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Comparing Oncologist, Nurse, and Physician Assistant Attitudes Toward Discussions of Negative Emotions with Patients

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Abstract

Purpose—Although research shows that empathic communication improves patient outcomes, physicians often fail to respond empathically to patients. Nurses and physician assistants (PAs) may be able to help fill the need for empathic communication. Our study compares the attitudes of oncologists, nurses, and PAs toward communication with patients who demonstrate negative emotions.

Methods—We analyzed surveys from 48 oncologists, 26 PAs, and 22 nurses who participated in the Studying Communication in Oncologist-Patient Encounters trial. Surveys included previously validated items that examined attitudes toward communication with patients about emotion.

Results—The mean age of oncology physicians was higher (49 years) than that of PAs (40 years) or nurses (43 years), and 19% of physicians, 81% of PAs, and 100% of nurses were female. Race, years of oncology experience, and previous communication training were similar across provider types. Most nurses (82%) and PAs (68%) described themselves as having a

socioemotional orientation, while most oncologists (70%) reported a technological/scientific orientation ($p < .0001$). PAs and nurses indicated more comfort with psychosocial talk than did oncologists ($p < .0001$). Discomfort with disclosing uncertainty and provider confidence and expectations when addressing patient concerns were similar across provider types.

Conclusions—PAs and nurses were more oriented toward socio-emotional aspects of medicine and were more comfortable with psychosocial talk than were oncologists. Future studies should examine whether these differences are attributable to other factors, including gender, and whether nurses and PAs are more likely than physicians to demonstrate empathic behaviors when patients express negative emotions.

INTRODUCTION

Physician assistant (PA) programs are required to provide instruction in effective communication skills.¹ To design programs that uniquely address the educational needs of PA students, it will be useful to understand the attitudes of PAs toward different types of communication required in clinical practice and to learn how the attitudes of PAs compare to those of other practitioner types. This study addresses the following research question: How do oncologists, nurses, and PAs compare in their attitudes toward communication with patients about emotion?

Effective provider communication is a cornerstone of quality care. A large body of research shows that effective communication improves patient adherence, patient satisfaction, and health outcomes.^{2–4} Scholars of health communication typically categorize communication as instrumental or affective. Instrumental behavior comprises the exchange of information necessary to address the medical issue, while affective behavior involves the communication necessary to create and maintain a therapeutic relationship.⁵ Patients value both instrumental and affective communication, but affective communication is more closely related to patient satisfaction.⁶

Ideally, health care providers should respond to patient emotion with empathy. Pollak and colleagues defined empathic responses as those that “directly address patients’ emotions, validate their feelings, and invite further disclosure.”⁷ The willingness and ability of providers to respond appropriately to patient emotion may be especially important in the care of patients with advanced cancer, whose levels of emotion may be particularly acute.⁸ Zachariae et al found that cancer patients experienced less depression and anxiety when providers responded to patients’ emotion with empathic statements.² Unfortunately, other research by Pollak et al suggests that empathic responses by oncologists to expressions of negative emotion are relatively rare. Further, those oncologists who are less likely to use empathic statements than others describe themselves as having a technical/scientific rather than a socio-emotional orientation.⁷

Most of the research on effective communication between health care providers and patients has focused on physician communication. With predicted shortages of oncologists and a growing prevalence of cancer,⁹ it is possible that nonphysician clinicians such as PAs and NPs will be increasingly common in oncology patient care teams. Although little is known about nonphysician clinicians’ attitudes about communicating with patients about emotion, it is possible that using a mix of providers will allow teams to better address the range of patient medical, social, and emotional needs. For example, physicians with a primarily technical/scientific orientation might work best with nonphysicians who have a socioemotional orientation, combining the physician’s instrumental strengths with the nonphysician clinician’s complementary affective strengths. As new models of care are developed in oncology, it is important to know more about how non-physician clinicians

describe their orientation and how their attitudes toward addressing negative emotion compare to those of oncologists.

METHODS

This study analyzes survey data from Phase 3 of the Studying Communication in Oncologist-Patient Encounters (SCOPE) trial, a study conducted in oncology clinics at Duke University Medical Center, the Durham Veterans Affairs Medical Center in Durham, North Carolina, and at the University of Pittsburgh Medical Center in Pittsburgh, Pennsylvania.¹⁰ Forty-eight oncologists were enrolled in this phase of the study. Twelve of these oncologists did not work with any nonphysician providers during our study. Nonphysician clinicians who worked with the remaining 36 oncologists were invited to participate, and 26 PAs and 22 nurses completed the baseline survey. The nurses were comprised of 13 nurse practitioners, one registered nurse, six nurse clinicians, and two research nurses. For analytic purposes, the nurses were combined into one group.

Baseline surveys collected data on demographics (age, gender, race), education (whether the practitioner had prior formal training in communication skills), and practice (years that the practitioner had worked in oncology, number of direct patient-care hours per week). In addition, surveys included items from previously validated instruments examining self-reported provider primary orientation (socioemotional vs. technological/scientific),¹¹ comfort with psychosocial talk,¹² uncertainty,¹³ confidence,¹⁴ and expectations¹⁵ when addressing patients' concerns. Self-reported orientation was determined by asking providers whether they were "more inclined toward the social and emotional aspects of patient care or more inclined toward the technological and scientific aspects."

Comfort with psychosocial talk was assessed using the 32-item Physician Belief Scale,¹² with items modified only to change from first-person to third-person grammatical construction. Survey items from the Physician Belief Scale sought the degree of provider agreement with statements, such as "Health care providers cannot treat psychosocial problems," "Health care providers are intruding when they ask psychosocial questions," and "Patients with psychosocial concerns tend to become dependent on their health care providers." Clinician discomfort with uncertainty was assessed by degree of agreement with nine survey items, such as "I usually feel anxious when I am not sure of a diagnosis"; and "When health care providers are uncertain of a diagnosis, they should share this information with their patients."¹³

To assess provider confidence in addressing patient concerns, respondents were asked to rate their confidence on seven items adapted from the work of Baile et al¹⁴ and Parle et al¹⁵ that relate to communication with patients. These survey items included clinician confidence in aspects of care, such as initiating a "discussion about a patient's concerns," encouraging a "patient to elaborate on concerns," and managing their "own feelings when talking about a patient's concerns." Finally, clinician expectations when addressing patient concerns were assessed using nine items adapted from the work of Parle and colleagues¹⁵ that inquire about expected patient responses to clinician inquiries about their emotions. An example of an item in this section is, "Your patient will become uncontrollably upset if you ask about their feelings." The three practitioner groups were compared regarding descriptive characteristics and their attitudes toward communication using chi-square tests for categorical variables and ANOVA for continuous variables.

RESULTS

Demographic, practice, and educational factors are compared in Table 1. Mean age of physicians was higher (49 years, SD = 8.0) than that of PAs (40 years, SD = 10.3) or nurses (43 years, SD = 8.6). Most physicians were male (81%), while most PAs and nurses were female (81% and 100%, respectively). All provider types were predominantly white, had extensive experience in oncology, worked similar hours per week, and were similarly likely to have had communication training.

When presented with a choice between “social and emotional” or “technological and scientific” to describe their personal orientation, a large majority (70%) of physicians chose “technological and scientific,” while a substantial majority of nurses (82%) and PAs (68%) chose “social and emotional” ($p < .0001$) (see Table 2). PAs and nurses indicated more comfort with psychosocial talk than did physicians ($p < .0001$). Discomfort with disclosing uncertainty and provider confidence and expectations when addressing patient concerns were similar across provider types.

DISCUSSION

PAs and nurses were more oriented toward socioemotional aspects of medicine and were more comfortable with psychosocial communication than were oncology physicians. The largest differences were found between the self-described orientation of the types of providers, with most nurses and PAs describing themselves as primarily having a socioemotional orientation and most oncologists reporting a technological and scientific orientation.

Research among physicians has shown that socioemotional orientation declines as length of training increases.¹¹ This effect could explain some of the difference that we observed because PAs and nurses have shorter training programs than physicians. It is also possible that people who describe themselves as socioemotional may be more attracted to the PA or nursing professions than to the physician profession. There could also be differences in the training of PAs, nurses, and physicians that promote a more socioemotional orientation among the non-physicians.

In previous research using SCOPE data, oncologists who described themselves as socioemotional were more likely to respond empathically to patient expressions of emotion than were oncologists who described themselves as technical/scientific.⁸ Although our current project did not address a potential correlation between socioemotional orientation and practice of empathic communication, the stronger socioemotional orientation found in this study among PAs and nurses warrants further investigation.

Results of this study suggest that nonphysician participants were more comfortable than oncology physicians with psychosocial talk, as shown by scores on the Physician Belief Scale.¹² Again, this difference could be explained by gender, training, or the types of personalities that are attracted to the different professions. In addition, it is possible that the non-physicians are more comfortable with psychosocial talk because their roles present them with more opportunities to practice and develop comfort with psychosocial talk. In the other areas examined (confidence and expectations when discussing patient concerns and discomfort with uncertainty), we found no differences in responses of physicians and non-physicians.

A weakness in our study is the gender imbalance among the provider groups. Previous research has shown that provider gender is associated with comfort with psychosocial talk.¹⁶ Because oncologists in our study were predominantly male and the PAs and nurses were

predominantly female, our results could be explained by these gender differences. We were unable to test gender effects given the skewed distributions in our samples.

Our findings suggest that important differences may exist between attitudes of oncology PAs, nurses, and physicians toward responding to patient emotion. These differences could have important implications for the design of future oncology care teams. Future studies should examine whether the differences we found are attributable to factors other than provider type (ie, gender, age, training) and whether, in practice, nurses and PAs are more empathic than physicians when patients express negative emotions.

Research regarding communication about emotion could have important implications for health professions education. This research should elucidate best practices in communication with patients about negative emotion and evaluate educational interventions designed to improve the ability of clinicians to meet patient needs and improve outcomes. Research on team approaches to care should address the roles of different team members in supporting patients' emotional, social, and physical health. PA educators can contribute by engaging in this research and by designing and evaluating educational programs that will help prepare PAs and other professionals to address the range of patient needs.

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Table 1

Characteristics of Practitioners

	Physicians	Physician Assistants	Nurses
N	48	26	22
Age (years) Mean (SD) *	49 (8.0)	40 (10.3)	43 (8.6)
Female (%)	19	81	100
White (%)	79	96	100
Years in oncology practice Mean (SD) *	20 (8.1)	10 (7.8)	15 (7.3)
Number of direct patient care hours per week Mean (SD)	29 (22.8)	34 (15.9)	31 (8.4)
Communication training in past (%)	64	50	55

* 1 MD and 1 PA are missing data for age; 1 PA is missing data on years in oncology practice.

Table 2

Comparison of Practitioner Attitudes

	Physician	PA	Nurse	P value	
Discomfort with uncertainty Mean (SD)	24.2 (7.9)	25.3 (8.9)	22.5 (7.8)	0.49	Scale 0–54. Higher score indicates practitioner is more reluctant to discuss or disclose uncertainty
Confidence in addressing patient concerns Mean (SD)	4.0 (0.6)	4.1 (0.5)	4.0 (0.5)	0.85	Scale 1–5. Higher score indicates greater confidence
Expects bad outcome when discussing patient's concerns Mean (SD)	3.9 (0.4)	4.0 (0.3)	3.9 (0.4)	0.63	Scale 1–5. Higher score indicates worse expectations
Discomfort with psychosocial talk (Physician Belief Scale) * Mean (SD)	84.5 (10.0)	70.8 (12.5)	78.0 (10.4)	< .0001	Scale 0–160. Higher score indicates more discomfort
Socioemotional orientation (as opposed to technological and scientific orientation) (%) *	30.0	68.0	82.0	< .0001	

* 2 physicians and 1 PA are missing data on socioemotional orientation; 1 PA is missing data on discomfort with psychosocial talk