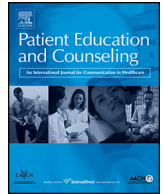




Contents lists available at ScienceDirect

Patient Education and Counseling

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



How can we explain physician accuracy in assessing patient distress? A multilevel analysis in patients with advanced cancer

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ARTICLE INFO

Article history:

Received 8 July 2013

Received in revised form 15 October 2013

Accepted 30 October 2013

Keywords:

Physician empathic accuracy

Oncology

Patient distress

Rapport

Expressive suppression

ABSTRACT

Objective: To examine the determinants of the accuracy with which physicians assess metastatic cancer patient distress, also referred to as their empathic accuracy (EA). Hypothesized determinants were physician empathic attitude, self-efficacy in empathic skills, physician-perceived rapport with the patient, patient distress and patient expressive suppression.

Methods: Twenty-eight physicians assessed their patients' distress level on the distress thermometer, while patients ($N = 201$) independently rated their distress level on the same tool. EA was the difference between both scores in absolute value. Hypothesized determinants were assessed using self-reported questionnaires. Multilevel analyses were carried out.

Results: Little of the variance in EA was explained by physician variables. EA was higher with higher levels of patient distress. Physician-perceived quality of rapport was positively associated with EA. However, for highly distressed patients, good rapport was associated with lower EA. Patient expressive suppression was also related to lower EA.

Conclusion: This study adds to the understanding of EA in oncological settings, particularly in challenging the common assumption that EA depends largely on physician characteristics or that better rapport would always favor higher EA.

Practice implications: Physicians should ask patients for feedback regarding their emotions. In parallel, patients should be prompted to express their concerns.

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1. Introduction

Due to its high prevalence in cancer patients, from 22 to 58% [1], and particularly in metastatic cases [2–4], emotional distress has been endorsed as the 6th Vital Sign by the International Psycho-Oncology Society (IPOS) [5]. Routine distress screening has been strongly recommended to identify cancer patients who may need

psychological or social interventions. However, systematic distress screening with validated tools is still rare [6]. Oncologists in particular may not consider distress screening an essential part of their job [7] and prefer to rely on their own clinical skills rather than using validated questionnaires [8]. Therefore, along with a continuous effort to implement routine screening, it is essential that oncologists infer patient distress accurately *by themselves* in order to make the necessary referrals. Besides, this ability to detect the emotions and cognitions of others accurately, also called empathic accuracy (EA) [9], has positive effects for patients, such as treatment adherence and appointment-keeping [10,11]. Unfortunately, it seems that physicians do not perceive cancer patient distress accurately [12,13]. To understand this phenomenon, we

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set out to investigate the correlates of physician EA on metastatic cancer patient distress. In fact, factors of EA have rarely been studied in a clinical setting, especially in oncology [10].

The theoretical framework of Norfolk et al. [14] guided our analyses. It was originally proposed in general practice and has been used successfully for the design and validation of physician training to develop rapport with patients [15].

In this model, the physician's empathic attitude, i.e. their willingness to understand and give room to a patient's emotions and feelings [16], is the starting point for the physician to detect patient cues concerning their thoughts and feelings. This empathic skill should lead to an accurate representation of the patient's state [17].

The model also specifies the importance of patient or physician-patient relationship variables. An important variable when applying this general model to our purpose is the patient's distress level. Indeed, a study of advanced cancer patients suggested that higher patient distress is more frequently detected and addressed by oncologists [18], probably because it is more visible than moderate distress. Therefore, we expected EA to increase with patient distress. However, this link could be moderated by two variables in Norfolk's model.

The first one is patient expressive suppression, i.e. the inhibition of ongoing emotion-expressive behavior [19]. Previous experimental research supports the importance of a person's verbal and non-verbal disclosure in allowing a 'perceiver' to detect his/her emotions [20–23]. This should be true in a naturalistic clinical setting. Therefore, patient expressive suppression should be a barrier to physician EA, particularly in the case of high distress where the gap between a patient's actual and visible state can be large.

The second potential moderator is rapport. Defined as the connection between patient and physician and their mutual commitment to the relationship, rapport is essential for effective clinical communication [24]. Without it, patients would not feel at ease in expressing their emotions and/or physicians would pay less attention to patient cues. Consequently, poor rapport is expected to relate to lower EA, particularly again in the case of high patient distress where the EA gap can become huge.

To summarize, following the model of Norfolk et al. [14], the hypothesized correlates of EA were physician empathic positive attitude, higher self-efficacy in empathic skills, as well as lower patient expressive suppression and physician perception of low rapport as moderators of the link between patient distress and EA.

2. Methods

2.1. Inclusion criteria

Inclusion criteria for physicians were working in a cancer ward or in a palliative care unit and treating patients meeting the following inclusion criteria: age over 18 years, metastatic cancer from and beyond the 4th line of chemotherapy for primary breast cancer, and from and beyond the 2nd line of chemotherapy for any other type of primary cancer. Second and 4th lines of chemotherapy were chosen to reach patients likely to have symptoms of their disease, often associated with distress. Patients had to have already consulted the physician at least 3 times before their inclusion, so that they had a minimum knowledge of each other. Non-inclusion criteria were psychiatric comorbidities and hematological cancers, deemed too specific compared to other cancers.

2.2. Procedure

Physicians at the 'Institut Curie' (Paris), the 'Institut de Cancérologie de l'Ouest' (Nantes), 'Hôpital Nord Laennec'

(Nantes) and at the 'Polyclinique Bordeaux Nord Aquitaine' (Bordeaux) were invited to participate in the study. They were given a detailed description of the study and a written informed consent to sign.

Upon acceptance, they completed a questionnaire assessing their empathic attitude and self-efficacy in empathic skills. They then had to include 10 consecutive patients meeting the inclusion criteria. At the end of a consultation with the physician, patients were briefly introduced to the study by the physician and given a detailed written study description, the questionnaires and a written informed consent. If patients agreed to participate, they signed the informed consent and had one week to complete the questionnaires and return them to the research team in the prepaid envelope provided. When data were missing, participants were contacted by phone by the research assistant and asked to provide the missing information. On the same day of each inclusion, physicians had to fill in a short questionnaire assessing their perception of the patient (i.e. an empathic accuracy task, see Section 2).

The study protocol was approved by the institutional review board of the Curie Institute and by the French national advisory committee for the processing of information in health research. All patient and physician data were anonymous.

2.3. Samples

Data collection was carried out from May 2011 to March 2012.

Following the usual recommendations of sample size for multilevel designs such as this one [25], our goal was to obtain a sample of 50 physicians, each with a minimum of 5 patients, ideally 10.

Sixty-four physicians were invited to participate. Among them, 11 physicians had no eligible patients, 14 refused to participate and 11 accepted, but eventually 9 of these did not include any patients because of lack of time and 2 because they found it too difficult to suggest this study to metastatic cancer patients. So, the final physician sample was composed of 28 clinicians, mostly medical oncologists (see Table 1).

Two-hundred-and-one patients were included. The number of patient refusals and whether they differ from the others are unknown. Most participants were female and lived with someone, their mean age was 62 years and the primary cancer sites were breast, colorectal and lung cancers (Table 1).

2.4. Measures

Physician empathic attitude was measured using the Jefferson Scale of Physician Empathy (JSPE), a 20-item 7-point Likert response scale. It provides physician self-evaluation (e.g. 'An important component of the relationship with my patients is my understanding of the emotional status of the patients and their families') and a global score ranging from 20 to 140 [26]. Its psychometric properties have been verified in numerous studies [26,27]. In our sample, Cronbach's alpha was 0.69 for the overall scale.

Physician self-efficacy in empathic skills was assessed by a single self-reported 7-point Likert ad-hoc item: 'In general, I feel competent to detect my patients' emotional distress and needs' rated from 0 'strongly disagree' to 7 'strongly agree'.

Rapport was assessed by a single 7-point Likert ad-hoc item assessing physician-perceived quality of rapport with a patient: 'What is the quality of your relationship with this patient?' rated from 1 'very difficult relationship' to 7 'very easy relationship'.

Patient emotional distress was evaluated with the distress thermometer [28], the widely used screening visual analog scale (i.e. without anchors), which ranges from 'no distress' at the

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