesized that:

- Self-efficacy for SSE will be higher immediately after the SSE-intervention than before the intervention.
- Self-efficacy for SSE will remain higher at three- and twelve-month post-intervention follow-ups as compared to the pre-education level.
- The level of perceived physician support of SSE at baseline will be associated with the level of patient self-efficacy for SSE over the following 1.5 years.

2. Methods

2.1. Participants

Individuals diagnosed with melanoma recruited from two major teaching hospitals in Montreal, Canada, participated in the current project after obtaining an approval from the hospitals' research ethics boards. The eligibility criteria included the ability to speak and read English or French, being at least 18 years of age, and having a medically confirmed diagnosis of melanoma.

2.2. Procedure

2.2.1. Design

The present study employed a repeated-measures, longitudinal design with four assessment points (baseline, Time 2, 3 and 4) over the span of 18 months. In order to reduce potential socially desirable responding likely to emerge in longitudinal research, the study was designed in such a way that the patients would interact with different research staff throughout the study. They were also repeatedly reassured that their answers will remain confidential. The initial recruitment was conducted by research assistants (RAs), who obtained informed consent and administered baseline questionnaires in person. A different RA, who was not involved in recruitment or data collection delivered the dermatological intervention on how to perform SSE at Time 2. Questionnaires used for Time 3 and Time 4 assessments were sent by mail. All participants received questionnaires to fill out and were offered a participation in an education session on melanoma and SSE as part of the study. The physicians' behaviour was not manipulated in any way.

2.2.2. Recruitment

Patients were notified by the clinic coordinator about the possibility of taking part in this study. Recruitment fliers were posted in the waiting areas of the two melanoma clinics and clinic coordinators advertised the study to all patients. Patients had the possibility of signing up on the premises or they could take home the study materials (consent forms and baseline questionnaires) and later contact the study coordinator via phone to express interest in participating. The research assistants present in the clinic were also able to approach the patients in the waiting room inviting them to participate. Written informed consent to participate was collected from individuals, who expressed interest in participation in the study. The participants received a questionnaire package to be completed after their clinical appointment or to be returned in a pre-addressed pre-stamped envelope.

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