



Communication Study

The power of clinicians' affective communication: How reassurance about non-abandonment can reduce patients' physiological arousal and increase information recall in bad news consultations. An experimental study using analogue patients



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ABSTRACT

Objective: The diagnosis of incurable cancer may evoke physiological arousal in patients. Physiological arousal can negatively impact patients' recall of information provided in the medical consultation. We aim to investigate whether clinicians' affective communication during a bad news consultation will decrease patients' physiological arousal and will improve recall.

Methods: Healthy women ($N = 50$), acting as analogue patients, were randomly assigned to watch one out of the two versions of a scripted video-vignette of a bad news consultation in which clinician's communication differed: standard vs. affective communication. Participants' skin conductance levels were obtained during video-watching, and afterwards their recall was assessed.

Results: While the diagnosis increased skin conductance levels in all analogue patients, skin conductance levels during the remainder of the consultation decreased more in the affective communication condition than in the standard condition. Analogue patients' recall was significantly higher in the affective condition.

Conclusion: Breaking bad news evokes physiological arousal. Affective communication can decrease this evoked physiological arousal and might be partly responsible for analogue patients' enhanced information recall.

Practice implications: Although our findings need to be translated to clinical patients, they suggest that clinicians need to deal with patients' emotions before providing additional medical information.

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1. Introduction

The devastating diagnosis of incurable cancer has a major effect on patients' well-being [1], and drastically alters patients' perspective on the future [2]. Patients have to cope with a life limiting illness and many decisions are to be made [3–5]. The

impact of a bad news consultation is evident and patients often report strong emotions, such as anxiety [6,7] and depressive feelings [7,8]. However, emotional arousal might not be limited to self-reported psychological arousal. There is growing evidence that the body reacts to mental stress as well [9–14]. Stress, negative thoughts and emotions, as for example evoked by the diagnosis of incurable cancer, may activate the sympathetic nervous system (SNS) [15–18]. As a subsystem of the autonomic nervous system, the SNS controls visceral functions and operates mostly unconsciously. Activation of the SNS leads to the so-called *fight-flight response*, which increases physiological arousal and prepares the body for action [18,19]. Physiological arousal is an important underlying component in emotional experiences [15,16] and is expected to influence memory of provided information [18].

Indeed, patients' recall of medical information is problematic: on average patients forget about 40 to 80% of the provided information [5,20–23]. Previous research reported that only 49 to

Abbreviations: AP, analogue patient; SCL, skin conductance level; SNS, sympathetic nervous system.

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83% of newly diagnosed cancer patients were able to recall provided information about the proposed treatment correctly [21]. In older cancer patients, recall is even worse; only 21.9% of recommendations nurses made in a consultation about chemotherapy were remembered [5]. The emotional arousal, evoked by the bad news, might be responsible for the poor information recall during medical consultations [5]. Emotional arousal promotes focussing of attention on the source of arousal (*attentional narrowing*), thereby reducing processing of more peripheral details. As a result, memory for information that is directly connected to the emotional event (central information) will be better than memory for more peripheral information [18,24]. In case of bad news consultations this might imply that information about diagnosis and prognosis (central information) is better remembered than, for example, information about treatment options, side effects and implications for the patient (more peripheral information compared to the diagnosis and prognosis). However, to deal with the difficult decisions associated with an incurable cancer diagnosis, knowledge about the remaining palliative treatment options and their side effects is essential [3,25]. Patients mainly rely on the information provided by their clinician to make such treatment decisions [26].

Addressing patients' emotional arousal in clinical communication, for example by means of affective communication, might be a promising starting point to both lower physiological arousal and improve patients' information recall. Clinicians' affective communication consists of several components including empathy, reassurance and support [27] and proved to reduce (analogue) patients' self-reported anxiety [6,7,28–30]. Adler hypothesised that affective communication has the potential to lower physiological arousal [31]. Evidence from psychophysiological research on social interactions indeed points in this direction. Affective communication creates an atmosphere of positive affect, social support and trust [32], which in turn seems capable of decreasing stress-induced physiological arousal [33–37]. Due to its expected potential to reduce physiological arousal, affective communication might be particularly suitable to improve patients' recall of provided information. Besides, a recent study from our group showed that clinician's affective communication can reduce (analogue) patients' anxiety and improves their information recall [38].

This study aims to test in an experimental design whether clinicians can lower (analogue) patients' physiological arousal and improve their recall of provided information in a bad news consultation by means of affective communication.

2. Methods

2.1. Design

This study has a randomised experimental design using two versions of scripted, role-played video-vignettes of a bad news consultation. These versions only differed in clinician's communication: affective communication vs. standard communication. Participants acted as analogue patients (APs), i.e. they watched one of the two videos and were asked to identify with the patient in the video.

2.1.1. Analogue patient paradigm

Following previous studies [6,28,29], the AP approach was chosen because for obvious ethical reasons it is not possible to manipulate clinicians' communication in real clinical bad news consultations. The validity of this methodology has been supported by indirect evidence for the existence of a mirror-neurons system in humans; observing other peoples' emotions, for example in videos, leads to similar activation patterns in the brain as

experiencing the observed emotion [39,40]. A recent systematic review of our research group concluded that the use of scripted video-vignettes including APs is indeed a valid approach [41]. The validity of psychophysiological measurements in this methodology is confirmed in an empirical study, which showed that APs had similar psychophysiological responses when participating in a videotaped medical consultation, as while watching that same consultation [42]. Most studies in clinical communication research use a correlational design, preventing causality analysis. Besides, physiological responses are seldom examined as an objective measure of patients' emotional arousal [43,44]. Using an experimental design allowed us to assess causality and conduct physiological measurements.

2.1.2. Videos

This study was part of a larger project for which different scripted video-vignettes of a consultation were developed, addressing the transition from curative to palliative care. In this consultation, a middle-aged white oncologist discloses an incurable breast cancer diagnosis to a middle-aged female patient, who is accompanied by her husband. Subsequently, prognosis, treatment options, and implications for the patient (e.g. side effects, and day to day routine during treatment) are discussed. To facilitate the identification of the APs with the video-patient, the consultation was preceded by a *priming* scene in which the video-patient introduces herself and expresses her feelings towards the upcoming consult. The scripts for the vignettes were based on a previous qualitative study [45]. A detailed description of the process of creating and validating the (role-played) vignettes is provided elsewhere [46].

For this study, the existing vignettes were supplemented with an extra segment in which the treatment was discussed in detail. This segment was analysed by an expert panel (oncologist and a communication expert) to ensure its internal and external validity. Two videos were constructed (standard communication: 579 s vs. affective communication: 617 s). No so called 'filler communication' was used to compensate for the difference in length between videos. Real clinical consultations with more or less affective communication also differ in length and 'filler communication' might not be neutral and unintentionally influence APs' reaction to the video [46]. APs were randomly allocated to watch one of the two videos. The first part of the video (including the delivery of the bad news itself) was identical in both conditions. In the second part, clinician's communication was manipulated. Clinician's communication included empathic remarks in the affective condition, whereas these remarks were absent the standard condition (see Table 1). Clinical empathy is not limited to understanding a patient's feelings, communicating and acting upon this understanding are as important [47]. Therefore the inserted remarks not only convey empathy and clinician's affect, they specifically focus on reassurance (communicating) and ongoing support (acting). Non-verbal communication was not explicitly manipulated in this study; non-verbal communication supported verbal communication in all vignettes.

Table 1

Overview of the empathic remarks that were added to the script in the affective communication condition. These remarks were absent in the standard communication condition.

- "But whatever action we do take, and however that develops, we will continue to take good care of you. We will be with you all the way."
- "We will do and will continue to do our very best for you"
- "And whatever happens, we will never let you down. You are not facing this on your own."
- "I completely understand your reluctance. We'll look at this decision together carefully and we'll pay attention to your concerns."

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