Factors influencing patient satisfaction after treatments for early-stage non-small cell lung cancer

Cecilia Pompili1,5, Sanjush Dalmia2, Finn McLennan Battleday1, Zoe Rogers1, Kate Absolom1,3, Hilary Bekker3, Kevin Franks4, Alex Brunelli4, Galina Velikova1

Received: 30 July 2021 / Accepted: 3 September 2021 / Published online: 13 September 2021 © The Author(s) 2021

Abstract

Purpose Patient-reported outcome measures, including satisfaction with treatment decisions, provide important information in addition to clinical outcomes, survival and decision-making in lung cancer surgery. We investigated associations between preoperative clinical and socio-demographic factors and patient-reported satisfaction 6 weeks after radical treatment for early-stage non-small cell lung cancer (NSCLC).

Methods We conducted a sub-group analysis of the prospective observational longitudinal study of 225 participants in two treatment groups—surgical (VATS) and radiotherapy (SABR). The Patient Satisfaction Questionnaire-18 (PSQ-18) was used to measure patient satisfaction 6 weeks after treatment. Clinical variables, Index of Multiple Deprivation decile and Decision self-efficacy scores were used in regression analysis. Variables with a p level < 0.1 were used as independent predictors in generalised linear logistic regression analyses.

Results As expected, the two groups differed in pre-treatment clinical features. The SABR group experienced more grade 1–2 complications than the VATS group. No differences were found between the groups in any subscale of the PSQ-18 questionnaire. Patients experiencing complications or living in more deprived areas were more satisfied with care. Prooperative factors independently associated with patient satisfaction were the efficacy in decision-making and age.

Conclusion We showed that efficacy in treatment decision-making and age was the sole predictor of patient satisfaction with their care after radical treatment for early-stage NSCLC. Patients from more deprived areas and patients who suffered complications reported greater subsequent satisfaction. Involving patients in their care may improve satisfaction after treatment for early-stage NSCLC.

Keywords Quality of life · Lung cancer surgery · VATS · SABR · Patient-reported outcomes

Abbreviations

MIS Minimally invasive surgery
NICE National Institute for Clinical Excellence
NIHR National Institute for Health Research
NSCLC Non-small cell lung cancer
PROs Patient-reported outcomes
PROMs Patient-reported outcome measures
SABR Stereotactic ablative radiotherapy
VATS Video-assisted thoracoscopic surgery

Introduction

Lung cancer is associated with high morbidity and mortality. In addition, significant comorbidities often markedly reduce the patient’s baseline performance status. The high prevalence and significant symptomatic burden of lung cancer on patients is befitting to patient satisfaction as a surgical outcome measure.

UK National Institute for Clinical Excellence (NICE) guidelines recommend that early-stage non-small cell
lungenkrebs wird in erster Linie durch Videoassistierte Thorakoskopie (VATS) behandelt, wenn die Patienten für die Operation geeignet sind, und durch stereotaktische Ablationsbestrahlung (SABR) bei Patienten, bei denen VATS nicht anwendbar ist (NICE 2019).

Patientenberichtete Ergebnisse (PROMS) bieten Informationen darüber hinaus als zusätzliche Information zu Langzeitüberleben, Risiko-Vorteil-Entscheidungen und operativen Ergebnissen in der Lungenkrebschirurgie. Patientenzufriedenheit ist eines von vielen wichtigen PROMS und ist essentiell, um die Qualität der Behandlung zu beurteilen (Chow et al. 2009). Patientenzufriedenheit nach Behandlung ist ein Schlüsselqualitätsindikator für die Lungencancerversorgung (Brunelli und Rocco 2007), da sie eine Patientenperspektive der Qualität der erhaltenen Versorgung widerspiegelt. Obwohl klinische Indikatoren mit der Chirurgie verbunden sind, ist es wahrscheinlich, dass die Patientenzufriedenheit nach der Behandlung verschlechtert wird, da die Häufigkeit und das Ausmaß der Symptome, die durch verschiedene Behandlungen verursacht werden, von Patient zu Patient variiert. Daher ist die Messung der Patientenperspektive der Zufriedenheit mit der Versorgung für die effektive Praxis und den patientenzentrierten Management essentiell.

Es gibt keine spezifischen Lungenkrebs Fragebögen, um die Patientenzufriedenheit mit der Versorgung zu bewerten. Zufriedenheit ist ein abstraktes und multi-dimensional konzept, das schwierig direkt zu beobachten oder zu messen ist; daher sollte es mit einer Vielzahl von mehrfachem Bewertungsskalen (Avery et al. 2006) beurteilt werden. Die Messung der Patientenzufriedenheit erfordert validierte Werkzeuge, von denen es mehrere gibt. Trotzdem, die konstante Assoziation der sozioökonomischen Ungleichheit in Beziehung zum Lungenkrebsinzidenz und Mortalität (Mackenback et al. 2004) fragt, ob die Gesundheitstüchtigkeit und die Herausforderungen der Zugänglichkeit zu Lungenkrebsversorgung die Patientenzufriedenheit nach der Behandlung beeinflussen.

Ziel dieses Studien ist, zu überprüfen, ob spezifische präoperative Faktoren, entweder klinische, demografische oder patientenberichtete, mit der Patientenzufriedenheit nach der Behandlung in Zusammenhang stehen.

Wir hypothesisierten, dass es eine Assoziation zwischen der Patientenentscheidungseffizienz für die Lungenkrebsbehandlung und der post-treatment Zufriedenheit gibt.

**Materials and methods**

Dies ist ein Subanalyse der Lilac-Studie, einer prospektiven Beobachtungsstudie mit wiederholten Patientenberichteten Outcome-Messungen zu Baseline, 6 Wochen und 3, 6 und 12 Monaten nach der Behandlung für frühe Stadium-I-II Lungenkrebs (NSCLC). Die Studienpopulation bestand aus Patienten unter der Behandlung für VATS (Architekturen-Lungenresektion) oder SABR (Stereotaktische Ablationsbestrahlung) für frühe Stadium-I-II NSCLC in einem UK-Center in einer Periode von 12 Monaten. Alle Patienten schrieben den geschriebenen Einverständniserklärung und die Studie erhielt ethische Genehmigung durch das National Research Ethics Service Yorkshire and the Humber-Leeds East Committee (REC Ref: 16/YH/0407). Die Studie ist in der Clinical Trial database registriert (ClinicalTrials.gov Identifier: NCT02882750).

**Treatments groups**

Die Studienpopulation umfasste Patienten mit frühen Stadium-Lungenkrebs, die entweder VATS (Architekturen-Lungenresektion) oder SABR in Leeds Teaching Hospitals Trust in einer Periode von 12 Monaten bekamen. Die Patientenqualifikation für die Studie war an den Kriterien in Tabelle 1. Abenteuerende Patientenberichtete Outcomes (PROs) wurden unter Verwendung von sicherer online Zugang via QTool Software zu Hause oder in der Praxis erfasst. Appropriate Training für die Verwendung von QTool wurde angeboten (Holch et al. 2017). Der Patientenberichtete Outcome warerte für Patienten ohne Internetzugang. Die Ausschüttung von Patientenberichteten Outcomes (PROs) wurde mit den elektronischen Patientenmedizinischen Akten (EPR) zu den Konsensuntersuchungen in Echtzeit bereitgestellt. Patienten berichten Qualität des Lebensdaten durch die Verwendung der Europäischen Organisation für Forschung und Versorgung (EORTC) Qualität des Lifes Code (QLQ C-30) und seiner Lung Cancer specific Module (LC-13) zu Baseline, und post-treatment.

| Table 1 | Inclusion and exclusion criteria |
|---------|---------------------------------|
| **Inclusion criteria** | **Exclusion criteria** |
| Age 18 years and over | Advanced disease (III–IV stages) |
| Diagnosis of NSCLC either from histology or multi-disciplinary team meeting (MDT/Tumour Board) with agreement on > 95% likelihood of diagnosis based on radiological evidence or both | Patient included in another quality of life study, which may increase patient burden and bias the answers of the questionnaires |
| Decision for either surgery or SABR | |
| Able to give informed consent | |
| Able to understand the language of the questionnaire | |

[ Springer]
at 6 weeks, 3, 6 and 12 months. At the baseline, they were also collecting decision self-efficacy data and at 6 weeks patient satisfaction through the PSQ-18.

The Patient Satisfaction Questionnaire Short Form (PSQ-18) was chosen as it is a cross-cultural validated survey for use in different settings (Thayaparan and Mahdi 2013). It is short, reducing patient burden of filling in multiple questionnaires and covers the most important aspects of hospital attendance. The PSQ-18 questionnaire is an 18-item self-administered survey including different scales reflecting the perceived level of satisfaction in relation to the care provided by doctors. The team behind this Likert scale questionnaire proposed seven dimensions of patient satisfaction directed toward their doctors. These are general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctor, and accessibility and convenience (Thayaparan and Mahdi 2013). Patient satisfaction was only assessed at the first post-treatment time point (6 weeks). All items are scored 1–5 so that high scores reflect satisfaction with medical care. This was done to maximize response rate, as suggested by Bredart et al. (2005). Moreover, assessing satisfaction close to hospital recovery could allow for a better distinction among elements of satisfaction and higher response variability (Kane et al. 1997).

The Decision Self-Efficacy (DSE) scale is an 11-item questionnaire assessing the efficacy of decision-making with a 5-point response scale to generate a score between 0 and 100, with 0 indicating very low decision self-efficacy and 100 indicating very high decision self-efficacy. This instrument was shown to be reliable and valid for use in this population (Pompili et al. 2020). We administered the DSE at the pre-treatment time point.

Results

Recruitment

In total, 356 patients were eligible to participate in the study in a 12 months period, with 244 consenting to take part (60%). Of these, nineteen patients were excluded from the analysis: seven did not receive any treatments for oncological reasons, and twelve were deemed ineligible prior to treatment due to their suitability for open operation. Of the remaining 225 patients, 44 did not complete the trial: 23 died (13 in the SABR group and 10 in the VATS group); 9 became ineligible and 12 (eight patients in the SABR group and four in the VATS group) actively withdrew. Of the 12 patients who actively withdrew, five felt they had too many other time commitments to continue participation and the remaining seven did not provide a reason. Of the 225 participants, 91 failed to complete a patient satisfaction questionnaire at 6 weeks and thus were excluded from the analysis.

Patient baseline demographics and clinical characteristics

The clinical details and baseline (pre-treatment) demographics of the 225 patients who underwent VATS or SABR are presented in Table 2. The two groups differ considerably in their pre-treatment clinical features. There were no major differences in the available demographic data for the total patients treated in the same period.

Clinical outcomes analysis demonstrated that patients treated with SABR experienced a higher proportion of Grade 1–2 complications, as defined by the Common Terminology Criteria for Adverse Events (CTCAE) v3.0 (Trotti et al. 2003) resulting in a higher rate of complications overall (Table 2).

Patients’ satisfaction results

The patient satisfaction questionnaire, administered at 6 weeks, was completed by 60 SABR (66.6%) and 74 VATS patients (62.7%). We did not find any significant differences between the two groups in any of the PSQ-18 questionnaire subscales. In all scales, patients reported a moderate level of satisfaction with the care provided (Table 3).

The comparison between known groups (IMD domains, age, PS, gender and complications) in terms of general satisfaction showed that patients living in more deprived areas (higher IMD scores) were more satisfied. Patients
experiencing minor and major complications were also more satisfied 6 weeks after treatment (Table 4). The continuous variables are categorized and split at the mean value.

### Patient satisfaction model

The univariate analysis of patient satisfaction was carried out on 134 patients (60 SABR + 74 VATS) who completed
Results of the regression are shown in Table 5. Multivariable regression analysis showed that the only pretreatment factors that remained independently associated with patient satisfaction were decision-making self-efficacy and age.

### Discussion

Patient satisfaction results showed no difference between the two treatments for early-stage NSCLC. However, patients who experienced minor or major complications reported higher scores of patient satisfaction. We also demonstrated in our cohort that patients living in the more deprived areas reported higher satisfaction with care, although this association was no longer present in the regression analysis. Further, patients who felt more able to be involved in their treatment decision-making and patients who were older were more satisfied with care.

That patient satisfaction measure offers health services something different to clinical indicators, so is useful in helping services to identify ways to improve patient care. The fact that no association was detected between clinical indicators and patient satisfaction probably does not reflect the effect of the disease and treatment but rather provides information about the service.

Our results are discordant to the work by Barlesi et al. who found that the absence of postoperative complications in similar thoracic surgery patients, was the only quality index that showed weak but significant positive correlation with an index rating the satisfaction with the structure (Barlesi et al. 2005).

Furthermore, results from this study regarding patient satisfaction and post-treatment morbidity also differ from those we have previously found in lung resection patients (Pompili et al. 2015) and in other studies using the European Organisation for Research and Treatment of Cancer (EORTC) IN-PATSAT32 (Bredart et al. 2005). The EORTC In-PATSAT32 is a multi-dimensional questionnaire, adapted to measure patient satisfaction related to physician and hospital staff, as well as aspects of organisation of care and services (Bredart et al. 2005). It demonstrates reliability having been used in previous research (Pompili et al. 2013). It could be argued that some of the dissatisfaction caused by adverse events after surgery may not be alleviated by clear communication or the intensive care that complicated patients require. However, in this previous study, we used a different questionnaire which was administered at discharge. These factors may have influenced these divergent results. The two groups included in the current analysis were heterogeneous and the SABR population are day-cases and were, therefore, unable to rate satisfaction with the system and staff to the same extent that patients would be able to during an inpatient journey.

More recently, a US study found that patient satisfaction scores amongst patients undergoing surgery for lung cancer were not significantly affected by postoperative complications. Satisfaction in the areas of communication

| Group                      | IMD $^a$ > 4.6 (most deprived) | IMD < 4.6 (least deprived) | $p$ value |
|----------------------------|---------------------------------|-----------------------------|-----------|
| Group                      | Age > 72                        | Age < 72                    |           |
|                            | 3.8 (1)                         | 3.89 (0.9)                  | 0.85      |
| Group                      | PS $^b$ > 1                     | PS < 1                      |           |
|                            | 3.7 (1)                         | 3.9 (0.9)                   | 0.24      |
| Group                      | Major complications             | No major complications      |           |
|                            | 4.06 (0.97)                     | 3.72 (1)                    | 0.04*     |
| Group                      | Minor complications             | No major complications      |           |
|                            | 4.06 (0.99)                     | 3.72 (1)                    | 0.03*     |
| Group                      | Female                          | Male                        |           |
|                            | 3.83 (1)                        | 3.88 (1)                    | 0.64      |

Results are expressed as mean (SD)

$^a$Statistical significance

$^b$IMD: Index of multiple deprivation score 1–10. For all domains of the IMD, a greater score corresponds to greater deprivation

$^c$Eastern Cooperative Oncology Group (ECOG) Performance Score

---

**Table 4** General patient satisfaction scores difference in known groups

| Group                      | IMD $^a$ > 4.6 (most deprived) | IMD < 4.6 (least deprived) | $p$ value |
|----------------------------|---------------------------------|-----------------------------|-----------|
|                            | 4.02 (0.9)                      | 3.66 (1)                    | 0.02*     |
| Group                      | Age > 72                        | Age < 72                    |           |
|                            | 3.8 (1)                         | 3.89 (0.9)                  | 0.85      |
| Group                      | PS $^b$ > 1                     | PS < 1                      |           |
|                            | 3.7 (1)                         | 3.9 (0.9)                   | 0.24      |
| Group                      | Major complications             | No major complications      |           |
|                            | 4.06 (0.97)                     | 3.72 (1)                    | 0.04*     |
| Group                      | Minor complications             | No major complications      |           |
|                            | 4.06 (0.99)                     | 3.72 (1)                    | 0.03*     |
| Group                      | Female                          | Male                        |           |
|                            | 3.83 (1)                        | 3.88 (1)                    | 0.64      |
with doctors and nurses, however, decreased significantly with increasing length of stay suggesting an important role on enhancing provider communication skills (Singer et al. 2019). However, it is not easy to put these results in the context of studies exploring possible correlation between socio-economic level and patient satisfaction. Comparability across studies is hampered by heterogeneous reporting and differences in participant demographics. Systematic reviews show that socio-economic factors influence the use of health care services and subsequent survival rates in lung cancer patients (Forrest et al. 2013; Finke et al. 2018). In previous reports from our centre, there did not appear to be a significant relationship between socio-economic status and stage, performance status or outcome from lung cancer (Cheyne et al. 2013). Results from the UK National Cancer Patient Experience Survey (2012) showed that the significant differences that exist among IMD and satisfaction of care are not unidimensional (Department of Health and Social Care 2012). However, there was a certain degree of consistency in the kind of questions that were less highly ranked by patients in the most deprived areas as identified by the IMD quintile, with most of the items relating to the providing and understanding of information. There may be some other factor in our population which resulted in the most socio-economically deprived patients being more satisfied with care. On the other hand, the more affluent patients have lower satisfaction, as they may have higher expectations and demands, having more access to external resources or private healthcare, which eventually may be translated into more information and confidence in seeking good care. Future analysis comparing our results with more up-to-date data from the 2017 National Cancer Patient Experience Survey may help to explore these differences and help commissioners to reduce inequalities.

In our study group, there was a positive association between preoperative DSE scores and post-treatment satisfaction, supporting our initial hypothesis. These results

### Table 5 Generalised linear regression of patient satisfaction by preoperative factors (N = 134)

| Characteristic               | Patient satisfaction (N = 134) | Unadjusted standardised coefficient (beta) | CI | p value | Adjusted standardised coefficient (beta) | CI | p value |
|------------------------------|--------------------------------|-------------------------------------------|----|---------|-----------------------------------------|----|---------|
| Gender                       |                                |                                           |    |         |                                         |    |         |
| Female                       | 76                             | 56.7                                      | 0  | 0       | -0.02                                   | -0.19 to 0.15 | 0.80 | -0.05   | -0.22 to 0.12 | 0.53 |
| Male                         | 58                             | 43.3                                      | -0.62 | 0.02 | -0.03                                   | -0.64 to 0.02 | 0.003* | -0.47   | -0.89 to -0.05 | 0.03* |
| Age (years)                  |                                |                                           |    |         |                                         |    |         |
| ≤ 65                         | 25                             | 18.7                                      | -0.64 | 0.02 | 0.03*                                   | 0.70 to -0.18 | 0.001* | -0.38   | -0.64 to -0.11 | 0.005* |
| 65–75                        | 58                             | 43.3                                      | 0   | 0       | -0.03                                   | -0.64 to 0.02 | 0.07 | -0.21   | -0.56 to 0.13  | 0.22 |
| 75+                          | 51                             | 38.1                                      | -0.31 | 0.02 | 0.07                                   | -0.64 to 0.02 | 0.07 | -0.21   | -0.56 to 0.13  | 0.22 |
| Treatment                    |                                |                                           |    |         |                                         |    |         |
| VATS                         | 74                             | 55.2                                      | 0   | 0       | 0                                       | 0 | 0       |
| SABR                         | 60                             | 44.8                                      | -0.03 | 0.02 | 0.71                                   | -0.20 to 0.14 | 0.001 | -0.17   | -0.17 to 0.99  | 0.99 |
| DSE                          |                                |                                           |    |         |                                         |    |         |
| High > 90                    | 62                             | 46.3                                      | 0   | 0       | 0                                       | 0 | 0       |
| Low < 90                     | 52                             | 38.8                                      | -0.44 | 0.02 | 0.001*                                  | 0.70 to -0.18 | 0.001* | -0.38   | -0.64 to -0.11 | 0.005* |
| Not known                    | 20                             | 14.9                                      | -0.15 | 0.02 | 0.14                                   | -0.42 to 0.20 | 0.41 | -0.14   | -0.49 to 0.21  | 0.43 |
| Index of multiple deprivation |                                |                                           |    |         |                                         |    |         |
| 3, 4 or 5 (most deprived)    | 73                             | 54.5                                      | 0   | 0       | 0                                       | 0 | 0       |
| 1 or 2 (least deprived)      | 61                             | 45.5                                      | -0.18 | 0.02 | 0.10                                   | -0.34 to -0.01 | 0.04 | -0.10   | -0.27 to 0.07  | 0.25 |
| FEV1                         | 1.9                            | 0.70                                      | 0.62 |         |                                         |    |         |
| CCI                          | 1.5                            | 1.15                                      | 0.56 |         |                                         |    |         |
| ECOG performance             |                                |                                           |    |         |                                         |    |         |
| ≤ 1                          | 88                             | 65.7                                      | 0.25 |         |                                         |    |         |
| > 1                          | 38                             | 28.4                                      | 0.50 |         |                                         |    |         |
| Not known                    | 8                              | 6.0                                       | 0.50 |         |                                         |    |         |

*SD standard deviation, CI confidence interval, VATS video-assisted thoracoscopic surgery, SABR stereotactic ablative radiotherapy, DSE decision self-efficacy, FEV1 forced expiratory volume in 1 s, CCI Charlson comorbidity index

*Statistical significance at < 0.01
may be affected by the 6-week time interval selected for data collection. Participant attrition was greater at this point, especially in the VATS group, but the decision was made to assess satisfaction closer to hospital recovery to allow for a better distinction among elements of satisfaction and response variability (Kane et al. 1997).

Patients living in least deprived areas reported lower patient satisfaction and may in fact be DSE driven. The deprived group has a higher proportion of those with high DSE (61%) compared to the affluent group (46%).

Our data suggest that patients reported lower patient satisfaction if they also have low DSE whether they are in the affluent or the deprived group. The difference in DSE may be more conflict from the researched, informed affluent group (borderline sig $p = 0.1$) and could suggest that the association between IMD and satisfaction is no longer significant in the multivariable model because the association with DSE is stronger.

Decision self-efficacy is not a measure of quality of the decision-making process, but rather measures the involvement of the patient in key decisions relating to treatment. But it has highlighted for the first time, the importance of patient attitudes surrounding treatment choices. Understanding the role of post-treatment patient satisfaction and its association with decision-making factors may provide important information for clinical practice and future research.

Limitations

This cohort study was designed to explore factors associated with satisfaction and illustrate that patient satisfaction measures have an independent part to play in informing service quality apart from indicators of clinical and treatment effectiveness. However, it was not a randomised control trial of an intervention designed to improve care, so although we can say decision self-efficacy and patient satisfaction are associated, we cannot say why. Prior evidence would suggest that interventions designed to enhance patient involvement in care are likely to increase decision self-efficacy and patient satisfaction with care, for example those involving patient decision aid interventions (Stacey et al. 2017). Although patient-reported measures are essential in understanding patient perspective in care, there are several limitations such as low response rates of questionnaires. In additional, patient satisfaction measures may be subject to social desirability bias in reporting, especially if care is continuing in a service before treatment is completed. Furthermore, the PSQ-18 questionnaire has been designed to assess generic satisfaction and is not specific to either inpatient or outpatient care. This questionnaire was chosen instead of the EORTC PATSAT32, as SABR is an outpatient treatment. We cannot rule out the possibility that this questionnaire may not be capturing the same domains in these two different groups.

Conclusions

Patient satisfaction measures are important in service improvement as independent of the patient perception of the health problem and burden of symptoms and impact of treatment. It seems likely that supporting patient involvement in treatment decision-making is associated with satisfaction, independent of the treatment type. Socio-demographic factors did not affect reported satisfaction but may have influenced the efficacy in making the decision about treatment for early-stage NSCLC. The understanding of the clinical decision-process from patients deserves more investigation to improve patient-reported satisfaction with care for early-stage NSCLC.

Funding This research was supported by Yorkshire Cancer Research Grant (L-399).

Data availability No data from this study is available for sharing.

Declarations

Conflict of interest Dr. Pompili reports personal fees from BARD, Astra Zeneca and Medela outside the submitted work. Dr. Brunelli reports personal fees from BARD, personal fees from Astra Zeneca, personal fees from Roche, personal fees from Medtronic and personal fees from Ethicon, outside the submitted work. Dr. Franks reports personal fees from Astra Zeneca, Roche, Boehringer-Ingeheim, Bristol-Meyers-Squibb, Lilly, ELEKTA, ESMO and Takeda, outside the submitted work. Prof. Velikova reports personal fees from Roche, Eisai, Novartis and Seattle Genetics and roles as chair of the NCRI Living With and Beyond Cancer Group and board member of the EORTC. The remaining authors declare no conflicts of interest.

Ethics approval This study has received ethical approval from The National Research Ethics Service Yorkshiere and the Humber East Committee—(REC Ref: 16/YH/0407). Two substantial amendments to this study were granted with no request of modifications. One amendment (Substantial Amendment 1, 18/04/17) was to send a letter with PIS and consent form to the patient before their clinical appointment and the second one (Substantial Amendment 3, 09/05/18) was to modify the end-of-study interview schedules.

Consent to participate All participants provided written informed consent.

Open Access This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article’s Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in

 Springer
References

Avery KN, Metcalfe C, Nicklin J et al (2006) Satisfaction with care: an independent outcome measure in surgical oncology. Ann Surg Oncol 13(6):817–822. https://doi.org/10.1245/ASO.2006.08.01

Barlesi F, Boyer L, Doddoli C, Antoniotti S, Thomas P, Auquier P (2005) The place of patient satisfaction in quality assessment of lung cancer thoracic surgery. Chest 128(5):3475–3481. https://doi.org/10.1378/chest.128.5.3475

Bredart A, Bottomley A, Blazey JM et al (2005) An international prospective study of the EORTC cancer in-patient satisfaction with care measure (EORTC IN-PATSAT32). Eur J Cancer 41(14):2120–2131. https://doi.org/10.1016/j.ejca.2005.04.041

Brunelli A, Rocco G (2007) Clinical and nonclinical indicators of performance in thoracic surgery. Thorac Surg Clin 17(3):369–377. https://doi.org/10.1016/j.thorsurg.2007.07.007

Cheyne L, Taylor A, Milton R, Fear J, Callister MEJ (2013) Social deprivation does not affect lung cancer stage at presentation or disease outcome. Lung Cancer 81(2):247–251. https://doi.org/10.1016/j.lungcan.2013.03.012

Chow A, Mayer EK, Darzi AW, Athanasiou T (2009) Patient-reported outcome measures: the importance of patient satisfaction in surgery. Surgery 146(3):435–443. https://doi.org/10.1016/j.surg.2009.03.019

Department of Health and Social Care (2012) National Cancer Patient Experience Survey 2011/2012—national report. https://www.gov.uk/government/publications/second-national-cancer-patient-experience-survey

Finke I, Behrens G, Weisser L, Brenner H, Jansen L (2018) Socioeconomic differences and lung cancer survival—systematic review and meta-analysis. Front Oncol 8:536. https://doi.org/10.3389/fonc.2018.00536

Forrest LF, Adams J, Wareham H, Rubin G, White M (2013) Socioeconomic inequalities in lung cancer treatment: systematic review and meta-analysis. PLoS Med 10(2):e1001376. https://doi.org/10.1371/journal.pmed.1001376

Holch P, Warrington L, Bamforth L et al (2017) Development of an integrated electronic platform for patient self-report and management of adverse events during cancer treatment. Ann Oncol 28(9):2305–2311. https://doi.org/10.1093/annonc/mdx317

Kane RL, Maciejewski M, Finch M (1997) The relationship of patient satisfaction with care and clinical outcomes. Med Care 35(7):714–730. https://doi.org/10.1097/00005650-199907000-00005

Mackenback JPH, Andersen M et al (2004) Inequalities in lung cancer mortality by the educational level in 10 European populations. Eur J Cancer 40(1):126–135. https://doi.org/10.1016/j.ejca.2003.10.018

NICE (2019) Lung cancer: diagnosis and management. https://www.nice.org.uk/guidance/ng122

Pompili C, Brunelli A, Rocco G et al (2013) Patient satisfaction after pulmonary resection for lung cancer: a multicenter comparative analysis. Respiration 85(2):106–111. https://doi.org/10.1159/000337262

Pompili C, Tiberi M, Salati M, Refai M, Xiume F, Brunelli A (2015) Patient satisfaction with health-care professionals and structure is not affected by longer hospital stay and complications after lung resection: a case-matched analysis. Interact Cardiovasc Thorac Surg 20(2):236–241. https://doi.org/10.1093/icvts/ivu371

Pompili C, Holch P, Rogers Z et al (2020) Patients’ confidence in treatment decisions for early stage non-small cell lung cancer (NSCLC). Health Qual Life Outcomes 18:237. https://doi.org/10.1186/s12955-020-01496-9

Singer ES, Merritt RE, D’Souza DM, Moffatt-Bruce SD, Kneuerz PJ (2019) Patient satisfaction after lung cancer surgery: do clinical outcomes affect hospital consumer assessment of health care providers and systems scores? Ann Thorac Surg 108(6):1656–1663. https://doi.org/10.1016/j.athoracsur.2019.06.080

Stacey D, Légaré F, Lewis K, Barry MJ, Bennett CL, Eden KB, Holmes-Rovner M, Llewellyn-Thomas H, Lydiatt A, Thomson R, Trevena L (2017) Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev 4(4):CD001431. https://doi.org/10.1002/14651858.CD001431.pub5

Thayaparan AJ, Mahdi E (2013) The Patient Satisfaction Questionnaire Short Form (PSQ-18) as an adaptable, reliable, and validated tool for use in various settings. Med Educ 18:21747. https://doi.org/10.3402/meo.v18i0.21747

Trotti A, Colevas AD, Setser A et al (2003) CTCAE v3.0: development of a comprehensive grading system for the adverse effects of cancer treatment. Semin Radiat Oncol 13(3):176–181. https://doi.org/10.1016/S1053-4296(03)00031-6

Publisher’s Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.