



Caring for dying cancer patients in the Chinese cultural context: A qualitative study from the perspectives of physicians and nurses



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ABSTRACT

Objective: To explore the experiences of Chinese physicians and nurses who care for dying cancer patients in their practical work.

Method: This was a qualitative study using semi-structured face-to-face interviews. Fifteen physicians and 22 nurses were recruited from a cancer center in mainland China. The data were analyzed by qualitative thematic analysis.

Results: Disclosure of information on death and cancer to dying cancer patients is taboo in traditional Chinese culture, which greatly decreases the physicians' and nurses' effective communication with dying patients in end-of-life (EOL) care. Both physicians and nurses described strong ambitions to give dying cancer patients high-quality care, and they emphasized the importance of maintaining dying patients' hopes in the death-denying cultural context. However, the nurses were more concerned with dying patients' physical comfort and wish fulfillment, while the physicians placed greatest emphasis on patients' rights and symptom management. Both physicians and nurses suffered whilst also benefitting from taking care of dying patients which helped with their personal growth and allowed greater insight into themselves and their clinical practice. Our results also indicated that Chinese physicians and nurses require improved methods of communication on EOL care, as well as needing more support to provide quality EOL care.

Conclusion: Chinese physicians and nurses experience a challenge when caring for dying cancer patients in the Chinese cultural context. Flexible and specific education and training in EOL cancer care are required to meet the needs of Chinese physicians and nurses at the cancer center studied.

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1. Introduction

Health professionals working in cancer centers are often confronted with dying patients and bereaved family members. In their role as supporters, they are the ones to facilitate a dignified, comfortable death that honors patient and family choices, no matter where the setting of death occurs. However, caring for dying cancer patients and experiencing patient death can stir myriad emotions and thoughts within them, such as raising doubts about their competency, feelings of guilt, loss or injury from failure to meet their expectations of care (Cevik and Kav, 2013; Gibbins et al., 2011; Penson et al., 2000; Wang et al., 2004a).

The presence of dying cancer patients has been thought to be a significant contributor to burnout and turnover of health

professionals (Kendall, 2006; Penson et al., 2000). They are under pressure to return to an environment where they must care for other cancer patients who may also be critically ill and expect an imminent death. Researchers (Lange et al., 2008; Peterson et al., 2010) have stated that health professionals with better skills and more experience tend to provide good-quality EOL care and establish meaningful and supportive relationships with patients and family members, leading to improved patient outcomes and satisfaction of patients and their families.

Cultural factors take an important role in the practice of medical issues. To a large extent, people's beliefs and attitudes about health and disease are influenced or determined by their traditional culture (Ekblad et al., 2000). Chinese culture has a particular perspective on dying and death developed over five millennia due to the profound influences of Taoism, Confucianism, and Buddhism (Cui et al., 2011; Hsu et al., 2009). Confucianism, which is a vital aspect of non-disclosure in China, to some extent greatly influences Chinese medical ethics, and it tends to advocate a beneficence-

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oriented stance (Jiang et al., 2007). Even for contemporary Chinese, including health professionals, talking about death and dying is very challenging (Dickinson et al., 2008; Wang et al., 2004b; Xu et al., 2006), especially for those who are dying; discussion about death is avoided as such talk may hasten the pace of their dying process and incur bad luck (Hsu et al., 2009; Wang et al., 2004a). Compared to Chinese culture, Westerners are better prepared to face death, and talking about death with dying patients and making necessary preparation to deal with death are encouraged in Western cultures where the majority of people identify themselves as Christians (Xu, 2007).

The perception of cancer is also influenced by culture. There is a common belief in Chinese societies that cancer diagnosis is regarded as a metaphor for death because of its high mortality rate. Due to the family-oriented cultural context (Lu et al., 2011; Olsen et al., 2010), Chinese physicians and nurses are required to give priority to families who decide whether or not to tell the patients the terminal diagnosis (Sun et al., 2011; Wong and Chan, 2007). The family members usually exclude telling the patient the truth, even when they are at the EOL stages, which is considered by their families as a good way to protect them emotionally (Wang et al., 2004b; Xu et al., 2006). However, some dying patients may know very well what their health condition is, even though they are kept uninformed (Zeng et al., 2008). In fact, some Chinese physicians preferred disclosure to dying patients, as they thought such disclosure may allow dying patients to resolve unfinished business and manage the last days of their lives (Jiang et al., 2007). On the other hand, Chinese cancer patients' attitude toward truth-telling was greatly influenced by their disease stage; fewer patients wanted to know their diagnosis during terminal stages than early stages of cancer (Jiang et al., 2007). Consequently, Chinese health professionals are in a dilemma whether terminal cancer information should or should not be disclosed to dying patients, and how to deliver quality EOL care to facilitate a good death for the patients.

Researchers indicate that culture imposes certain limitations on health professionals' options and behaviors when caring for dying patients (Clark, 2012; Mystakidou et al., 2004). Chinese physicians' and nurses' experience of caring for dying cancer patients may have different implications and significance for each (Schlairet, 2009; Xu et al., 2006; Zhai and Dai, 2006). To our knowledge, no study has simultaneously involved Chinese physicians and nurses in exploring the experiences of caring for dying cancer patients in a Chinese traditional cultural context. Thus, a public discussion is essential to develop a better understanding of the points of view of Chinese physicians and nurses, and also to learn how to integrate these perspectives.

The purpose of this study was to identify Chinese physicians' and nurses' perceptions of caring for dying cancer patients who are in their final days or hours in Chinese cultural contexts, with the objective of illuminating similarities and differences in experiences and helping to develop effective training.

2. Methods

A qualitative research design was chosen for this study as qualitative study is considered to be an ideal way of yielding information and exploring a specific phenomenon; it also helps to gain a full view of the phenomenon under research. This study was based on the phenomenology study approach (Merriam, 2009) and was presented according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist for qualitative research (Tong et al., 2007). Research ethics approval was gained from the Human Research Ethics Board of Tianjin Medical University Cancer Institute and Hospital.

2.1. Sample

This descriptive qualitative research was conducted in a 2400-bed cancer hospital in northern mainland China. Purposive sampling (Merriam, 2009) was used to include participants with a variety of professional titles, ages, and years of clinical experience in different departments of the hospital during May to October 2014. To be eligible to participate in this study, the participants had to have worked with and been exposed to dying cancer patients for at least half a year; to be more than 18 years old; to be willing to participate; and to be a Chinese speaker. Fifteen physicians participated in this study, with a mean age of 34.56 years ($SD = 8.50$); the youngest was 27 years old, and the oldest was 54. The mean number of years of clinical experience of the physicians was 8.31 ($SD = 7.71$); the maximum experience was 25 years, and the minimum was 1 year. Twenty-two nurses were also recruited. The mean age of the nurses was 29.34 years ($SD = 6.63$); the youngest was 24 years old, and the oldest was 49. The mean number of years of clinical experience of the nurses was 7.47 ($SD = 6.52$); the maximum length of clinical experience was 27 years, and the minimum was 0.5 years.

2.2. Data collection

A semi-structured face-to-face interview guide was developed based on the purpose of the study; this was pretested with two nurses and two physicians to ensure the questions were understandable and answerable, on the basis of which we adapted this interview guide again. Prior to the one-to-one interviews, participants completed a demographic form, were made aware of the aims of the study, and provided written information consent. They were guaranteed that they could withdraw from the study at any time; the study was anonymous, and identifying factors were removed from the data. All the material and information was locked by the first researcher in a cabinet and accessed only by the researchers.

The interviews, ranging in length from 30 to 60 min, were carried out at a site of each participant's choosing by a single researcher (R.S. Zheng) who had received training in qualitative research. Each participant was asked to recount their feelings and personal experiences regarding caring for dying cancer patients. Interview questions included 'How do you feel when you are caring for a dying cancer patient?', 'What are your thoughts and feelings when doing that?', 'What do you think of quality EOL care?', 'What would you do for a dying cancer patient?' and 'How does the experience of caring for dying cancer patients impact you?' Probes were used to encourage participants to elaborate on their experiences: for example, "Could you tell me more about that?", "What do you mean by saying that?" etc.

2.3. Data analysis

Interviews were digitally recorded and transcribed verbatim. Data analysis was done independently by the first and second authors, who followed the standard methods for qualitative thematic analysis. Data analysis began with the first interview and was done in conjunction with data collection (Merriam, 2009). The method used for analyzing qualitative data was Colaizzi's approach (Colaizzi, 1978): (1) to read the transcripts repeatedly while listening to the digital recordings; (2) to extract essential elements and meaningful statements from the transcripts; (3) to code the same elements and statements; (4) to arrange the formulated meanings into clusters of themes; (5) to state detailed descriptions for every extracted theme; (6) to read the themes and the descriptions again; (7) to return the transcripts to the participants to

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