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Title: The difficulties experienced by nurses and healthcare staff involved in the process of breaking bad news

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Abstract

Aims

To explore the difficulties experienced by nurses and healthcare professionals when engaging in the process of breaking bad news

Background

The challenges faced by staff when breaking bad news have previously been researched in relation to particular settings or subjects. This study involved staff from diverse settings and roles to develop broader insights into the range of difficulties experienced in clinical practice.

Design

The study utilised a descriptive survey design involving self-reported written accounts and framework analysis.

Methods

Data was collected using a structured questionnaire containing a free text section that asked participants to describe a difficult experience they had encountered when involved in the process of breaking bad news. Data was collected from healthcare staff from hospital, community, hospice and care home settings attending training days on breaking bad news between April 2011 and April 2014.

Findings

Multiple inter-related factors presented challenges to staff engaging in activities associated with breaking bad news. Traditional subjects such as diagnostic and treatment information were described but additional topics were identified such as the impact of illness and care at the end of life. A descriptive framework was developed that summarises the factors that contribute to creating difficult experiences for staff when breaking bad news.

Conclusion

The framework provides insights into the scope of the challenges faced by staff when they engage in the process of breaking bad news. This provides the foundation for developing interventions to support staff that more closely matches their experiences in clinical practice.

Summary Statement

The three headings should be in bold:

- **Why is this research or review needed?**

- Guidance on breaking bad news tends to focus on planned clinical consultations; this does not reflect the diverse contexts in which this information is provided.
- The difficulties experienced by healthcare staff when involved in the process of breaking bad news in a range of clinical settings has not been systematically explored.
- Identifying the difficulties experienced by staff engaged in the process of breaking bad news enables the development of interventions that more closely reflect clinical practice.

- **What are the key findings?**

- The findings provide evidence to support the proposal that breaking bad news is a process that involves activities that are not restricted to information giving.
- Being involved in difficult situations and events associated with breaking bad news has negative consequences for patients, relatives and healthcare staff.
- The difficulties faced by nurses and other healthcare staff when engaging in the process of breaking bad news are influenced by multiple, complex and inter-related factors.

- **How should the findings be used to influence policy/practice/research/education?**

- The findings provide a framework for understanding the challenges associated with the process of breaking bad news that can be developed and refined using evidence from existing literature and further research
- The findings identify the breadth of knowledge and skills required by staff involved in the process of breaking bad news that provide direction to both education commissioners and providers.
- The findings highlight factors to be addressed by organisations, including resources, facilities and interventions to provide adequate support for staff involved in the process of breaking bad news.

Key words

Breaking bad news, communication, patient information, framework analysis, nurses, nursing, allied health professionals

Title: The difficulties experienced by nurses and healthcare staff involved in the process of breaking bad news

INTRODUCTION

This paper presents the findings of a study that explored the difficulties encountered by nurses and healthcare professionals during the process of breaking bad news. Bad news in healthcare settings has been described as any bad, sad or significant information that has a negative impact on a person's views or expectations of their present or future (Fallowfield & Jenkins 2004). A diverse range of subjects can be perceived as bad news by patients and relatives and many healthcare workers play a role in providing this information (Eggly *et al* 2006, Rassin *et al* 2013). The potential challenges associated with breaking bad news have tended to be explored in relation to pre-planned consultations when information about prognosis or diagnosis is given by medical staff.

Background

The majority of patients want to be given reliable and accurate information about their diagnosis, treatment options and potential outcomes (Clayton *et al* 2007). Patients who understand their situation are better equipped to make informed decisions, have a greater sense of control and are less likely to pursue inappropriate or ineffective treatments (Campbell *et al* 2010, Hancock *et al* 2007). Information plays a role in coping; without adequate knowledge patients may experience uncertainty about their present and future, and be unable to marry what is happening to them with the information they have received (Innes & Payne 2009, Hancock *et al* 2007).

How bad news is given influences satisfaction with care and the way in which patients subsequently cope with their situation (Randall & Wearn 2005). A number of guidelines have been developed to support healthcare staff when breaking bad news, but these are often focused on the events that take place in pre-planned consultations when medical information about diagnosis, prognosis, treatment and death is given to patients and relatives (Baile *et al* 2000, Campbell *et al* 2010). This perspective captures significant healthcare moments that require careful management to ensure distressing information is given well (Rassin *et al* 2006). However, there is increasing recognition that this focus may

be too narrow in terms of the information which is classified as bad news, the emphasis on a single interaction and the contexts in which patients receive and healthcare staff provide this information (Eggly *et al* 2006, Griffiths *et al* 2015).

Patients have described the moment of receiving significant information as part of a process or journey rather than an isolated event (Tobin & Begley 2008). In supporting patients through this process healthcare staff engage in a range of activities such as preparing patients for receiving bad news, clarifying the information received, supporting decision making and helping patients and relatives adapt as the implications of the news become apparent (Gauthier 2008, Warnock *et al* 2010). This process can be ongoing and involve multiple interactions when healthcare staff find themselves engaging in the process of breaking bad news (Dewar 2000, Warnock *et al* 2010).

While there are considerable benefits to patients being knowledgeable about their situation, there are challenges for healthcare staff involved in providing this information (Fallowfield & Jenkins 2004). These challenges can arise from a diverse range of intrinsic and extrinsic factors. Problems can arise when the context is complex, where there is uncertainty about outcomes (Pavlish *et al* 2012) or due to patient's perceptions of, and reactions to, the information being given (Prouty *et al* 2014, Eggly *et al* 2006). Other challenges include the effectiveness of communication between the healthcare team (Wittenburg-Lyes *et al* 2013), the need to tailor information to meet individual needs (Innes and Payne 2009) and addressing differences in opinion between patients, relatives and care providers on the content and timing of information and who it should be disclosed to (Prouty *et al* 2014, Erichsen *et al* 2010).

Difficulties experienced by healthcare staff involved in providing bad, sad or significant information have previously been explored by focusing on a particular type of information, patient group, healthcare provider or care setting. Examples include providing cancer patients with prognostic information (Helft *et al* 2011), transitions from curative to palliative and end of life care (Shannon *et al* 2011) and the demands associated with specific care settings such as intensive care (Stayt 2006), inpatient wards (Warnock *et al* 2010) and community care (Griffiths *et al* 2014). While differences are revealed according to the

research focus, shared themes and concerns can be identified. Examples include not having adequate time to anticipate or meet the emotional needs of patients and relatives (Pavlish *et al* 2014, Prouty *et al* 2013, Hancock *et al* 2007), lack of congruence within the healthcare team (Pavlish *et al* 2014, Wittenberg-Lyles *et al* 2013, Tobin 2012, Helft *et al* 2011, Erichsen *et al* 2010), knowing when to initiate difficult subjects (Griffiths *et al* 2015, Leung *et al* 2011) and dealing with emotional reactions (Campbell *et al* 2010, Gauthier 2008).

Guidance currently exists to support those involved in breaking bad news but its narrow focus on planned consultations means there are limitations to its usefulness in the diverse contexts and situations when events may occur (Warnock *et al* 2010). Identifying the difficulties experienced by staff engaging in the process of breaking bad news is an important step in the development of interventions, education and guidance that more closely reflects the reality of clinical practice.

In an earlier study the challenges faced by in-patient ward nurses when involved in the process of breaking bad news were explored by analysing written descriptions of difficult experiences provided by participants (Warnock *et al* 2010). Factors that contributed to the challenges faced were identified which provided insights into the hospital ward context. The study presented here builds on this work by exploring the experiences of nurses and other healthcare staff employed across a range of settings to develop a framework for describing shared concerns that reflects their experiences in clinical practice.

THE STUDY

Aim

The aim of the study is to explore the difficulties experienced by nurses and healthcare professionals when involved in the process of breaking bad news in diverse contexts and clinical settings.

Design

A descriptive survey design was employed. A questionnaire generated qualitative data to identify the difficulties encountered when breaking bad news in clinical practice.

Participants

Participants were nurses and healthcare professionals attending an education day designed to support healthcare staff involved in the process of breaking bad news. The study day was run twice a year and was open to all healthcare staff who worked in a region in the North of England. There were a total of 145 participants in a two stage study.

Stage 1. Initial analysis: Data was collected on seven separate study days. 158 staff attended in total and 138 returned questionnaires. 109 of these completed the part of the questionnaire relating to difficult experiences encountered when involved in the process of breaking bad news and were included in the initial analysis. The age ranged from 21 to 61, mean 40.7, the number of years of employment in healthcare ranged from 1 to 40 years, mean 13.3.

Stage 2. Verification: Verification data was collected on a further two study days. 36 participants returned questionnaires with the appropriate section completed. The age range for this group was 23 to 64, mean 36, the number of years in healthcare ranged from 1 to 37, mean 13.5.

All study days were predominantly attended by female healthcare staff and only four participants in total were male. Participants were from a wide range of professional backgrounds and settings including acute hospitals, hospices, nursing homes and community teams. Details of participants roles and areas of practice are in table one.

Data collection

Questionnaire

Data was collected using a structured questionnaire that had been developed for a previous study which explored the experiences of nurses when breaking bad news in in-patient care settings (Warnock 2010). The original questionnaire was adapted for use on the study day by using terms applicable to all healthcare settings but was otherwise unchanged.

Difficulties experienced when breaking bad news were explored in a free text question that was worded as follows: "Describe briefly one example of a difficult experience you have encountered when involved in the process of breaking bad news".

The questionnaire was completed at the start of the study day by attendees with the intention of providing them with an opportunity for quiet, structured reflection on their own experiences in relation to breaking bad news. At the end of the session attendees were invited to hand in the questionnaire if they wished to do so.

Data for the initial analysis was collected over seven study days between April 2011 and March 2013. The framework verification analysis was carried out on questionnaires completed on two study days between November 2013 and April 2014.

Ethical considerations

The project was reviewed by the Trust clinical effectiveness department and identified as service evaluation. Full ethics committee approval was deemed not necessary and the Trust's regulations for ethical practice in service evaluation were followed (Mawson *et al* 2007). Participants were informed verbally and in writing on the front of the questionnaire that the findings would be used for the development of future study days and would be written up in reports and publications. It was emphasised that participation was voluntary. No names or identifiers were on the questionnaires and participants were informed that confidentiality would be maintained and no content that could identify individuals would be used in written or published reports.

Data analysis

The free text descriptions were analysed using framework analysis (Ritchie *et al* 2014). The process of analysis involved a series of independent and collaborative phases by two investigators (CW and JB). Each stage of the analysis was carried out separately by the investigators and then agreed.

The investigators read all of the descriptions to identify themes, which formed a preliminary thematic index. The participants' descriptions were then placed in the preliminary index under all themes where they were relevant; some were placed in two or more themes. Both investigators agreed the placement of the descriptions within the thematic index. The investigators independently developed summaries of the characteristics and content of each of the themes within the index. The summaries were discussed until agreement was

reached on the final description of each theme within the framework. Descriptions of difficult experiences from the questionnaires of attendees on a further two study days were then reviewed against the framework to search for similarities and differences, identify additional characteristics and confirm the content of the initial analysis.

Rigour

Rigour was established using approaches appropriate to qualitative research (Ryan-Nichols & Will 2009, Guba & Lincoln 1985). Measures which aimed to enhance the credibility of data analysis included the use of constant comparison analysis, which is inherent to framework analysis (Ritchie *et al* 2014). Participants descriptions were returned to frequently throughout analysis to ensure the findings were grounded in their accounts. In addition, two researchers carried out data analysis and interpretation independently and the findings were discussed, refined and agreed. Dependability was approached by both researchers maintaining a clear documented trail of the decision making processes through written records. Verification of the initial findings was strengthened by comparison with additional data.

FINDINGS

Activities carried out in relation to breaking bad news

In total 145 accounts were provided describing difficulties experienced when breaking bad news. In 70 of these the participants described the role they had played. These roles were categorised into four subject areas as follows (details in figure one):

- ***Diagnostic and treatment information, including test results:*** in some descriptions the role was to give this information, in others it was to provide support before, during or after the patient or relative received it.
- ***The impact of illness:*** a range of roles were described by participants that helped patients manage the consequences of their situation such as loss of independence or reduced function. Roles included activities around decision-making, discharge planning and practical guidance on adaptation and self-care. Many of these descriptions involved patients or relatives who had found it difficult to accept or come to terms with the information they had been given.

- **Managing reactions:** these roles included preparing patients for information before it was given, anticipating their reactions or needs for additional information and support and picking up the pieces when others had mishandled information giving.
- **Care at the end of life:** many descriptions related to end of life care. Examples of the roles carried out by participants included informing relatives of a patient's deterioration or death, supporting patients and families through the transition to end of life care and explaining the process of, and care around, dying.

Additional activities were identified that that did not fit within these groups including failing a student nurse on placement and supporting patients through treatment procedures.

Consequences of difficult breaking bad news events

The potential consequences arising from the difficult events described were identified. For patients and relatives they included, not receiving the care the participant felt was needed/optimum, additional difficulties coping with information and events, increased and/or unnecessary distress and breakdown in the relationships between the patient/family and healthcare team. Consequences for participants included increased demand on resources such as workload and time, breakdown in relationships within the multi-disciplinary team and feeling unsupported or let down by colleagues or the organisation. Personal consequences were also described such as doubts about their own practice, feeling guilty or compromised and a sense of helplessness when unable to resolve the situation.

Sources of difficulty

Four main sources of difficulty were identified: situation, organisation, patients and relatives, and individual.

Situation

This theme related to the circumstances surrounding the breaking bad news event and included difficult subjects, challenging situations and the practicalities surrounding communication such as location and method (for example over the phone). Illustrative extracts from participant's descriptions are provided in figure two. Complex ethical or care events featured frequently as difficult subjects for breaking bad news. These included

transitions in treatment pathways such as moving from curative to palliative treatment and emotive aspects of care such as explaining the process of dying or hydration at the end of life.

News and events that were not expected created a difficult context for breaking bad news. Unexpected situations could arise from events that were not anticipated, such as a sudden death or not being pre-warned or adequately prepared that significant information was to be communicated. Early reassurance from healthcare staff that was not borne out by later developments contributed in some cases to events seeming unexpected from the perspective of the patient or relative. The difficulties associated with unplanned situations were compounded by practical factors that restricted how they were managed such as lack of privacy or having to give information over the phone.

Tensions within the multi-professional team due to different perspectives or practices regarding information provision also featured in this theme. Seeing information given badly by others or having to “pick up the pieces” afterwards was a source of difficulty present in many descriptions. Examples of poor communication from others included an abrupt manner, not answering questions and use of jargon and euphemisms. Inadequate planning and preparation was a common factor in many descriptions and included medical staff giving bad news to patients without family members, or nurses, being present. Disagreement between the team regarding who should be given information also featured, for example, acting on relatives requests that the patient is not given diagnostic information.

Organisation

This theme encompassed work related factors such as time, staffing, relationships between departments and the services available to support information provision. Illustrative extracts from participant’s accounts regarding “organisation” are contained in figure three. Not having enough time to manage events or support the patient and relatives was a common source of difficulty which was linked with staff shortages in some descriptions. Staffing issues also arose when key personnel were absent due to shift changes, events

occurring “out of hours” or participants working outside their usual role expectations by standing in for more experienced colleagues.

Poor communication between services featured in the descriptions and occurred when participants had been given inadequate information by staff from other departments so were unable to respond to questions or concerns raised by patients and relatives. The organisation’s rules and structures for information provision could also be problematic. For example, one participant described how a patient had to wait until their outpatient appointment to receive test results and felt this had left the patient in limbo. Organisational factors could also exacerbate challenging circumstances where inadequate resources or services were provided such as quiet, private spaces free from interruptions and lack of appropriate interpreting services.

Patients and relatives

This theme contained four categories: reactions to information and events, family context, breakdown in relationships with the healthcare team and communication barriers.

Illustrative extracts are detailed in figure four. A significant number of descriptions included patient and/or relative reactions that were emotionally heightened such as anger, screaming, shaking, being distraught or devastation. The terms “denial” or “non-acceptance” were present in many accounts but were complex concepts used to represent multiple meanings. For example, both words were used to describe the following situations: when patients/relatives did not want information or events to be true, when they refused to accept the reality of the situation, when they could not cope with what was happening or when they refused to think about or engage with events.

Family context contained two key elements; issues around disclosure, where one, or more, family members wanted to control information provision, and family dynamics where pre-existing issues, such as long-standing rifts entered the care setting. Tensions could be created in the relationships between patients and/or relatives and the healthcare team when their expectations of care or treatment differed. Examples included, wanting curative treatment after being told the aim was palliative and wanting to live at home when the multi-disciplinary team felt this was not feasible. Barriers to communication were also

described in participants' accounts. These included patients or relatives with speech or hearing problems, events where there was no shared language between the patient/relative or healthcare team, difficulties with comprehension due to health related conditions, such as dementia or inability to take in the information due to being overwhelmed by events.

Individual

This theme described factors relating to the participant's own knowledge, confidence, skills and emotional responses. Figure five contains illustrative extracts of these factors. Balancing was a key concept in this theme and had both positive and challenging consequences. Many descriptions contained evidence that participants felt a sense of responsibility for the care their patients received and took action that they thought was in the patient's best interests. While this was described in a positive way it could have negative consequences when it brought about increased workload and emotional labour that was not matched by additional resources. Where events had not gone well feeling responsible was accompanied by expressions of negative feelings such as guilt and distress. Evidence of this was seen in the presence of reflective questions such as "I was left wondering could I have done things differently"? Some also expressed responsibility for situations or outcomes they were not able to control. Often descriptions revealed how being involved in the process of breaking bad news triggered emotional reactions and responses for the participants. This could be heightened when the participants identified with the patient or their circumstances.

Descriptive framework

A descriptive framework was developed to provide a summary of the factors that were associated with difficult experiences (figure six). It presents a systematic overview, but many of the factors are interrelated as individual descriptions contained elements of multiple categories. This is exemplified in the following extracts with the categories identified in bold and bracketed:

"Having to tell 3 children that were aged approx 25-40 that didn't communicate between themselves (**family context**) that their mum was for end of life care. Having to tell 3 times and making sure all 3 versions were all correct and all questions

answered **(balancing)** i.e. why stopping fluids, why stopping some medications, what was a syringe driver etc” **(difficult subjects)**

“A patient who was told of bowel cancer diagnosis had liver mets but needed scans to determine if mets were operable **(difficult subjects)**. Patient was very distressed prior to news being given, physically shaking and tearful **(reactions to information and events)**. Found news difficult and needed a lot of telephone support while awaiting scans and return appointment **(services available)**. On return appointment liver mets not operable and for palliative chemo **(difficult subjects)**. Very emotionally charged environment **(reaction to information and events)**. Period that patient is waiting for results is a difficult time, difficult over the phone” **(context of communication)**.

DISCUSSION

Much of the research into the difficulties and challenges surrounding breaking bad news has tended to focus on a specific setting, patient group, subject or problem. This approach has provided insights into particular aspects of breaking bad news. By taking a broader inclusive approach, this study has identified factors that contribute to difficulties encountered across a range of settings, professional groups and scenarios. This provides a framework for understanding the challenges associated with the process of breaking bad news.

The findings support the proposal that bad news encompasses diverse subjects and can be seen as a process that occurs over time involving the multi-disciplinary team (Eggle *et al* 2006, Rassin *et al* 2013, Griffiths *et al* 2015). In this current study, descriptions of difficult experiences included the subjects traditionally associated with bad news such as information about tests, diagnosis and prognosis. However, additional subjects were revealed, particularly regarding managing the impact of illness and transitions in care, that suggest that the participants in this study had a broad perspective on the type of information they classified as bad news.

The range of activities being carried out by participants indicates that there are multiple moments across the healthcare pathway when significant information is given or managed.

This includes addressing the implications of the patient's situation, such as reduced functional ability, discharge planning and supporting patients and families through end of life care. Their descriptions also revealed how their involvement in the process of breaking bad news was not restricted to information provision. For the study participants, engaging in activities such as listening to concerns, explaining information, clarifying misunderstandings, assisting with decision making and helping patients and relatives cope with emotional reactions were ways in which they were involved in breaking bad news.

Many of the themes and categories identified in the study are present in research that has explored factors that influence communication around significant information. For example, Prouty et al (2014) examined care provider's perspectives on the reasons for communication breakdown in cancer care and discovered that influential factors included poor information exchange between healthcare providers and insufficient time available to spend with patients. The transition between curative and palliative care has also been identified as a challenging subject which can be made more difficult when there is denial, conflict or issues around disclosure between family members (Griffiths *et al* 2015). All of these factors were present in the descriptions provided by the participants in our study, suggesting they may reflect common experiences.

In developing the thematic framework, it was noted that the descriptions frequently contained multiple factors representing more than one theme. This suggests that the difficulties faced when engaging in the process of breaking bad news can be influenced by multiple, complex and inter-related factors. Some factors will be prevalent in particular settings and contexts, for example, different challenges will be faced by those engaged in diagnostic and treatment contexts compared with rehabilitation or end of life care. However, many were present across contexts, subjects and settings such as time, resources, reactions to bad news, family context, personal confidence and support between services. While challenges may be experienced differently depending on the context there are common factors that shape experiences of being involved in breaking bad news.

There are factors that were not present in our findings that have been described elsewhere. For example, "getting the timing right" has been highlighted as a difficulty encountered by

healthcare staff involved in initiating discussions around the transition to end of life care (Griffiths *et al* 2015, Leung *et al* 2011, Gauthier 2008) but this did not feature in our participants' descriptions. Factors that can influence this are contained in the framework, for example staff confidence to introduce subjects (individual factors) and congruence between medical and nursing staff that end of life care is the appropriate treatment pathway (complex ethical or care events). Our findings may provide a preliminary framework that could be developed and refined using evidence from existing literature and further research.

Cultural factors can affect the provision of bad news, particularly around diagnosis and prognosis (Hancock *et al* 2007). Information disclosure is the norm in Western Anglo-Saxon societies but in some cultures there can be a preference for the family to be given information while the patient is not provided with the full facts (Hancock *et al* 2007). Culture does not appear as a separate theme or category in the framework as it did not emerge as a consistent theme. Events were usually described in relation to the individual preferences and behaviours of the patients and their family. In the majority of the accounts where there were issues around disclosure culture was not mentioned in the description and it is possible, or likely, that some of these events occurred in white British families. The decision to not include the term culture reflects Hallenbeck and Arnold's (2007) proposal that significant differences exist within cultural groups, and individuals may personally wish to be informed and involved in decision making even when they are part of a culture that prefers non-disclosure. Similarly, not all people of Western Anglo-Saxon cultures want to be fully informed (Hancock *et al* 2007).

The framework developed in this study builds on earlier research that used hospital nurses' descriptions of their difficult experiences to develop insights into the difficulties they encountered when involved in the process of breaking bad news (Warnock *et al* 2010). All of the challenges identified in the previous work were present in this current study but additional items were revealed.

The approach to data analysis led to the development of a structured framework that has multiple potential uses. It can be used by nurses and other healthcare staff to reflect on

clinical events and practice. It identifies the breadth of knowledge and skills required by staff involved in the process of breaking bad news that could provide direction to both education commissioners and providers. In particular, it suggests the need to look beyond the traditional focus on communication skills in education and include topics such as working with family systems, managing ethical dilemmas, conflict resolution, team working and supporting coping and adaptation. The framework also highlights factors that need to be addressed at an organisational level such as staff resources, availability of facilities to support breaking bad news such as interpreters and private spaces and the provision of opportunities for structured learning and reflection.

Limitations

One limitation of the study is that was carried out within a relatively small geographical area in England, UK. While a range of disciplines and clinical settings were included the findings may be reflective of a local culture surrounding the provision of bad news. The participants were nurses and healthcare staff who were motivated to attend a study day on breaking bad news and may have had a particular interest due to their prior experiences. Self-report methods were used to obtain the descriptions and no other data was collected to triangulate the findings against. These factors may have influenced the content and type of descriptions generated. Other methods, such as in-depth interviews, may have yielded different insights into difficult experiences but using self-report descriptions allowed the collection of a greater range of perspectives of clinical experiences. There was good compliance with the methods used and the diversity may have been difficult to capture using other approaches.

Participants represented a breadth of roles and settings but further research is required to increase the relevance to other healthcare contexts and events. The framework provides a basis for conducting such work.

CONCLUSION

The breaking bad news framework has been derived from the personal accounts of healthcare staff and as such has the potential to capture experiences that reflect clinical practice. Participants' descriptions revealed that nurses and healthcare staff from hospital,

community, hospice and care home settings carry out a diverse range of roles as they provide information and support to patients and relatives during significant health related events. They also highlight the ways in which multiple, inter-related factors can act as sources of difficulty for healthcare staff engaged in the process of breaking bad news.

Previous guidance on breaking bad news has tended to focus on the way in which information is given (for example, Baile *et al* 2000, Campbell *et al* 2010). Our framework suggests other factors may also be fundamental to ensuring bad news is given well and could provide the foundation for developing education, practice and organisational interventions that take account of the complexity of the challenges faced.

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