Patient Education and Counseling 56 (2005) 72–77

Patient Education and Counseling

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Identifying the concerns of women undergoing chemotherapy

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Received 5 June 2003; received in revised form 12 November 2003; accepted 22 December 2003

Abstract

This cross-sectional study aimed to identify key concerns of cancer patients receiving in-patient chemotherapy, determine the prevalence of anxiety and depression, and assess whether ward nurses could identify patients' concerns. Thirty-three women on a chemotherapy ward in the northwest of England who had breast, ovarian, cervical or uterine cancer were interviewed using a Concerns Checklist and the Hospital Anxiety and Depression Scale. Patients expressed an average of 10.3 concerns (range: 2–27). Eighty percent of these were not identified by the nurses, who showed a clear bias towards physical symptoms and treatment-related concerns. The nurses were unable to identify the three main concerns in 70% of patients. Twenty-four percent of patients were found to be probable cases of anxiety and/or depression; there was a moderate correlation between the number of concerns and levels of anxiety and depression. Given the body of evidence that lack of identification of concerns leads to unmet needs, increased psychological distress, dissatisfaction with care and possible complaints, this study has provided clear evidence for the need to address this key area of care, and has highlighted the potential of the Concerns Checklist in busy clinical environments.

Keywords: Concerns; Cancer; Chemotherapy; Nurses; Communication

1. Introduction

Up to one-third of patients with cancer develop a depressive illness and/or anxiety disorder [1,2]. A strong association has been found between the number and severity of patients' concerns after diagnosis and the later development of anxiety and depression [2]. The number of concerns expressed by patients has also been linked to high levels of emotional distress [3–5]. If nurses are to provide better emotional support for patients, and promote emotional adjustment, then accurate identification of concerns is clearly essential.

The nature and severity of concerns experienced by cancer patients cannot be predicted by disease type, age or gender [4]. So, there is a need to assess patients' concerns individually, particularly as patients have been shown to be highly selective in what they disclose to different health care professionals [6,7]. Disparity in disclosure has been shown across professional groups, e.g. between doctors and nurses [6,8], and, most importantly, between different professionals of the same discipline. In Heaven and Maguire's study, for example, patients were shown to disclose different concerns to different nursing carers, depending on factors including perception of role and time, perception of emotional strength of the nurse and also the nurses' communication skills [7].

The majority of patients' concerns are not usually detected by nursing or medical staff [7–9]. Some studies suggest that as few as 20% of concerns are identified [7] whilst other would put the figure higher [10]. A number of possible reasons for this have been suggested. These include such things as professionals' fear that psychological enquiry will in some way be damaging for the patients and make the situation worse [9,11]; for example, a belief that asking about suicidal ideation may put the idea into a patient's mind, or asking about fear of dying may put the patient in touch with intolerable fears which they have not considered. Professionals also fear that psychological enquiry may result in emotions which the professional will find difficult to handle [9,11], and report other deterrents, for example lack of training in the relevant communication skills [12] and/or a lack of emotional support for staff [11,13].

Chemotherapy is known to be associated with a high physical and psychiatric morbidity [12–14]. However, the extent to which patients undergoing chemotherapy disclose their concerns to their nursing carers has not been studied and

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doi:10.1016/j.pec.2003.12.008

there has been little research into the ability of nurses to identify these concerns. Whilst other research has looked at psychological morbidity during chemotherapy [14], the link between concerns and morbidity at this illness stage has not been established. We, therefore, studied individual concerns of patients receiving chemotherapy as in-patients and determined whether their concerns were identified by ward nurses and recorded in the nursing records. We also determined the prevalence of anxiety and depression and the potential link to levels of concern.

2. Methods

This was a cross-sectional study in which patients' self-report, nurses perception and the written nursing records were compared to determine current concerns.

2.1. Study sample

The study was carried out in a female ward with 18 beds where patients were admitted for in-patient chemotherapy. Ward activities focused on administering chemotherapy infusions that required an overnight stay. The average length of stay was 24 h. Therefore, there was a rapid turnover of patients on the ward and full occupancy was usual. The nursing staff on the ward included nine qualified nurses and two nursing assistants. The nursing system adopted on the ward was the 'named nurse team system'. On admission each patient was allocated a nursing team, under the management of a named nurse. Each team was responsible for a small number of patients with the aim of improving continuity of care and nurse–patient communication [15].

Patients were asked to participate in the study if they were over 18 years old, able to speak and understand English, had a diagnosis of breast, ovarian, cervical or uterine cancer. We did not have the resources available to have our measures translated and translators employed. Ethical approval was obtained.

2.2. Assessment tools

2.2.1. Patients

An interview schedule was designed to elicit patients' views on their concerns, and determine any associated psychological morbidity. The schedule included a short questionnaire collecting demographic details of the patient, the Concerns Checklist [16], the Hospital Anxiety and Depression Scale [17], and questions aiming to elicit which member of nursing staff the patient perceived knew most about their concerns.

The Concerns Checklist was originally devised by Devlen [16] and subsequently has been used in a number of studies with cancer patients at various stages of illness [2,4,7]. It has undergone psychometric testing and has been found to be a valid and reliable method of assessing different dimensions of patients concern in the cancer setting [18]. The checklist is a 14-item questionnaire which can either be self-administered [2,4] or used as a semi-structured way to elicit details of concern [7]. The latter method was used in this study, with the patient's three main concerns being identified following a summary of everything discussed.

2.2.2. Nurses

The nurse responsible for each patient recruited was asked to write a list of the patient's concerns. They were asked to identify all those things they were aware of which were current problems, concerns or worries for the patient. The Concerns Checklist was not used as the study aimed to gain a naturalistic reflection of the nurse's working knowledge and memory of their patients concerns, i.e. what they might communicate to colleagues.

2.2.3. Nursing records

After each patient and nurse had been interviewed, the nursing records were reviewed for evidence of documentation of each concern mentioned either by the patient or by the nurse.

2.3. Procedure

Eligible patients were identified from the chemotherapy nurses' list of admissions and then selected at random. They were given verbal and written information about the study. Those who consented were given the opportunity of being interviewed in a quiet room or the bedside. The patient then completed the questionnaires detailed above. Following this the nurse responsible for their care was asked to complete the short questionnaire about their perceptions of the patient's main concerns, and any other concerns or problems they perceived the patient to have. Finally the nursing records (Kardex) were examined to identify the documentation of patients' concerns.

2.4. Statistical analysis

All quantitative data were entered into the data entry component of SPSS. Descriptive statistics were used to describe the samples. Non-parametric tests, for example Mann–Whitney *U*-tests, were used to compare patients' and nurses' perceptions of concerns. The significance level was set at the conventional 5%.

To compare patients' and nurses' responses, 14 categories of concern were entered into a word processing package and examined independently by two raters to search for common themes and areas of concern within the specified categories. The responses of patients and nurses were cross-tabulated to search for similarities and disparity between patients' expressed concerns and nurses' perceptions of these concerns.