

How do Physicians Talk and what do They Say in the Difficult Conversations with Patients and their Loved Ones in Palliative Care? A Qualitative Study to Investigate Strategies to Help Improve Difficult Conversations

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Abstract

Objective: Although having difficult conversations is part of their role, many professionals feel that they are often ill-equipped to deal with them. Professionals need training in how best to meet difficult questions so that the conversation can flow effectively. This study is a continuation of an earlier study on how healthcare professionals described strategies to facilitate difficult conversations.

Methods: A qualitative method with in-depth interviews was chosen to acquire a deeper understanding of the participants' strategies in having these conversations.

In order to strengthen the knowledge of and strategies for conducting their difficult conversations in particular, we examined the interviews with the physicians who participated in the study.

Results: The study describes a conversation pattern to help in dealing with difficult conversations. This conversation pattern can help physicians to have conversations that flow effectively and that move in a straightforward way. The different strategic areas described in this study were: Introduction; Finding out what the patient and loved ones already know; Discuss the actual problem; Find out how the patient feels and what is most urgent for the patient to deal with; Planning for the future; and Summary. There are important factors that need to be considered in having these conversations which, in addition to the medical knowledge, include the strategies adopted by patients and families, hope, and how the family constellation might influence the conversation.

Conclusion: This framework for difficult conversations can be helpful for physicians to improve conversations with the patient and her/his family in their life situation where a fatal disease has influenced their life within many dimensions. Developing their conversational skills and strategies in combination with a carefully planned structure appeared to facilitate difficult conversations with patients, families and loved ones.

Keywords: Cancer conversation; Skills for difficult conversations; End-of-life questions; Strategies in conversations; Palliative care

Introduction

Healthcare professionals working in palliative care must engage in a range of conversations to discuss the consequences of the disease. These conversations can take place with both the patients and their loved ones, alone or together, and can contain both medical information about the disease and discussion about the psychological, social and existential dimensions of having a fatal disease [1-4]. Meeting these kinds of questions and thoughts on a daily basis can be problematic for the professionals if they do not feel secure in having the skills to engage in those conversations.

Several studies have shown that the patients and their loved ones want information about the prognosis, the treatment of the disease, the management of pain and practical information [5-8]. The information can be relayed through conversations with the professionals as the

disease progresses, or through their own search for information, depending on how the patient and loved ones talk to each other [9]. But how can the professionals know that the patients and their loved ones understand the information that is provided? There are studies that show how the professionals estimate this understanding through the way the patients and their loved ones express their questions and their behaviour in dealing with daily life [9,10]. Hope is reported to be crucial and is a factor that influences wellbeing and the strategies that patients and their families adopt to deal with problems [11,12]. As Olsman et al. found, there are three perspectives of hope, described as: something to grip on to that implies safety; a source of strength; and a coping mechanism [13,14]. Because of the importance of hope and the strategies that are employed both by patients and loved ones, as well as the family values and how they communicate within their family network, it is important that the professionals must take into consideration that these elements will also influence difficult conversations [12,15,16].

Many professionals feel that having these conversations is a difficult part of their work and they often feel ill-equipped to deal with issues related to death and dying [17-19].

In having these conversations, the professionals may need some training in how best to meet difficult questions so that the conversation can flow effectively. There have been previous studies in the effectiveness of training for such skills frameworks, and these have shown a variety of outcomes, as shown in an overview presented by Gysse et al. [20].

Professional caregivers need to be prepared for conveying difficult information and the discussions that arise in the different dimensions of palliative care. An earlier study [18] has described strategies that healthcare professionals use to facilitate difficult conversations. This study provides a deepening of the results of this earlier study by exploring how physicians in particular attempt to enable these difficult conversations.

Significant Concepts

‘Loved ones’ is an expression denoting those persons who are close to the patient, regardless of whether they are spouses, significant others, relatives, adult children or friends.

The term, ‘professionals’ includes registered nurses, assistant nurses and physicians.

Material and Methods

The data were collected as a part of a study about professionals’ views about having difficult conversations. A qualitative method with

in-depth interviews was chosen to acquire a deeper understanding of the participants’ strategies in facilitating these conversations. The study was conducted in a University Hospital in the west of Sweden over a three-month period between February and May 2010 in the Hospital’s geriatric, oncology and urology departments. The patients in the urology and oncology departments were suffering from cancer and those clinics treat patients affected by cancer in the curative stage as well as in early and late palliative stages. The patients in the geriatric department were suffering from multiple diseases, all in the late palliative stage. A qualitative design was chosen to gain a deeper understanding of the various methods used by the professionals to support their actions and in facilitating the conversations.

ParticipantsThe participants in the earlier study were nurses, assistant nurses and physicians working at those clinics and the physicians included in this study had already participated in the previous one [18]. Of the 48 people who took part in the previous study, 35 professionals agreed to participate and, of those, 12 were physicians. Those participants who were willing to participate in this interview study were asked to send their informed consent to the researcher. Because it is the physician’s responsibility to convey the diagnosis and the progression of the disease to the patient and their loved ones, we examined the interviews with the physicians participating in the study. Eleven physicians participated in the interviews because one did not want to be interviewed after providing their consent. Table 1 explains the the characteristics of the study participants.

	Physician	11
Gender		
	Male	3
	Female	8
Age		
	20-29 years	1
	30-39 years	1
	40-49 years	5
	50-years	3
	No answer	1
Years of employment		
	1-10 years	2
	11-20 years	2
	21-30 years	4
	31-years	2
	No answer	1
Department		
	Oncology	5

	Urology	3
	Geriatric	3

Table 1: Characteristics of study physicians.

Data collection

The interviews took place at the hospital and were conducted using a conversational approach. That meant that the interview was conducted in the form of a conversation with the physicians telling their story of how they provide information and in which various ways, prompted by specific questions from the interviewer to clarify the research questions. To ensure adherence to the research questions throughout the interview, certain key questions were highlighted: How do you convey difficult information?

How do you express yourself when conveying a difficult message? How do you begin and how do you end those conversations?

Data analysis The transcribed interviews were analysed using content analysis. The interviews were conducted by the first author and were transcribed verbatim. The analysis was carried out in close cooperation with the co-author to ensure that the results were interpreted as objectively as possible. Any differences were discussed and a common description was formulated.

The analysis comprised several steps. Initially, text that was relevant to the research issues was marked. Units of meaning were then identified and grouped into codes. These codes were subsequently discussed, compared, categorised and labelled. In the final step, the categories were structured into sub-themes and themes [21,22].

Ethical consideration

The study was approved by the Regional Ethical Review Board in Gothenburg. The professionals were given written information and gave informed consent prior to participating.

Trustworthiness

Many factors must be taken into account to ensure trustworthiness in qualitative research. Compared to using a questionnaire, in-depth interviews make it possible to acquire a deeper understanding of the participants' strategies in facilitating these conversations. To ensure credibility, all the participants in this study were physicians who worked on a daily basis with patients affected by an incurable disease and who also met with the patients' loved ones. To reduce any potential sources of bias in the investigators' preunderstanding, the interviews included questions that elucidated the experiences of the participants.

Despite the variety of differences in age and genders, the results revealed many similarities. To reduce the impact of the pre-understanding, the interviews included questions that elucidated the experiences of the participants [21,22].

Results

The physicians' way of talking to the patients and their loved ones can be divided into six areas of their conversations. All physicians did not use all of the identified areas, but all of them perceived that those areas seemed to be important when having these conversations. These six areas are described in detail below.

Introduction: First, clarify what the conversation leader (CL) has perceived as being the purpose of this conversation and verify that it matches that of the other participant(s). As an introduction, give the history of who has asked for the meeting.

We are having this meeting because you wanted to see me ...

I wanted to see you to be able to inform you about the latest test, x-ray ...

I wanted to see you because I shall tell you about the ...

Finding out what the patient and loved ones already know: If there are some doubts about what the patient and loved one really knows, ask them to describe what information they have been given so far. This will give an overview of their knowledge in their own words. This provides an opportunity for the CL to identify areas that need to be highlighted, the patient and loved ones' knowledge, and to verify that any information given earlier is correct.

What have they told you about your disease so far ...?

Can you describe what information you have been given earlier in your own words ...?

Discuss the actual problem: Ask the patient and the loved ones what they estimate to be the problem in their view. What do they see as recourse and what are their fears? Here information can be provided about the disease, new results, the progression of the disease, and whether referral is necessary. It is important that the physician does not shield the patient and the loved ones from unfavorable information. Here are some phrases which will prepare the patient to understand that the conversation will convey a difficult message:

Now, I shall be very straight with you ... You have a serious disease which we cannot cure. You will die from this disease, but we shall ease the suffering as much as we can.

Now, I must say something that is not so good ...

To find out how the patient feels and what is most urgent for the patient to deal with: Physicians cannot know what the patient and loved ones experience as their most urgent needs, or what their fears or worries are at the present time. Asking about these provides the physician with an opportunity to give proper information and engender as sense of security in the patient and the loved ones.

What is the most complicated issue now?

I start to explain that this is a serious disease and then give the information step by step, with some pauses. I try to meet the patient on his/her level of knowledge. If the patient wants to have more information, you can go further and provide some facts about what we can do.

Planning for the future: Discuss how things will progress in the future according to medical treatment, and the need for support in caregiving at home; for example, what the follow-up treatment will be, and who will be responsible for the follow-up.

We shall now start planning what happens next and we need to discuss what is important to you ...

Summary: It is important to end with a summary of the conversation. If something has been decided, provide a summary of this, and describe any follow-up that will be arranged, and so on. Ask if the summary corresponds with the understanding of the other participants. Ask if they have any more questions or thoughts. If so, talk about these if there is time. If time is limited and there are more issues to discuss, set up a new time for a further meeting. If no more questions arise, close the conversation.

The following sections illustrate some of the strategies that physicians adopt to facilitate the conversation.

Using metaphors: A metaphor is something that is representative of something else and might be connected to a word, a feeling or an event. Some words used in palliative care are difficult to say directly, but using a shared metaphor can make it easier to talk about these sensitive topics. For example, instead of the word 'dying', the use of the metaphor 'pass away' 'more and more tired' is sometimes experienced as being easier to say. It is important to listen to the patient and family to determine whether and which metaphors they use and, if they do, use the same ones consistently.

"Sometimes I say we humans want something but God decide, and both patient and loved ones understand the seriousness, regardless if they believe in God or not"

To give hope to the patient and loved ones: Hope is crucial for living. To have hope is to have something to look forward to, even if that event might never happen. It is not what you say that takes hope away, it is how it is said. Hope can be extinguished by the way that information is presented, for example:

There is nothing more that we can do.

However, saying the same thing in a different way can foster hope:

There are a lot of things we can do to help you to feel better, but we cannot take away the disease ...

Discussion

What makes a conversation a difficult conversation? It depends on many factors and these can vary. To talk about something that is very important to a person is one factor. A fatal disease can be just such a subject and, as Kuuppelomäki [17] found, death and dying is a difficult subject for many professionals. It can also be a difficult subject for the patient and loved ones, even if they do want to talk about it [5,6]. It can also depend on who participates in the conversation and how the pattern of their internal family conversation works and whether they use more direct words or metaphors [15,23]. The quality of communication in terms of content and exchange of information is a key factor when meeting patients and their loved ones in conjunction with discussing the consequences of a fatal disease [24].

Knowledge of the different subjects that patients and their loved ones want to discuss during the course of a fatal disease is increasing, but there is still a lack of knowledge and practical skills among professional regarding the way such information is provided. When a patient receives information about a life-limiting disease they only hear some parts of the information [1,25]. If the conversations should include both the patient and the loved ones, this can take the form of a family meeting that facilitates them all to discuss the actual situation

with the professional. Among the professionals in the earlier study [18], there was an agreement that employing hope as a strategy is common for patients and loved ones and is always a part of these conversations. Not the hope of being cured, but the hope of being able to live to the end of life with the best quality that is possible [13,14,26]. To facilitate these conversations the professionals can use different phrases when a difficult measure is communicated, employing special words as metaphors described earlier as a strategy [23,27]. Nevertheless, it was also considered important to discuss the progression at all stages of the disease and this led to suggestions relating to the skills and strategies that physicians adopt in order to facilitate these conversations. In line with other studies [25,28,29] the physicians in this study reported that guidelines for conducting difficult conversations comprised several steps. The different areas described in this study: Introduction; Finding out what the patient and loved ones already know; Discuss the actual problem; Find out how the patient feels and what is most urgent for the patient to deal with; Planning for the future; and Summary, provide an overview of the topics that are important in the conversations that provide new information for patients and their loved ones. We have found that these areas are particularly important and that using them can facilitate difficult conversations. While all of these areas may not appear in all conversations, each can be used as a way of supporting the physicians when they conduct difficult conversations. Similar to this framework, other models have been described earlier, as step-by-step guides, themes in the conversation, and strategies and skills for having difficult conversations comprising several steps [25,28-30].

Conclusion

There are important factors that need to be considered in having these conversations which, in addition to the medical knowledge, include the strategies adopted by patients and families, hope, and how the family constellation might influence the conversation. This framework for difficult conversations can be helpful in improving conversations with the patient and her/his family in their life situation where a fatal disease has influenced their life within many dimensions. Using conversational skills and strategies in combination with a carefully planned structure appeared to facilitate difficult conversations with patients, families and loved ones. The results can be useful for discussion on this topic among training physicians, both as a foundation in their education and in practice after the physicians have some experience. Further research is required, which in turn must be related to the specific circumstances in which any such conversations take place and in the topic to develop the strategies for these difficult conversations further.

Methodological Consideration

We acknowledge that generalisation could be called into question, however, qualitative research has the advantage of revealing a deeper insight into the physicians' strategies. This study comprised interviews with physicians where most of them were experienced and had a long career of caring for patients affected by an incurable disease. Despite the variety of differences in the ages and genders of the participants, the results revealed many similarities between them. This finding leads to the conclusion that the results can be recommended as a strategy to improve conversation skills.

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