instrument has five functional scales (physical, role, cognitive, emotional, and social) three symptom scales (fatigue, pain, and emesis), and a global health/quality of life scale. The remaining single items assess dyspnea, appetite loss, sleep disturbance, constipation, and diarrhoea. The analyses focused on intraclass correlation coefficients (ICCs). An ICC > 0.95 is considered excellent, lower values indicate a critical interval with a critical value of 0.70. RESULTS: Subjects who did not complete the second assessments within 72 hours or who had score differences on the scales or items exceeding two standard deviations were excluded from the per protocol analyses. The sample sizes used in the per protocol analyses ranged from 112 to 115 subjects. The ICCs for the 9 multi-item scales were all above 0.69, ranging from 0.696 to 0.926 (ICC 95% lower CI range: 0.608 to 0.901). All of the scales were significantly different from our threshold reliability of 0.70, with the exception of the cognitive functioning scale. The ICCs for the 6 single items ranged from 0.782 to 0.908 (ICC 95% lower CI range: 0.714 to 0.876) and all were statistically different from 0.70. The evidence supports the stability of the scores obtained on the IVR version of the QL-C30 upon repeated measurement. CONCLUSIONS: The equivalence of the IVR and paper versions of the QL-C30 has been demonstrated elsewhere. This analysis provides additional evidence of the test-retest reliability of the IVR version of the QL-C30.

A METHODOLOGICAL APPROACH TO DEFINE A CLINICALLY RELEVANT CUTOFF POINT IN THE ORDINAL SCALE OF THE EORTC QL-C30 QUESTIONNAIRE

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OBJECTIVES: The objective of this analysis was to develop a new analytic methodology to identify a clinically relevant cut-off point in the EORTC QL-C30 ordinal pain score by comparing patient and clinician reporting for the same symptom. Ability to translate between clinician and patient reported symptoms will be useful in planned future analyses. METHODS: Closed European Organisation for Research and Treatment of Cancer Randomized Controlled Trials, where the symptom pain was scored at baseline by the patient (EORTC QL-C30) and the clinician (Common Toxicity Criteria (CTC)), were pooled and analysed to test the optimal cut-off point. The CTC was dichotomized as 0,1,2, 3, 4, defined as a clinically relevant cut-off point for clinical practice. Percent agreement with various dichotomizations of the QL-C30 pain scale was calculated, and McNemar’s test applied. Verification of the accuracy and generalisability of the findings was undertaken with a validation set, and by applying the same cut-off point on another symptom, i.e. fatigue. RESULTS: Data were available for pain (number of trials = 8, number of patients = 21241) and fatigue (n = 5, n = 1237). Model and validation set were obtained by splitting the dataset in half. Percent agreement and p value from McNemar tests, between patient and clinician dichotomized scores using different cut-off points for the QL-C30 scale, were: median <2.19, <2.19, 64%, p < 0.01, quartile (cvs 3.0, 81%, p = 0.55), decile <4.0 vs. 4.0, 85%, p = 0.01). The quartile split reflects best the dichotomized CTC score. This was confirmed in the validation set (quartile cut-off point: 82%, p = 0.86). However, when the quartile cut-off was applied to the QL-C30 fatigue scale, a significant difference (p < 0.01) between patient and clinician results was found. CONCLUSIONS: Our results indicate that a quartile split of the QL-C30 pain score is optimal. However, a single cut-point may not generalize to other QL-C30 symptoms; symptom-specific cut-points may be required.

PROVISION OF QUALITY OF LIFE INFORMATION AND PHYSICIAN TRUST AMONG FAMILIES OF CHILDREN WITH LIFE-LIMITING CONDITIONS

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OBJECTIVES: To examine what information that parents of children with life-limiting conditions want from physicians and whether the provision of this information promotes parents’ trust in physicians. METHODS: We conducted telephone surveys from November 2007 through April 2008 with a random sample of 266 parents whose children had life-limiting conditions and enrolled in Florida’s State Title V Children with Special Health Care Needs Program. Parents were asked if they wanted information about the following: the child’s quality of life, pain relief, prognosis, incorporating spiritual beliefs into the treatment plan; and the child’s treatment goals. RESULTS: Parents divided the information into four categories: general information, health status and desired information. We also tested whether provision of this desired information was associated with greater trust in physicians. RESULTS: Most parents wanted information on their children’s quality of life (95%), followed by the prognosis (88%) and pain relief (84%). Forty-nine percent of the parents desired advice from family/friends. Compared to parents with a high school education or higher, parents with less than a high school education showed a greater desire for information on pain relief and spiritual beliefs (p = 0.05). Compared to White non-Hispanic parents, Hispanic and Black non-Hispanic parents showed a greater desire for information on the child’s prognosis, incorporating spiritual beliefs into the treatment plan, and the impact of the treatment on the child’s appearance (p = 0.05). Providing information on children’s quality of life and pain relief was associated with greater trust in physicians after adjusting for parental characteristics (p < 0.05). CONCLUSIONS: Parents wanted information on their children’s quality of life more than any other information category. Providing this information along with information about pain relief increased the families’ trust in the physicians.

HOW DOES TRUST IN PHYSICIANS AFFECT PARENTS’ TREATMENT DECISION MAKING FOR THEIR CHILDREN WITH LIFE-LIMITING CONDITIONS?

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OBJECTIVES: To examine the association between characteristics of parents whose children are diagnosed with life-limiting conditions, trust in physicians, and problems in the shared decision making process. METHODS: This study used data collected from...