Asian Journal of Current Research in Clinical Cancer
ISSN: 3062-4444
2021, Volume 1, Issue 1, Page No: 49-59

Available online at: www.galaxypub.co/page/journals

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Influence of Global Health Status, Communication Satisfaction, and Timing on Decisional Conflict Following Consideration of Early Phase Clinical Cancer Trial Participation

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Received: 17 December 2020; **Revised:** 01 March 2021; **Accepted:** 04 March 2021

ABSTRACT

When conventional treatments are no longer effective, patients with advanced cancer may consider enrolling in early-phase clinical trials. The process of deciding on participation is often complex, and supporting patients in this process could enhance their quality of life. This multicenter prospective study explored factors contributing to decisional conflict—a reflection of decision-making quality—in patients who recently made a choice about joining phase I or I/II trials. We examined whether health-related quality of life, health literacy, hope, satisfaction with consultations, decision timing, and the decision itself were linked to decisional conflict. Among 116 patients, the average decisional conflict score was 30.0 (SD = 16.9). Regression analyses indicated that lower decisional conflict was observed in patients reporting better overall health ($\beta = -0.185$, $p = 0.018$), greater satisfaction with the consultation ($\beta = -0.246$, $p = 0.002$), and those who decided either before ($\beta = -0.543$, $p < 0.001$) or within a week after the consultation ($\beta = -0.427$, $p < 0.001$). Together, these factors explained 37% of the variation in decisional conflict. These findings suggest that patients with poorer health or who need more time to decide may benefit from additional support. While inherent patient characteristics are difficult to change, oncologists can influence satisfaction during consultations. Future research should investigate whether improving patient-centered communication can help reduce decisional conflict.

Keywords: Hope, Early phase clinical trials, Quality of life, Decision making, Health literacy, Patient satisfaction

How to Cite This Article: Liew KH, Tan AB, Fernandez CM. Influence of Global Health Status, Communication Satisfaction, and Timing on Decisional Conflict Following Consideration of Early Phase Clinical Cancer Trial Participation. Asian J Curr Res Clin Cancer. 2021;1(1):49-59. https://doi.org/10.51847/hcz6Hofnb6

Introduction

Patients with advanced cancer frequently reach a stage where conventional treatment options are no longer effective. For those in adequate clinical condition, participation in early-phase clinical trials—investigational therapies without established clinical benefit—represents a potential option, whereas others may opt for palliative care without further systemic therapy. Given the uncertain survival advantage of early-phase trials, it is crucial that patients make well-informed decisions that align with their personal values, ensuring their remaining time is spent meaningfully [1]. Supporting patients in this decision-making process is also associated with improved health-related quality of life, even for those with terminal illness [2, 3]. Therefore, examining the quality of decisions about early-phase trial enrollment is essential for optimizing life quality in this vulnerable population.

A widely used measure of decision-making quality is decisional conflict, typically assessed using the validated Decisional Conflict Scale (DCS) [4, 5]. The DCS captures the extent to which patients experience unresolved needs in their decision-making, including uncertainty, gaps in knowledge, unclear values, or perceived lack of support [6]. Scores range from 0 to 100, with higher scores indicating greater unresolved decisional needs. Previous work suggests that scores above 25 reflect clinically meaningful decisional conflict, highlighting patients who may require additional guidance [5, 7]. While the DCS is commonly applied to decisions regarding standard cancer treatments [8], its use in early-phase trial decisions has been limited. A scoping review indicated that DCS

scores for typical cancer treatment decisions are modestly elevated (≈28), whereas end-of-life or palliative care choices often yield higher scores (≈45) [5]. Specifically, Flynn *et al*. found that patients deciding about phase I trial participation exhibited clinically relevant decisional conflict, with acceptors scoring 26 and decliners 34 [9]. These findings underscore the relevance of the DCS for assessing decision quality in the context of early-phase clinical trials.

Factors influencing decisional conflict in early-phase trial decisions remain poorly understood. Studies of standard treatment choices suggest that higher baseline health-related quality of life [10] and lower health literacy [11] can be associated with greater conflict. Additionally, hope may play a key role in trial-related decisions, as many patients pursue early-phase participation with the expectation of potential benefit [1, 12, 13]; greater hope could be linked to lower conflict. Satisfaction with the initial consultation may also impact decisional conflict, as patients who feel well-informed and supported are likely to experience less uncertainty [14]. Moreover, prior research has shown that patients declining trial participation may report higher conflict than those who accept [9]. Timing is another potentially relevant factor: decisional conflict is generally higher when measured soon after a decision is made, compared with later assessments [5, 8]. Beyond measurement timing, the actual moment when patients make their decision may be critical, with earlier decisions potentially associated with lower conflict. Understanding how these factors interact can inform strategies to improve decision quality in this challenging context.

This study aims to examine decisional conflict in patients with advanced cancer recently faced with a choice about early-phase trial participation (phase I or I/II). We hypothesize that higher decisional conflict is associated with: (1) higher health-related quality of life, (2) lower health literacy, (3) lower hope, (4) lower satisfaction with the initial consultation, (5) a decision not to participate, and (6) delayed decision-making. Findings may guide healthcare professionals in providing targeted support during this critical decision-making process.

Materials and Methods

Study design

This investigation is part of a prospective study examining decision-making processes related to early-phase clinical trial participation [15], registered in the Netherlands Trial Registry (NL7335). The study protocol was approved by the Medical Ethics Committee of Erasmus MC (MEC-2018-151) and received governance clearance from all participating institutions: Erasmus MC (Rotterdam), Netherlands Cancer Institute (Amsterdam), and UMC Utrecht (Utrecht). Collectively, these centers see approximately 400–500 new patients annually who consider enrolling in early-phase trials.

Participants

According to the study protocol [15], eligible participants were adults (≥18 years) with advanced cancer who were considering their first enrollment in an early-phase clinical trial (phase I or phase I/II), had sufficient proficiency in Dutch to complete study questionnaires, and provided written informed consent. Patients were excluded if they had documented cognitive impairment, lacked internet access to complete the online surveys, or were already enrolled in another component of the project (n = 13).

Measurements

Participants were asked to complete two web-based questionnaires: one at baseline, before their first consultation with a medical oncologist about enrolling in an early phase clinical trial, and a follow-up questionnaire three weeks after this consultation. An overview of the questionnaire measures is shown in **Table 1**. The primary outcome, decisional conflict, was assessed using the DCS [6, 7, 16], a tool previously validated as reliable [8]. Additional assessments included health-related quality of life—covering subscales such as global health status, physical, role, emotional, cognitive, and social functioning, fatigue, nausea/vomiting, pain, dyspnea, insomnia, appetite loss, constipation, diarrhea, and financial difficulties [17, 18]—health literacy [19–21], sense of hope [22, 23], sociodemographic information (age, gender, education, nationality, living arrangements, and employment), satisfaction with the consultation, and timing of the decision. Further information on patient choices regarding trial participation and clinical details (e.g., WHO status) was subsequently retrieved from electronic patient records by local trial monitors.

Table 1. Overview of measurements.

Outcome	Instrument
	Main endpoint (post-consultation survey)
Conflict in decision-making	A Dutch-adapted version [16] of the Decisional Conflict Scale (DCS) [6, 7] was applied. This tool features 16 statements scored on a 5-point scale (0 = strongly agree, 4 = strongly disagree) grouped into areas of information awareness (3 statements), value alignment (3 statements), decision support (3 statements), uncertainty (3 statements), and decision quality (4 statements). Per guidelines [7], responses were added, divided by 16, and scaled by 25 to produce an overall score from 0 to 100. Values below 25 signal ability to proceed with a choice, whereas those over 37.5 indicate postponement.
	Initial assessments (pre-consultation survey)
Overall well-being	Well-being was measured using the Dutch translation of the EORTC QLQ-C30 version 3.0 [17]. The questionnaire includes sections for overall health (2 questions), physical abilities (5 questions), daily role performance (2 questions), emotional state (4 questions), mental sharpness (2 questions), social interactions (2 questions), tiredness (3 questions), nausea/vomiting (2 questions), pain (2 questions), shortness of breath (1 question), sleep issues (1 question), loss of appetite (1 question), constipation (1 question), diarrhea (1 question), and money problems (1 question). Overall health used a 7-point scale (1–7); other areas used a 4-point scale (1–4). Following the official guide [18], all results were converted to a 0–100 scale.
Ability to understand health information	Patients' skills in reading and math needed for healthcare were evaluated with the 3-question Brief Screening Set (SBSQ) [19] on a 5-point scale (1–5). The established Dutch edition (SBSQ-D) [20, 21] was utilized. Drawing from earlier studies, an average score ≤2 meant limited literacy, while >2 indicated sufficient literacy.
Level of hope	A broad, timeless feeling of hope was captured with the Herth Hope Index (HHI) [22]. Its 12 statements are rated on a 4-point scale (1–4) using the approved Dutch translation [23]. As suggested for this version, all responses were totaled into one score from 12 to 48, without breaking into subgroups.
	Additional items (post-consultation survey)
Contentment with discussion	Contentment with the first meeting was gauged by one query ("How pleased were you with the starting appointment?") answered on a 7-point scale (1 = not at all pleased, 7 = fully pleased).
Moment of choice	The point at which a choice was made was asked via one item ("Around when did you decide about joining or skipping an early-stage trial?") with 5 options (1 = prior to first meeting, 2 = in the first week after, 3 = 1–2 weeks later, 4 = beyond 2 weeks, 5 = still undecided). The final two categories were grouped together for review.

Procedure

Between 18 February 2019 and 18 December 2020, patients referred to the early-phase clinical research units at the three participating hospitals were invited to take part in the study. Recruitment was temporarily paused from 16 March to 20 May 2020 due to COVID-19–related restrictions. Eligible patients were initially contacted by a nurse practitioner, trial secretary, or study researcher from their hospital to assess interest in participation. Those expressing initial interest received an email with detailed study information from the researcher (L.G.G.v.L.), followed by a phone call to obtain preliminary verbal consent. Patients who provided verbal consent were then sent the baseline questionnaire via email, with instructions to complete it before their consultation with a medical oncologist. The questionnaire began with a consent question specific to that survey. Formal written informed consent was obtained from patients prior to the oncologist–patient consultation. Three weeks later, participants automatically received the follow-up questionnaire, which generally allowed sufficient time for decision-making but typically preceded the potential start of early-phase trial treatment.

Statistical analysis

Data were analyzed using IBM SPSS Statistics 25. Descriptive statistics were computed for demographic and clinical characteristics, as well as for the various measurements. To examine potential differences between participants who completed the study and those who dropped out after providing written consent, chi-square tests, Fisher's exact tests, and t-tests were conducted for variables including gender, age, education level, living situation, and employment. Internal consistency of the health literacy, sense of hope, and decisional conflict scales was assessed using Cronbach's alpha. Relationships between decisional conflict scores (DCS) and other variables were initially explored through univariate analyses, including independent t-tests, one-way ANOVA with Tukey

post hoc tests, and Pearson correlations. Variables showing associations with a liberal significance threshold ($p \leq 0.15$) in univariate analyses were subsequently included in a multiple linear regression with backward selection, using DCS as the dependent variable [24].

Results and Discussion

Of the 302 patients approached, 227 (75.2%) provided preliminary consent, and 193 (63.9%) completed written informed consent **(Figure 1)**. A total of 149 patients returned the final questionnaire three weeks after their consultation (77.2% of those with written consent). Among these, 33 patients were later determined ineligible for trial participation due to reasons such as lack of available trials or clinical deterioration, meaning they technically did not meet the criterion of being eligible for first-time early-phase trial enrollment. Because these patients could not make the participation decision themselves, they were excluded from further analyses.

Consequently, 116 patients were included (60.1% of all patients providing written consent), seen by 11 oncologists, each managing an average of 10–11 patients (SD = 11.5). The sample was predominantly male (n = 78, 67.2%), of Dutch nationality (n = 115, 99.1%), living with a partner (n = 73, 62.9%), and retired or unemployed (n = 66, 56.9%). **Table 2** presents a detailed overview of patient characteristics, including minor missing data. Non-response analyses indicated no significant differences between included patients (n = 116) and dropouts (n = 77) regarding gender ($\chi^2(1) = 0.491$, $p = 0.483$), age ($t(191) = -0.503$, $p = 0.616$), living situation ($p = 0.323$, Fisher's exact test), or employment status ($p = 0.290$, Fisher's exact test). A significant difference emerged for education level ($\chi^2(2) = 9.216$, $p = 0.010$), with dropouts more often having a low education level (41.6% vs. 25.0%), less frequently a middle education level (20.8% vs. 39.7%), and comparable proportions of high education (37.7% vs. 35.3%) compared to patients included in the final analysis.

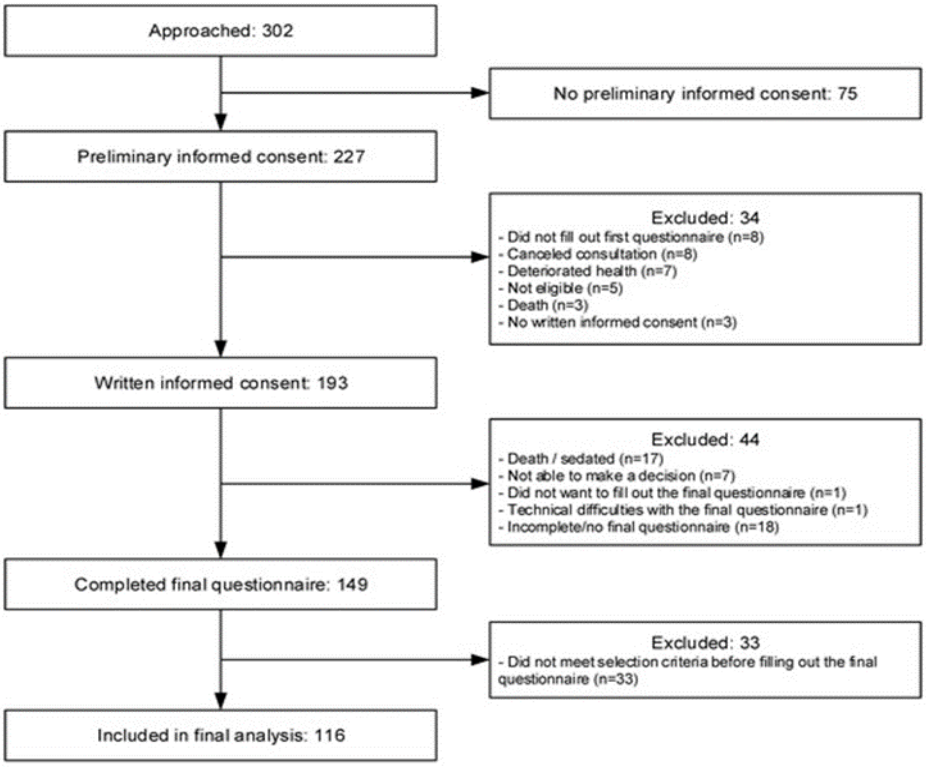

Figure 1. Flowchart for the inclusion of patients.

Table 2. Patient characteristics (n = 116).

Patient Characteristics	M (SD) or n (%)
Gender, n (%)	
Female	38 (32.8)
Male	78 (67.2)

Age, M (SD)	62.5 (8.8)
Education level, n (%)	
Low (no education to lowest level of secondary education)	29 (25.0)
Middle (senior general secondary and pre-university education)	46 (39.7)
High (higher vocational education and university)	41 (35.3)
Nationality, n (%)	
Dutch	115 (99.1)
Other	1 (0.9)
Living situation, n (%)	
Alone	12 (10.3)
With partner	73 (62.9)
With partner and child(ren)	27 (23.3)
With child(ren) or other relative(s)	4 (3.4)
Working situation, n (%)	
Paid job	32 (27.6)
No job (anymore)	66 (56.9)
In health insurance act	10 (8.6)
Other (e.g., voluntary work)	8 (6.9)
Hospital, n (%)	
Erasmus MC	84 (72.4)
Netherlands Cancer Institute	23 (19.8)
UMC Utrecht	9 (7.8)
WHO performance status at initial consultation, n (%)	
0	27 (23.3)
1 or 2	80 (69.0)
Missing/unknown	9 (7.8)
Primary diagnosis, n (%)	
Colorectal/anal cancer	35 (30.2)
Esophageal/stomach cancer	11 (9.5)
Hepatobiliary/pancreatic cancer	20 (17.2)
Gynecological cancer	6 (5.2)
Lung cancer/mesothelioma	8 (6.9)
Urinary tract cancer	26 (22.4)
Breast cancer	3 (2.6)
Melanoma/skin cancer	3 (2.6)
Other	4 (3.4)
Metastases, n (%)	
Yes	110 (94.8)
No	6 (5.2)
Number of previous lines of therapy, M (SD)	2.6 (1.6)
Missing/unknown, n (%)	6 (5.2)
Participated in another (phase II/III) clinical trial, n (%)	

Yes	26 (22.4)
No	90 (77.6)

The baseline assessments demonstrated adequate to high internal consistency, with Cronbach's alpha values of 0.761 for health literacy, 0.827 for sense of hope, and 0.902 for the primary outcome, decisional conflict. Among the 116 participants, the average DCS score was 30.0 (SD = 16.9). **Table 3** summarizes all measured variables along with the significance of their associations with decisional conflict. For categorical factors such as patient decision and timing, the mean DCS scores for each group are reported in **Table 4**.

Table 3. Patient measurements (n = 116). p-values are provided for the univariate relation with decisional conflict.

Patient Measurements	**M (SD) or n (%)**	**p-Value**
Decisional conflict (DCS), M (SD)		
Informed subscale	31.5 (21.3)	N/A
Values clarity subscale	36.6 (20.6)	N/A
Support subscale	24.2 (18.1)	N/A
Uncertainty subscale	36.6 (24.9)	N/A
Effective decision making subscale	23.3 (20.4)	N/A
Total decisional conflict	30.0 (16.9)	N/A
Quality of life (QLQ-C30), M (SD)		
Global health status		
Global health status	67.4 (18.4)	<0.001 ‡
Functional scales		
Physical functioning	80.1 (16.8)	0.052 ‡
Role functioning	68.4 (24.6)	0.105 ‡
Emotional functioning	76.3 (18.6)	0.190 ‡
Cognitive functioning	87.2 (18.8)	0.377 ‡
Social functioning	78.7 (23.8)	0.031 ‡
Symptom scales/items		
Fatigue	28.6 (20.8)	0.025 ‡
Nausea and vomiting	8.2 (15.5)	0.822 ‡
Pain	22.4 (24.5)	0.038 ‡
Dyspnea	13.5 (21.1)	0.077 ‡
Insomnia	19.3 (26.8)	0.099‡
Appetite loss	17.8 (25.4)	0.655 ‡
Constipation	12.9 (24.0)	0.021 ‡
Diarrhea	11.5 (19.2)	0.869 ‡
Financial difficulties	7.2 (16.9)	0.334 ‡
Health literacy, M (SD)	4.5 (0.6)	0.023 ‡
Sense of Hope (HHI), M (SD)	36.8 (4.9)	0.003 ‡
Satisfaction with the consultation, M (SD)	6.0 (1.3)	<0.001 ‡
Missing, n (%)	1 (0.7)	
Decision regarding trial participation, n (%)		0.036 ⊥
Decided to further consider participation	77 (66.4)	

Decided to not further consider participation (and not to participate)	39 (33.6)	
Timing of the decision, n (%)		<0.001 †
Before initial consultation	38 (32.8)	
Within 1 week after the initial consultation	47 (40.5)	
1–2 weeks after the initial consultation	9 (7.8)	
More than 2 weeks after the initial consultation	22 (19.0)	

‡—p-value from correlation analysis; ⊥—p-value from t- test; †—p-value from ANOVA.

Table 4. Mean DCS scores for categorical variables: decision and timing of decision

Variable	Group	DCS Score, Mean (SD)
Decision about trial participation	Chose to continue considering participation	27.7 (17.1)
	Chose not to pursue participation	34.6 (15.7)
Timing of decision	Made decision before initial consultation	22.4 (17.0)
	Made decision within 1 week after consultation	26.3 (14.1)
	Made decision 1–2 weeks after consultation	43.1 (7.5)
	Made decision more than 2 weeks after consultation	45.8 (11.0)

Analyses indicated several notable associations between decisional conflict and aspects of health-related quality of life. Patients reporting better overall health (global health status: $r = -0.322$, $p < 0.001$) and stronger social functioning ($r = -0.200$, $p = 0.031$) experienced less conflict regarding their decisions. Conversely, higher levels of fatigue ($r = 0.208$, $p = 0.025$), pain ($r = 0.193$, $p = 0.038$), and constipation ($r = 0.214$, $p = 0.021$) corresponded to increased decisional conflict. In addition, higher health literacy ($r = -0.202$, $p = 0.014$) and a stronger sense of hope ($r = -0.241$, $p = 0.003$) were linked with lower conflict, suggesting that patients who were better informed or more hopeful faced fewer uncertainties. Satisfaction with the consultation emerged as another influential factor ($r = -0.387$, $p < 0.001$); those reporting greater satisfaction experienced markedly lower decisional conflict.

When examining categorical outcomes, decisional conflict varied according to the patient's choice about trial participation ($t(114) = -2.127$, $p = 0.036$). Individuals opting to participate exhibited lower decisional conflict ($M = 27.7$, $SD = 17.1$) than those who declined ($M = 34.6$, $SD = 15.7$). The timing of the decision also played a significant role ($F(115) = 16.135$, $p < 0.001$). Patients who made their decision prior to or within one week following the consultation reported substantially less conflict ($M = 22.4$, $SD = 17.0$ and $M = 26.3$, $SD = 14.1$, respectively) than those deciding between one and two weeks ($M = 43.1$, $SD = 7.5$) or after more than two weeks ($M = 45.8$, $SD = 11.0$).

Building on these findings, a multiple linear regression analysis was conducted, including eight subscales of health-related quality of life (global health status, physical functioning, social functioning, fatigue, pain, dyspnea, insomnia, and constipation), health literacy, sense of hope, consultation satisfaction, patient decision, and timing of the decision. The final model **(Table 5 and Figure 2)** retained global health status, satisfaction with the consultation, and timing of the decision (reference: decision made more than two weeks post-consultation) as significant predictors of decisional conflict ($F(5,110) = 14.532$, $p < 0.001$). Collectively, these variables accounted for 37% of the variance in decisional conflict. Patients with better overall health, higher consultation satisfaction, and earlier decision-making reported the lowest levels of decisional conflict, highlighting these factors as key contributors to more effective decision-making.

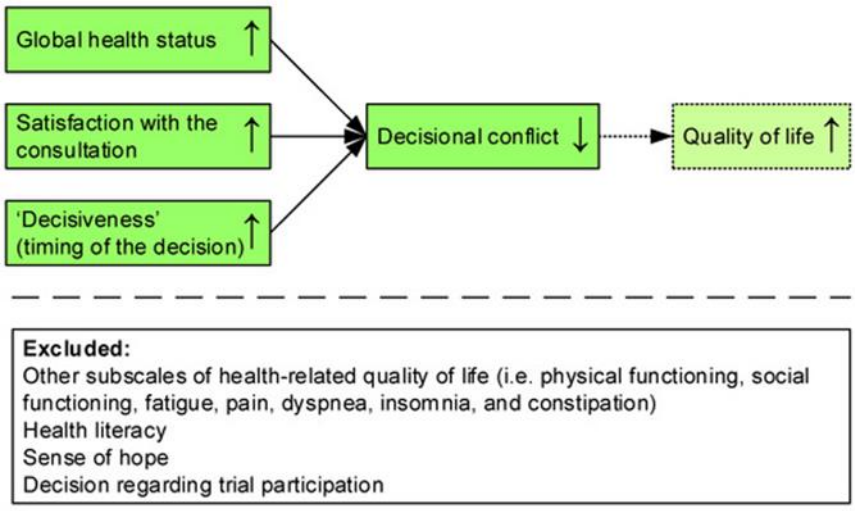

Figure 2. Model of predictors for decisional conflict.

Table 5. Linear model of predictors of DCS scores.

	F	**df**	**Adjusted R2**	**p-Value**
Model statistics	14.532	(5, 110)	0.370	<0.001
	b	**95% CI**	**β**	**p-value**
Global health status	−0.170	(−0.311, −0.030)	−0.185	0.018
Satisfaction with the consultation	−3.153	(−5.117, −1.189)	−0.246	0.002
Timing of the decision *				
Before initial consultation	−19.445	(−26.812, −12.079)	−0.543	<0.001
Within 1 week after the initial consultation	−14.644	(−21.900, −7.388)	−0.427	<0.001
1–2 weeks after the initial consultation	−2.047	(−12.588, 8.494)	−0.033	0.701
Constant	72.798	(58.826, 86.769)		<0.001

* The reference category for timing of the decision was "more than 2 weeks after the consultation".

This study sought to explore the factors influencing decisional conflict among patients with advanced cancer who had recently faced the choice of participating in early-phase clinical trials (phase I or phase I/II). The variables hypothesized to relate to decisional conflict were indeed relevant in this population. Contrary to our expectations, patients reporting higher health-related quality of life, especially a better global health status, experienced less decisional conflict. Supporting our other hypotheses, univariate analyses showed that decisional conflict was greater among patients with (1) lower health literacy, (2) reduced sense of hope, (3) lower satisfaction with the initial consultation, (4) a decision to not pursue trial participation (with levels comparable to those reported by Flynn *et al*. [9]), and (5) a decision made more than one week after the consultation. Multivariable regression further highlighted that clinically elevated decisional conflict was particularly associated with worse global health status, lower consultation satisfaction, and delayed decision-making. These findings provide potential avenues for improving decision support in this context.

It was somewhat unexpected that patients with poorer global health experienced greater difficulty in deciding, as one might assume they would perceive trial participation as less suitable. However, these patients may be weighing the risk of further decline in health-related quality of life against a small chance of benefit, where even minimal potential improvement can be appealing. Regarding intrinsic patient characteristics, we observed that those who decided sooner reported less decisional conflict. The timing of a decision may reflect individual decisional preferences, such as the drive to reduce cognitive dissonance—a psychological process in which threatening information, like a fatal prognosis, is unconsciously minimized [25]. Early decision-makers may possess this mechanism, which could facilitate decisiveness and reduce conflict. Alternatively, patients who were more certain of their choice may have required less time to decide, while those needing additional time might benefit from extra support from healthcare professionals, including oncologists and psycho-oncology specialists,

to address lingering uncertainties. Future research could clarify how to best support patients in this decision-making process. In this context, both initial global health status and the speed of decision-making may serve as indicators of the need for additional support.

While intrinsic patient characteristics may be difficult to modify, satisfaction with the consultation represents a factor that oncologists can directly influence. Patients reporting lower consultation satisfaction experienced higher decisional conflict, suggesting that unmet needs during consultations contribute to conflict [14]. This implies that effective patient–provider communication may reduce decisional conflict, although it is also possible that patients with lower conflict perceive the consultation more positively, irrespective of its content. Enhancing satisfaction could be achieved through patient-centered communication [26, 27]. However, the complex nature of early phase trials often prioritizes technical and medical information, with limited attention to patient values and preferences [28, 29]. Indeed, patients reported the greatest unresolved needs on the "values clarity" and "uncertainty" subscales. Addressing patient values more thoroughly may improve both satisfaction and decisional conflict, particularly for patients with lower global health status. Further research is needed to determine whether exploring patient values can effectively reduce decisional conflict.

Univariate analyses also highlight the importance of focusing on patients who choose not to participate or are considering non-participation. Although such patients are usually referred for symptom-oriented care, prior studies indicate that discussions around palliative care and prognosis are often limited during early phase trial deliberations [30, 31]. Providing these patients with more comprehensive information during decision-making may be beneficial. While intrinsic patient factors remain significant, oncologists play a critical role in mitigating decisional conflict, particularly through optimizing consultation quality and addressing patient needs more effectively.

Several potential biases may have influenced the findings of this study. Notably, not all eligible patients chose to participate, and dropout rates were considerable, suggesting that the broader population of patients approached for early-phase clinical trials is likely more diverse than our sample. First, participants in this study reported better health-related quality of life compared to typical patients with stage III/IV or recurrent/metastatic cancer [32], which is understandable since only those in relatively stable condition are considered for early phase trials, as reflected by exclusions due to declining health or mortality. The observed dropout rate is therefore consistent with the frailty of the patient group. Second, analysis of non-responders revealed that individuals with lower educational attainment were more likely to discontinue participation. Additionally, the final sample included only one patient below the threshold for low health literacy and one non-Dutch participant, which contrasts with national data indicating that 36% of people have low health literacy [33] and 25% have a migration background [34]. This imbalance may account for why health literacy was not retained in the regression analysis. It is plausible that early phase trials were preferentially offered to patients with higher health literacy—often associated with higher education [35]—because oncologists may have assumed these individuals could better comprehend the complex information provided [36]. Univariate results further suggested that greater health literacy was linked to more effective decision-making. Presenting trial details in a simplified and accessible manner could therefore benefit patients with lower literacy and enhance decision-making for all participants [36]. Third, similar to previous research [25], patients' sense of hope was high, reflecting the importance of hope for almost all individuals with advanced cancer [37], which likely explains its exclusion from the multivariable model. Lastly, because prior evidence on decisional conflict in early phase trial decisions is limited, other unexamined factors—such as differences in oncologists' communication styles—may also contribute. This study provides a foundational perspective for developing future models and theoretical frameworks on decisional conflict and decision-making.

Conclusion

In conclusion, decisional conflict is influenced either by intrinsic patient factors—namely global health status and timing of the decision—or by aspects of the patient-oncologist interaction, particularly satisfaction with the consultation. Although intrinsic characteristics are largely unmodifiable, oncologists can significantly reduce decisional conflict through tailored consultations. Future research should explore whether addressing patient values and preferences can enhance satisfaction, improve decision-making quality, and ultimately positively impact patients' quality of life.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

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