Yonder

Yonder: a diverse selection of primary care relevant research stories from beyond the mainstream biomedical literature

Breaking bad news, sleeping tablets, hysterectomy, and responsible officers

Breaking bad news. In recent decades, the focus on competence in medical education has meant that communication skills are now an integral part of undergraduate and postgraduate medical curricula, and students and junior doctors get comprehensive training on the optimal ways to break bad news. As we keep hearing in the media, patients unfortunately sometimes receive bad news in the emergency department, and this was the focus of a new Brazilian study.[1] The authors analysed 73 bad-news communication encounters from the perspective of physicians, patients, and family members. They found that doctors and receivers disagree in relation to what transpired throughout bad-news communications. Discrepancies were more evident in issues involving emotion, invitation, and privacy. Interestingly, they found that the physical structure of the emergency department was an important factor. The layout of consulting rooms in primary care is much more conducive to these challenging consultations, and something we probably take for granted.

Sleeping tablets. The harms of sleeping tablets have been widely recognised for some time. As such, there's often a difficult conversation when a patient requests them, with the physician desperate to find an alternative solution that can allow them to avoid prescribing. A recent Australian study looked at patients' perceptions of drug and non-drug treatments for insomnia.[2] The authors found that treatment preferences represent the endpoint of a dynamic decision-making process that is heavily grounded in the individual's illness and treatment beliefs, prior treatment experiences, and external social factors. The authors suggest that, rather than focusing on what treatment the patient would prefer, perhaps the key clinical questions are: How do the prospective treatment(s) align with patients' personal values? What does the patient already know about the prospective treatment? And from which sources did they draw upon? They argue that, by being attuned to these subtleties, we'll be able to engage in a more meaningful and sustainable way.

Hysterectomy. If you need to have your uterus removed, there are now all sorts of fancy, non-invasive procedures that you can have done, which all have promising research findings to support them. It surprises many in the gynaecology community, therefore, that many women still opt to have an old-fashioned total hysterectomy through an open, abdominal incision. An Australian research team recently explored this, surveying all women who had received any form of hysterectomy since 2015.[3] They found that the surgeon's preferred surgical approach was the most dominant factor influencing women's decisions, and that recovery time and surgical risk were also important factors. The authors suggest that both GPs and gynaecologists should be more active in discussing non-invasive options, and that patients should be given high-quality written information to support this.

Responsible officers. Appraisal and revalidation have become integral to UK medical practice. They have brought with them a plethora of new terms and roles. For example, they have placed considerable statutory powers and duties in the hands of a nominated medical professional in each organisation employing or contracting with doctors, formally titled the 'Responsible Officer' (RO). ROs are formally responsible for making recommendations about ongoing fitness to practise and are the subject of a new UK research paper.[4] The authors found ROs to be a distinct emergent group of hybrid professionals. Occupying a position where multiple agendas converge, ROs' work expands professional regulation into the organisational sphere in new ways, as well as creating new lines of continuous accountability between the wider profession and the GMC as medical regulator. Ultimately, ROs' responsibility for monitoring the performance of other doctors within organisations has altered the professional hierarchy, entrenching a divide between ROs as a 'governance elite' group and the 'rank and file' doctors subject to their oversight.

Ahmed Rashid,
GP and Senior Clinical Teaching Fellow, UCL Medical School, UCL, London.

Email: ahmed.rashid@ucl.ac.uk
@Dr_A_Rashid

DOI: https://doi.org/10.3399/bjgp18X699617

REFERENCES

1. Toutin-Dias G, Daglius-Dias R, Scalabrini-Neto A. Breaking bad news in the emergency department: a comparative analysis among residents, patients and family members' perceptions. *Eur J Emerg Med* 2018; **25(1):** 71–76.
2. Cheung JMY, Bartlett DJ, Armour CL, *et al.* To drug or not to drug: a qualitative study of patients' decision-making processes for managing insomnia. *Behav Sleep Med* 2018; **16(1):** 1–26.
3. Janda M, Armfield NR, Page K, *et al.* Factors influencing women's decision making in hysterectomy. *Patient Educ Couns* 2018; **101(3):** 504–510.
4. Bryce M, Luscombe K, Boyd A, *et al.* Policing the profession? Regulatory reform, restratification and the emergence of Responsible Officers as a new locus of power in UK medicine. *Soc Sci Med* 2018; **213:** 98–105.