Patient Education and Counseling 91 (2013) 243–248

Contents lists available at SciVerse ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Provider Perspectives

A qualitative study of stress and coping responses in doctors breaking bad news

Joanne M. Shaw [a,*], Rhonda F. Brown [b], Stewart M. Dunn [a]

[a] Sydney Medical School, University Of Sydney, Sydney, Australia
[b] School of Behavioural, Cognitive and Social Sciences, University of New England, Armidale, Australia

ARTICLE INFO

Article history:
Received 20 January 2012
Received in revised form 12 October 2012
Accepted 6 November 2012

Keywords:
Communication
Medical
Health care professionals
Stress/distress
Coping and adaption

ABSTRACT

Objective: Breaking bad news (BBN) is a significant source of stress for doctors. In this study we qualitatively explored doctors' perceptions of their BBN experiences, to identify the range of appraisal and coping processes associated with this task.
Methods: Individual semi-structured interviews were conducted with 28 junior and senior doctors.
Results: Doctors recalled physical and emotional stress symptoms during the BBN task, although they tended not to describe it as a 'stressful' experience. Senior doctors appeared to engage in more problem-focused and meaning-focused coping strategies than junior doctors, and this may have been due to their greater experience and control over patient selection and work structures.
Conclusions: This study provides insight into the range of different coping responses experienced by doctors in relation to the task of breaking bad medical news.
Practice implications: The results reinforce and refine the imperative for further training to address the impact of BBN from the doctor's perspective if performance of this critical task is to be improved.
Crown Copyright © 2012 Published by Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Breaking bad news (BBN) is a core component of medicine, and the often comes early in a doctor's training [1–3]. The current literature highlights many doctors view BBN with apprehension, fear, and anxiety [4–6] and have difficulty separating their own emotions from the situation [7]. Work by Oken [8] postulated early traumatic BBN experiences can result in the adoption of a rigid template for approaching this task, and this inflexible responding may contribute to later stressful encounters, thereby possibly increasing the experience of chronic stress, burnout, and low work-performance [9,10].

Much of the research investigating BBN stress is limited to examining whether doctors find the task stressful [11–13]. The Transactional Model of Stress and Coping (TMSC) [14], which has previously been used to characterise doctors' stress responses to BBN, postulates that a person's experience of stress is largely cognitive in nature. That is, what is appraised as stressful for one person may not be stressful for another [15]. More recently, the TMSC has been revised to include the positive emotions sometimes associated with coping [16,17]. This conceptualisation highlights the role of meaning-focused coping in helping to restore coping resources and motivation, enabling individuals to better sustain problem-focused coping over time [16]. However, the potential impact of this coping strategy has not previously been explored in the context of BBN.

In the revised TMSC model, cognitive and behavioural strategies used to manage stressful situations are described as those which: (i) alter the event causing the distress (i.e. problem-focused coping, PFC); or (ii) regulate negative emotional responses (i.e. emotion-focused coping, EFC) [18]. The model further postulates that if coping strategies fail to resolve a stressful situation, the need to try again will likely result in a shift in cognitive appraisal. Such shifts are aimed at finding meaning (MFC) in a stressful situation; for example revising task goals or positively reappraising the event. Finding meaning has further been conceptualised as a general search for meaning in negative situations (i.e. benefit-finding) or as an intentional effort to identify positive aspects within experience (i.e. benefit-reminding) [19,20].

Adapting the TMSC model to the clinical setting, theoretically, doctors should try to manage BBN situations by attempting to alter the BBN situation and/or regulate their emotional response during the task [21], and we will examine the premise in this study. We will further examine the role of positive emotion in doctors' experience of BBN, as the revised model posits the co-occurrence of positive and negative emotions in response to stressful situations.

Importantly, it is well known that *task performance* decreases in highly stressful work situations, due in part to a narrowing of perceptual focus [22]. This change in focus occurs when individuals shift their attention towards a more internal self-focus, designed to

* Corresponding author at: Surgical Outcomes Research Centre (SOuRCe), Royal Prince Alfred Hospital, Sydney, NSW 2050, Australia. Tel.: +61 2 95153464; fax: +61 2 95153222.
E-mail address: joanne.shaw@sydney.edu.au (J.M. Shaw).

0738-3991/$ – see front matter. Crown Copyright © 2012 Published by Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.pec.2012.11.006

reduce their experience of negative emotions [22–24]. Thus, from the perspective of BBN, doctors who find the interaction very stressful will more likely concentrate on strategies aimed at reducing their own discomfort, and less on the delivery of the news and patient cues, to the potential detriment of patients.

This problem has previously been discussed in the literature [25], but few studies have empirically examined the effects of BBN on doctors. Thus, in this study, we explored the way in which doctors respond and cope with BBN, using individual qualitative interviews; and using the revised TMSC model as a framework to explore responses. The aims of the study were therefore to investigate: (1) doctors' experiences of BBN, (2) how they responded, physically and emotionally, and (3) how they managed BBN situations.

2. Method

2.1. Study design

Twenty-eight doctors participated in semi-structured interviews to explore their perceptions of BBN and identify strategies used to manage the perceived stress associated with the task. The interview schedule included questions about BBN generally, as well as personally significant BBN encounter(s). Interviews were audio-taped and transcribed verbatim. The mean interview length was 37 min (range: 13–60 min). Recruitment of the doctors continued to the point of theoretical saturation. The study was approved by the NSCCAHS Human Research Ethics Committee.

2.2. Participants

Purposeful sampling was used to ensure that "Junior Medical Officers" (JMOs) – interns and residents; and "Senior Medical Officers" (SMOs) – registrars and staff specialists/consultants were recruited. One author (SD) approached department heads with a request to advise their staff about the study. Interested SMOs were then approached directly regarding their participation (JS); whereas JMOs were recruited via a single announcement at two JMO training sessions. Participants were recruited from a range of disciplines (e.g. medical & radiation oncology, dermatology, surgery, psychiatry, emergency medicine, cardiology).

2.3. Measures

Demographic information such as age, sex, general medical practice characteristics, including specialty, years of practice, position, BBN experience (i.e. estimated frequency), and training in BBN and communication skills, were collected to determine sample characteristics. Participants were also asked to rate perceived stress caused by BBN on a five point Likert scale (from not at all stressful to extremely stressful). Simple between-groups comparisons were conducted to identify potential differences between junior and senior doctors with respect to their perceived stress levels and BBN experience.

A semi-structured interview schedule was developed in accordance with the BBN and stress and coping literatures. Open-ended questions explored: (i) whether the doctors found the BBN task stressful and what strategies they used to deal with the potentially stressful situations, during and after the task; (ii) the emotional impact of the recalled BBN experience(s), during and after the task; and (iii) whether the recalled BBN event(s) led to changes in their later work behaviour.

2.4. Data collection and analysis

Comprehensive categorisation and coding of the interview data was carried out, using a phenomenographic approach [26–28]. This approach was chosen as it: (i) provides a theoretical framework to explore variations in doctors' interpretation BBN experiences, and (ii) is consistent with the TMSC model approach. Coding procedures were consistent with Strauss and Corbin's open, axial, and selective coding principles [29]. Initial coding of the data was conducted by the lead researcher (JS), with assessments of the coding strategies confirmed by others (SD & RB). All inconsistent findings were discussed until consensus was reached. Both similarities and contrasting views were considered [30] to highlight differences in doctors' conceptualisations of the task.

Coded data was analysed to identify overarching themes, subthemes and possible inter-relationships. Participant narratives provided rich illustrations of the main issues relating to BBN, and reflections, conveyed in doctor's own words, served to increase the face validity of the study [31].

3. Results

3.1. Demographic characteristics

Doctors' age, sex, and general medical practice characteristics are listed in Table 1.

Approximately equal numbers of JMOs ($n = 13$) and SMOs ($n = 15$) were interviewed. In this study, BBN was defined as any discussion involving unfavourable medical information with patients and their families about: diagnosis, illness recurrence, disease progression or treatment failure. This broad definition of BBN was used to capture a range of different BBN experiences. Twenty-six (93%) doctors indicated they had given bad-news in the past month. Frequency of BBN was higher among SMOs, with 75% indicating they had given bad-news five or more times in the past month, relative to 13% of JMOs. Most (93%) doctors had undertaken prior communication skills training: 57% ($n = 16$) had attended training in the past 2-years, whereas 36% ($n = 10$) had received training more than 3 years ago. Slightly fewer doctors (82%) reported having undertaken specific BBN training.

3.2. Doctors' BBN experiences

Doctors' narrative accounts of their past BBN interactions, and general perceptions of BBN identified two main themes: (1) doctors' perceptions and experience of BBN stress and (2) the strategies used to manage BBN stress. The first theme explored in detail how doctors contextualised the impact of BBN on their thinking and emotions. The second theme identified the strategies used to manage the personal impact of BBN, in terms of PFC, EFC and MFC responses.

Table 1
Participant demographics.

	JMOs ($n = 13$)	SMOs ($n = 15$)
Age	28.23 ± 6.24 years	37.93 ± 7.22 years
Gender (male:female)	7:6	5:10
Medical Experience (mean, sd)	1.4 ± 0.8 years	14.16 ± 7.38 years
BBN frequency in the last month		
Nil		
Less than 5 times	3	5
5–10 times	9	4
10–20 times	1	4
More than 20 times		2
Communication skills training		
No formal training	0	2
Training in the last 2 years	8	8
Training, but more than 3 years ago	5	5
BBN training		
Yes	12	11
No	1	4

Download English Version:

https://daneshyari.com/en/article/6152422

Download Persian Version:

https://daneshyari.com/article/6152422

Daneshyari.com