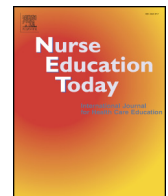




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Factors influencing the development of end-of-life communication skills: A focus group study of nursing and medical students☆

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SUMMARY

Background: Poor communication between health care professionals and dying patients and their families results in complaints about end-of-life care. End-of-life communication skills should be a core part of nursing and medical education but research suggests that qualified doctors and nurses find this a challenging area of practice.

Aims: The aim of this study was to explore factors influencing the development of end-of-life communication skills by nursing and medical students.

Design: A qualitative study comprising five focus groups.

Participants: Second year undergraduate nursing (n = 9 across 2 focus groups) and fourth year undergraduate medical students (n = 10 across 3 focus groups) from a London University.

Findings: Barriers and facilitators influenced nursing and medical students' experience of communication with dying patients and their families in clinical practice. Extrinsic barriers included gatekeeping by qualified staff and lack of opportunity to make sense of experiences through discussion. Intrinsic barriers included not knowing what to say, dealing with emotional responses, wasting patients' time, and concerns about their own ability to cope with distressing experiences. Facilitating factors included good role models, previous experience, and classroom input.

Conclusion: In addition to clinical placements, formal opportunities for reflective discussion are necessary to facilitate the development of students' confidence and skills in end-of-life communication. For students and mentors to view end-of-life communication as a legitimate part of their learning it needs to be specified written practice-learning outcome. Mentors and supervisors may require training to enable them to facilitate students to develop end-of-life communication skills.

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Introduction

Health care professionals who fail to acknowledge emotions aroused during conversations about end-of-life issues can leave patients and their families feeling unsupported (Krishnasamy, 1996; Shapiro, 2011). Poor communication is often the cause of complaints about United Kingdom (UK) National Health Service (NHS) end-of-life care (Parliamentary and Health Service Ombudsman, 2015). The Leadership Alliance for the Care of Dying People (2014, p. 19) highlighted 'sensitive communication' as a priority for end-of-life care arguing that 'all staff [...] must have the skills to do this effectively and

compassionately' (p. 32). In the UK the General Medical Council (2015) and the Nursing and Midwifery Council (2009) are responsible for setting standards for nursing and medical education and both require practitioners to be competent in end-of-life communication. Research suggests that students find the emotional aspects of communication challenging (Kruijver et al., 2001; Shapiro, 2011).

The stimulus for this study was students' concerns about end-of-life communication particularly knowing 'the right thing to say' and dealing with strong emotions. The undergraduate nursing and medical programmes included end-of-life issues and sessions on clinical communication but no classroom sessions gave students an opportunity to practise skills necessary for effective communication with dying people. Bell et al. (2009) maintain that the most successful way for students to develop clinical skills is through contact with real patients and therefore, arguably, the best way for students to develop end-of-life communication skills would be through interaction with dying patients and their relatives during clinical placements.

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Method

Aim

The aim of this study was to explore factors influencing the development of end-of-life communication skills by nursing and medical students.

Design

Single discipline focus groups with nursing or medical students explored whether they raised similar issues about end-of-life communication that might support an interprofessional educational intervention. Homogenous focus groups potentially give participants more confidence if they are comfortable sharing information with their peers (Mansell et al., 2004; Barbour, 2005). Choosing focus groups rather than individual interviews may decrease power disparity between researchers and the students taking part (Barbour, 2005). Student focus groups gave students the opportunity to evaluate existing end-of-life provision and contribute to programme development (Webb and Kevern, 2001).

Sampling and Participants

Participants were recruited from a population of second year undergraduate nursing students ($n = 180$) and fourth year undergraduate medical students ($n = 450$). By this stage in the course all students had experienced clinical practice but the amount of contact with dying patients and their families varied according to their clinical placements. Students received information about the project during main hall lectures and via the university intranet. Interested students completed a reply form that they left in a drop box.

Allocation to focus groups was on a first come, first served basis with the objective of having 4 to 6 participants in each group. The advantage of smaller numbers in focus groups is that each participant can have a voice (Wibeck et al., 2007). Students were free to drop out without explanation and there were fewer participants in some groups than anticipated. To achieve broadly even representation of nursing and medical students, five focus groups were conducted, two with nursing students ($n = 9$) and three with medical students ($n = 10$).

Ethical Considerations

The University ethics committee granted approval for this study. Participants could withdraw from the study at any time but, due to the interactive nature of focus groups, could not have their contribution up to that point deleted. None of the researchers had pastoral or academic responsibility for students involved in the study. Participants agreed not to reveal the content discussed to people outside the focus group but could come back to the moderators to talk about further issues. Assurances were given that direct quotations used in publications would be anonymous.

Data Collection

Five focus groups took place in university classrooms with lunch provided for participants. An experienced moderator facilitated the discussion (author KG) and a second researcher took field notes (author JB). The focus groups lasted between 32 and 64 min and followed a semi-structured topic guide designed to generate discussion about the participants' actual or anticipated experiences of communicating with dying patients and their families during their clinical placements. The focus groups also explored students' perceptions of their end-of-life communication training. The focus group process enabled students to identify and make sense of shared experiences with other members of

the group. Focus groups were audio recorded with participant consent and recordings erased after verbatim transcription.

Data Analysis

Transcription of the five focus groups inevitably yielded a large quantity of data. Focusing the analysis on the aims of the study assisted with the management of the data (Krueger and Casey, 2014). Focus group discussion produces co-constructed data, the analysis did not assume that the findings represent the perceptions of individual participants and effectively the focus group is the unit of analysis (Wibeck et al., 2007). The authors independently undertook an inductive thematic analysis of the data, reading, re-reading, coding, and categorising the data (Braun and Clarke, 2013). The independently generated themes were reviewed by the three authors and final agreement was reached. Comparison of themes across the nursing and medical student groups facilitated the identification of shared and disparate issues.

Findings

Analysis focused on participants' experience of communicating with dying patients and relatives during clinical placements. Two main themes emerged, intrinsic and extrinsic factors affecting students' ability to communicate with dying patients and their relatives [Fig. 1]. The analysis also explored whether the themes identified were common to both nursing and medical students. In the following section, the number relates to the focus group and paragraph. FN and MN denote female and male nursing students respectively and FM and MM denote female and male medical students.

Theme One – Intrinsic Factors Influencing End-of-life Communication

Intrinsic factors included the barriers and facilitators to end-of-life communication that originated from the students themselves.

Intrinsic Facilitators

Self-confidence. Nursing student participants described instances of positive end-of-life communication and were more likely to articulate what they saw their role as:

1/153 FN: That's the thing, I think is just being there, being available basically and not trying to fix things or fix them.

This self-confidence possibly related to nursing students having more clinical experience to draw on.

Relationships with Patients. Both nursing and medical students suggested that nurses have more time to develop relationships with patients:

1/125 MN: we spend so much more time with our patients we can actually build up a relationship.

Previous Experience. Some of the students mentioned experience outside their current education, for example, a medical student mentioned hospice voluntary work and a nursing student described drawing on personal experience from a death in her family.

Intrinsic Barriers

Coping with Emotions. Students voiced concerns about dealing with challenging emotions like fear, sadness, and anger. Alongside worries about dealing with the emotions of dying patients and their relatives, participants expressed concerns about their own emotional responses.

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