



Medical education

Breaking bad news: Patients' preferences and health locus of control

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ABSTRACT

Objective: To identify patients' preferences for models of communicating bad news and to explore how such preferences, and the reasons for the preferences, relate with personality characteristics, specifically patients' health locus of control (HLC): internal/external and 'powerful others' (PO).

Methods: Seventy-two patients from an oncology clinic watched videotaped scenarios of a breaking bad news moment, selected the model they preferred, filled an HLC scale and were interviewed about their choices. Data were analyzed with Chi-square, Kruskal–Wallis and Mann–Whitney tests. Interviews were content-analyzed.

Results: 77.8% preferred an "empathic professional", 12.5% a "distanced expert" and 9.7% an "emotionally burdened expert". Preferences varied significantly with HLC scores (patients with higher internal locus of control (ILC) and lower PO preferred the empathic model), presence of cancer, age and education. Patients explained their preferences through aspects of Caring, Professionalism, Wording, Time and Hope. ILC registered significant differences in regards to Wording and Time, whereas PO was associated with Hope and Time.

Conclusions: HLC is an important dimension that can help doctors to better know their patients.

Practice implications: Knowing whether patients attribute their health to their own behaviors or to chance/others can help tailor the disclosure of bad news to their specific preferences.

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1. Introduction

Bad news is "any information likely to alter drastically a patient's view of his or her future" [1]. The concern about breaking bad news (BBN) is justified by the strong impact it can produce in both patients and health professionals. Research shows that clinicians who feel insufficiently trained in communication skills have significantly higher distress levels when faced with patients' suffering [2]. An optimal delivery of bad news is, in turn, associated with increased patient satisfaction [3] and adjustment to cancer [3–5].

The growing interest in this area has led to the publication of guidelines intended to help clinicians with this critical task [6,7]. However, a systematic review on the degree of evidence of these guidelines revealed that only 55.5% of the 245 relevant publications provided new data and only 1.6% were rigorous intervention studies addressing psychosocial outcomes for patients [8]. Additionally, while the proposed guidelines provide

important directions for BBN and attempt to take patients' individual circumstances and desires into consideration, little research has focused on how aspects of patients' personality affect their preferences for receiving bad news. Yet, personality may play a crucial role in patients' perspectives on health, illness and medical interactions. This is particularly salient in bad news delivery situations when doctors do not know their patients well. In this case, doctors gather episodic information during brief encounters with patients about their reported wishes on how the situation could be handled. However, personality can be more general and pervasive than expectations stated at that moment about the doctor's role for that particular encounter. It may influence patients' fundamental views on what they expect from their doctors (e.g., more authority, more protection, more detachment, more empathy), particularly in bad news situations.

Studies addressing patients' preferences about BBN subdivide the areas examined in three components: content (physician's expertise and aspects of the content of the conversation), support (comfort and emotional support provided) and facilitation (setting and context aspects) [9]. Although the need for emotional support and the setting were highly rated, content received the highest rating from patients [9–14]. Patients combined the effect of content and support multiplicatively, such that high quality of

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information could not fully compensate for low supportiveness, and high supportiveness could not fully compensate for low quality of information [12].

Research has also addressed typical ways of breaking bad news. Brewin, for example, described three prototypes: the “blunt and unfeeling” professional, the “kind and sad” clinician, and the “understanding and positive” caregiver [15]. In a study about perspectives on BBN using these prototypes, participants (healthy women) perceived the “understanding and positive” professional as most emotional, least dominant, most appropriate when conveying information, most available and most expressive of hope; they showed more satisfaction and less increase in negative emotions than participants who watched videos showing the other two models [16]. A different study with cancer patients identified six subcategories of clinicians: “the inexperienced messenger”, lacking experience and knowledge of the medical, psychological or social situation of the patient; “the emotionally burdened expert”, lacking the ability to cope with his or her personal feelings despite being very kind; “the rough and ready expert”, providing information in a short and hard way, without regard for emotions and for patients’ knowledge about the disease; “the benevolent but tactless expert”, showing sympathy but lacking empathy; “the distanced expert”, communicating objectively, avoiding deeper contact with patients and lacking emotional competence; and “the empathic professional”, addressing both physical and psychological concerns, understanding and accepting patient’s feelings [17].

Although research has identified typical ways of breaking bad news, which physician’s model is preferred by cancer patients remains to be determined, as well as the understanding of important personality variables that may influence these preferences. Previous studies have shown an association between preferences and socio-demographic variables: younger, female and more educated patients tend more toward receiving as much detailed information as possible and appreciate facilitation aspects; and women value emotional support and facilitation more than men [9,14,18–20]. Concerning psychological dimensions, patients with a fighting spirit and higher anxiety levels place greater importance on all three aspects of the communication than their lower anxiety and fighting-spirit counterparts [20]. In addition, patients with higher levels of psychological distress value emotional support more [20]. Some medical factors (related to the disease and previous experiences) may also influence patients’ preferences: patients whose primary treatment had a curative intent placed content and facilitation higher [20]; those who were unhappy with their BBN consultation or had received bad news more frequently rated support and facilitation higher [11].

These results highlight important aspects that influence patients’ preferences about receiving bad news. However, other dimensions of individuals’ psychological functioning may also play a role in their expectations regarding health and caretakers. For example, patients who expect doctors to take care of all problems related to their health may differ from patients who tend to view their own attitudes and actions as important for their health outcomes. These features are captured in the concept of locus of control (LC). The multidimensional health LC refers to individuals’ perceived control over their own health as internal (believing that it is determined by their own behavior), related to chance (dependent upon outside factors, such as chance or destiny) or dependent on powerful others (like health professionals) [21].

The health locus of control (HLC) has been associated with health-related behaviors. Patients with a high score on the chance dimension engage in less health-promoting behaviors [22], while those scoring high on the internal dimension use more complementary medicines [23]. The HLC has also been associated with

health outcomes [24–26]. Internal locus of control (ILC) was associated with reduced risk of fair or poor self-rated health, of psychological distress, and also of obesity, overweight and, among women, of high blood pressure [27]. The dimension of powerful others (PO) correlated positively with waist-to-hip ratio and body fat content in men [24]. Levels of medical information needs (and information-seeking behavior) tend to be lower in patients with higher scores on the chance dimension [22] and on PO [28]. In addition, PO was positively related with trust in the physician [29]. Finally, ILC showed a positive relationship with levels of hope facing a cancer diagnosis, while the chance locus registered a negative relation [30].

The important contribution of LC to health has thus been established. However, the possible relation between HLC and patients’ preferences about BBN has not been studied. Yet, if it influences patients’ attitudes and preferences regarding health in general, it is likely to be particularly relevant in the specific case of bad news. Increased knowledge in this domain will contribute to the formulation of evidence-based guidelines and help tailor the delivery of bad news to patients’ needs and preferences. To these ends, this study aims to (i) identify patients’ preferences for styles of physician–patient interaction during the delivery of bad news, (ii) explore patients’ reasons for their preferences, and (iii) examine how such preferences relate with personality characteristics, specifically patients’ LC.

2. Methods

2.1. Procedure

This study consists of exposing patients of an oncology clinic to videos depicting different BBN models and querying them on their preferences and LC. To experimentally manipulate bad news or to interview patients immediately after they receive bad news raises ethical and methodological questions [31]. Showing videos depicting situations of bad news delivery to cancer patients is a viable way to overcome these issues and has been used in previous research on this topic [32]. Videos have the advantage of going beyond each patient’s experience to include several alternatives for comparison. They ensure exposure to the same situations without risking intra-scenario variation from patient to patient, and they are ready for use at participants’ convenience.

As another way to overcome those ethical and methodological concerns, this study included patients who received a cancer diagnosis already in the past and patients who were previously informed by their physicians that they might have cancer and who received the result of their fine-needle aspiration (FNA) biopsy immediately before this study, with a benign diagnosis. This procedure, while preventing the inclusion of patients whose experiences are distant from the reality of bad news situations, allows for the possibility to distinguish between cancer patients and healthy subjects. Thus, participants were randomly selected from appointment records among patients diagnosed with differentiated thyroid cancer in the past three years, or submitted to a thyroid nodule’s FNA biopsy in the previous months (for suspicion of malignancy, with a benign result). Focusing on thyroid cancer patients, this study assesses an often neglected population in research. The various studies on doctor–patient communication typically deal with other types of cancers. As differentiated thyroid cancer is usually associated with a better prognosis, its study provides useful information for comparison with previously studied malignancies with worse courses.

The study was approved by the local ethics committee. Patients were approached to participate in the study after their clinic appointments. The study began immediately with those who gave their informed consent.

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