Communication Between Clinicians and Patients With Chronic Idiopathic Constipation or Irritable Bowel Syndrome With Constipation: An Ethnographic Study of Office Visits

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Background

- Recognition and treatment of the functional gastrointestinal disorders chronic idiopathic constipation (CIC) and irritable bowel syndrome with constipation (IBS-C) relies primarily on patient-reported symptoms rather than clinical measures or findings (e.g., endoscopic, laboratory, imaging).[1]
- Diagnosis can be complicated if conditions are self-managed by the patient and not communicated to the healthcare professional (HCP).[2]
- Office visit communication between patients and HCPs is critical to successful patient outcomes.[3]

Aims

- This ethnographic research was designed to explore the nature of HCP-patient communication surrounding CIC and IBS-C.
- The application of observational sociolinguistic techniques is a unique research approach in this category and can identify gaps in HCP-patient understanding.

Methods

- This study was approved by the New England Institutional Review Board (IRB Number: 120180225; Protocol Number: 1379782), conducted in accordance with the amended Declaration of Helsinki, and was HIPAA-compliant; all participants provided signed informed consent forms.

Visit Dialogue

- Identify HCP mindset about treatment
- Understand dynamics between HCPs and patients
- Identify how HCPs monitor and assess CIC & IBS-C and treatment
- Learn what education is shared with patients

Post-visit Assessment

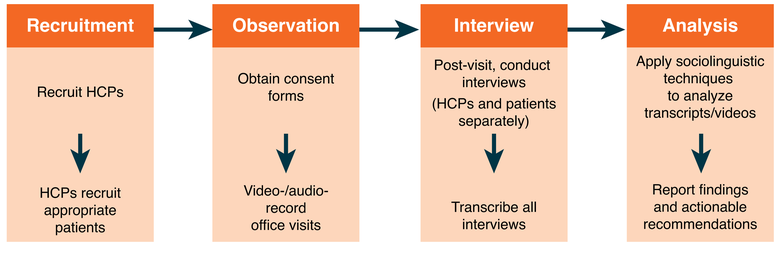
- Understand patient experience and quality of life (QoL) impact
- Compare patient language to HCP understanding of QoL impacts
- Uncover patient understanding about their disease, treatment choice
- Understand how this knowledge affects their treatment decisions

- HCPs were recruited by research staff based on inclusion criteria.
- HCPs identified and recruited patients who met inclusion criteria.

HCP Criteria	Patient Criteria
• Community-based • Board-certified or board-eligible • Solo or group practitioner • Gastroenterologist (GI), primary care physician (PCP), or physician assistant (PA) • Years in practice: 2–35 years • Spends ≥75% of time in direct patient care • Conducts ≥75% of patient discussions in English • Treats ≥20 CIC patients and ≥20 IBS-C patients in a typical month • Prescribes a mix of treatments	• ≥18 years old • CIC or IBS-C diagnosis • Treatment naïve or likely to discuss a treatment change during a visit • Fluent in English • No cognitive impairment • Had a significant discussion of CIC or IBS-C during the visit

- HCP and patient participants had their office visit video- and audio-recorded.
- HCPs and patients then participated in separate post-visit interviews, which were also video- and audio-recorded.
- Post-visit interviews were designed to assess intention, perception, and alignment.

- Visits and interviews will be analyzed using validated and standardized sociolinguistic techniques.[4,5]
- Sample size was appropriate for sociolinguistic research.[6]



Results

- 10 HCPs met the criteria and were enrolled (GI, n=13; PCP, n=16; PA, n=4).
- 38 patients were consented and recorded, of which 33 were enrolled (CIC, n=15; IBS-C, n=18) and 5 did not meet the criteria:
  - During visits with 3 patients, minimal discussion of CIC or IBS-C occurred.
  - 2 patients were not diagnosed with CIC or IBS-C.
- Analysis of office visits and post-visit interviews is ongoing.
- Areas of exploration include:

Visit	HCP Post-visit	Patient Post-visit
Disease Education • *What is discussed?* **Treatment** • *How are options framed?* • *Are risks vs benefits discussed?* • *What expectation/goal is discussed?* **Interactional Dynamics** • *Who dominates the conversation?* • *What gaps exist between patient and HCP?* • *What role do PAs play during and after the consultation?* • *Are there discussions of support?*	**Patient History and Relationship** • *What do HCPs know about patients' CIC/IBS-C (e.g. severity, QoL impacts, treatment adherence)?* **Treatment Algorithm** • *What impact has new therapies had on HCPs treatment approach?* • *How does the HCP choose a treatment?* • *Do QoL impacts affect HCPs treatment approach? Why or why not?*	**Patient's Pre-visit Impression** • *What they took away from the visit,* • *What they plan to do moving forward* **QoL Impacts** • *What is the daily impact?* • *What concerns are not shared with HCPs?* **Treatment Decisions** • *How do they feel? Why?* • *What could enhance treatment options?* • *Overall treatment satisfaction*

- Early observations suggest misalignment between patient experience of CIC and IBS-C symptom impacts (e.g., QoL, work productivity, and interpersonal relationships) and HCP recognition and understanding of the impacts due to limited discussion.
- Final analysis will be completed as a next step.

Conclusions

- **Preliminary results suggest that this study will provide greater insight into the nature of HCP-patient communication surrounding treatment for CIC and IBS-C and will identify key areas for improved communication.**
- **It is anticipated that these observations will lead to the creation of dialogue tools to both facilitate HCP treatment of CIC and IBS-C and assist patients in conveying their symptoms and impacts, thereby improving patient outcomes.**

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Disclosures

G. Sayuk is a consultant and speaker for Salix Pharmaceuticals and for Allergan/Ironwood Pharmaceuticals, as well as a consultant for the GI Health Foundation. **K. Hewett** is an employee of Ogilvy Health and was a paid consultant to Synergy Pharmaceuticals, Inc. in connection with performing this research and with the development of this poster.

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