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A qualitative analysis of staff-client interactions within a breast cancer assessment clinic

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ABSTRACT

Objectives: Breast screening clients recalled to an assessment clinic experience high levels of anxiety. The culture of the assessment clinic may impact upon client experience, which may influence their future re-engagement in screening. This study aimed to explore the culture of staff-client interactions within a breast cancer assessment clinic.

Materials and methods: Following an ethnographic approach, twenty-three client journeys were observed, followed by semi-structured interviews with the clients. The observation and interview data were analysed to produce research themes, which were then explored within two focus groups to add a practitioner perspective.

Results: Multiple staff-client interaction events were observed over a period of several weeks. Client interview feedback was overwhelmingly positive. Three recurrent and sequential themes emerged: *breaking down barriers*, *preparing the ground* and *sign-posting*. These themes outline the changing focus of staff-client interactions during the client's clinic journey, encompassing how anxieties were expressed by clients, and responded to by practitioners.

Conclusion: This study was the first to explore in depth the staff-client interaction culture within a breast assessment clinic using an ethnographic approach. A new perspective on professional values and behaviours has been demonstrated via a model of staff-client interaction. The model documents the process of guiding the client from initial confusion and distress to an enhanced clarity of understanding. A recommendation most likely to have a positive impact on the client experience is the introduction of a client navigator role to guide the clients through what is often a lengthy, stressful and confusing process.

Introduction

Breast cancer is the most common female cancer in Western civilisations,[1] and early diagnosis is essential for improved prognosis. Following mammographic breast cancer screening, the majority of women will have a negative result. However in England, 7.9% of women attending for their first (prevalent) screen and 3% of women attending for subsequent (incident) screens in 2013–14 were referred on to an assessment clinic for further evaluation.[2] The percentage of women subsequently found to be clear of cancer is variable, but previously noted to be 57.43% in the study centre.[3] However there is some evidence to suggest that these false positive [FP] women are at greater risk of interval cancers and larger cancers at presentation.[2,4,5] Re-engagement with routine screening following a FP result is therefore essential. A systematic review and meta-analysis of over 340,000 attendances[6,7] identified that, within Europe, FP women are just as likely to re-attend routine screening as those who had a normal mammogram result; however in some countries such as Canada FP women were less likely to re-attend.

The assessment clinic client experience can be intensely stressful, with increases in anxiety, worry and intrusive thoughts.[8] Brett et al.[9] reported the experience as a shock, with 37% (n = 109) of women in one study reporting their referral for assessment to be either 'very scary' or the 'scariest time in my life'.[10] Negative psychosocial consequences have been identified six months after FP diagnosis, experienced at a similar level to women who had received a diagnosis of cancer.[11] Three years later women still

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reported negative psychosocial consequences[11]; this timeframe coinciding with an invitation for the next routine screen in some countries such as the United Kingdom.

Clients attending an assessment clinic may have a combination of diagnostic tests in a single visit; some studies suggest the nature of the diagnostic workup does not influence re-attendance rates,[12] yet others note adverse effects on re-attendance following needle sampling or biopsy.[13,14] While the one-stop clinic may be resource efficient the clients may feel they are on a diagnostic conveyor-belt, potentially bewildered by the process and some of the complex medical terms used.[15] The client journey may involve several different client-health professional encounters, and while these are expected to be highly professional and empathetic, this may not always be the case.[16]

A retrospective six year audit undertaken within a UK breast screening service identified that the percentage of eligible FP women failing to re-engage with screening was considerably lower than non-engagement in the general screening population (15% compared to 29%).[3] However, those undergoing biopsies were more likely to return for routine screening than those undergoing minimally invasive assessment (93% compared to 82.5%).[3] This was at odds with published literature[12,14] and suggested that the additional support received by women having biopsies has a beneficial effect on their future re-engagement with screening.[3] A qualitative study was initiated to explore in detail the nature of staff-client interactions within a breast assessment clinic affiliated to the NHS Breast Screening Programme.[17,18]

Methodology

The study site is a breast screening service with a three year screening population of 88,000 women, covering a wide geographical area and serving a largely socially deprived, mixed ethnicity population in the North West of England. The clinic is staffed by consultant radiologists (physicians), different grades of radiographer (mammography practitioner, advanced practitioner and consultant practitioner), assistant practitioners and breast care nurses. The aim of the research was to study staff-client interaction culture within the assessment clinic using an ethnographic approach.[19] Culture is defined as 'the customs, civilisation, and achievements of a particular time or people'[20] and details the way of life and habits within a societal group. Ethnography is well-suited to producing a detailed description and interpretation to allow others to understand the culture within a social group – in this context a breast assessment clinic. No similar studies have been undertaken within the breast screening assessment environment, although ethnography has been applied within general radiography settings.[21,22]

The objectives of the study were to:

1. Observe the type and frequency of staff-client communication episodes within the assessment clinic
2. Identify the client perceptions of the assessment clinic
3. Explore staff perceptions of the observation findings
4. Develop a model to capture the culture of staff-client interactions in the assessment clinic

While the ethnographic approach is highly flexible, the central tenets of this methodology are the use of participant observation and prolonged immersion within the culture to be studied.[23] Additional research methods such as focus groups and interviews may be used to give valuable scope for triangulation in ethnographic research, and these were employed within this study. The researcher in this study (female radiography academic with experience of breast screening only as a service user) assumed an 'observer as a participant' role. First described by Gold in 1958,[24] this clarifies that observation is the main reason for the researcher's presence but facilitates participation in some activities, in this case for example assisting a client with limited mobility. Purposive sampling ensured all aspects of clinic business were observed over an extended period of several weeks; once the potential 'Hawthorne' effect has been overcome,[25] it is more likely that deviation from normal working behaviours is difficult to sustain for any length of time.[26]

Observations of a natural setting can yield an overwhelming amount of data and are best conducted within an agreed framework. Kurtz et al.[27] described a clinical examination as containing five discrete stages, and these were used as '*A Priori*' (known in advance) themes around which the observations were structured (Fig. 1). The observation events were captured via a data collection sheet (Appendix 1) and discretely recorded audio observations. A brief semi-structured interview with clients was undertaken at the end of the clinic visit (Appendix 2).

The observation and interview data was transcribed and analysed thematically, and emerging themes were used to inform a focus group schedule. Two staff focus groups were conducted: *practitioners* (radiographers/mammographers, assistant practitioners and reception staff; n = 9), and *consultants* (consultant radiographers and radiologists; n = 3). The focus groups were facilitated by two additional radiography researchers who had expertise in qualitative research methods, following a model proposed by Kruegar.[28] A pre-arranged question schedule (Appendix 3) sought further information and validation of the observation findings.

The focus group discussions were digitally recorded and transcribed, and analysed using an inductive approach to produce emergent themes using a process aligned to Thematic Content Analysis.[29] One researcher conducted the initial analysis which was then peer-reviewed by the second researcher. To ensure the findings reflected the meanings of the participants as closely as possible, the research team adopted the concept of 'trustworthiness'[30]; strategies included triangulation, member checking, peer

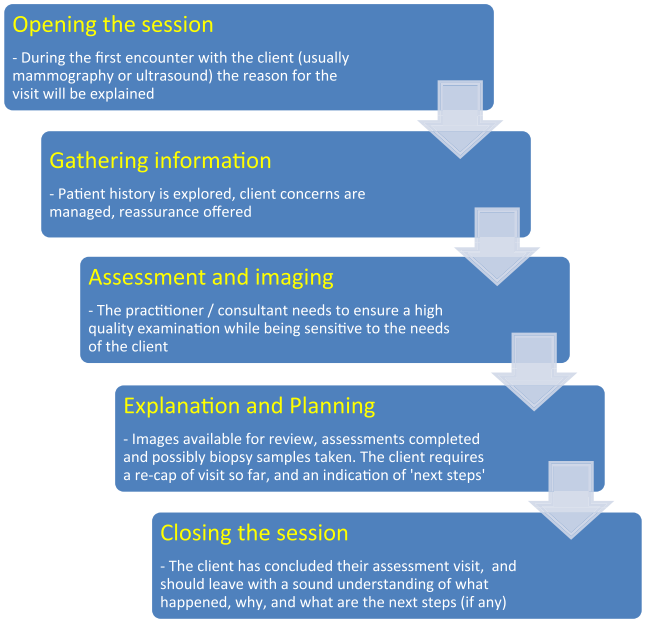

Figure 1. The Kurtz et al. model[27] (five stages of a clinical examination) adapted for mammography assessment.