

The inseparability of emotional and instrumental care in cancer: towards a more powerful science of clinical communication

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Abstract

Objective: Clinical communication literature currently distinguishes clinicians' emotional care of patients from instrumental aspects of clinical care, and regards clinicians' explicit emotional engagement with patients as the key to emotional care. Here we critically appraise this view.

Methods: We draw on empirical evidence and recent reviews and critiques focusing on cancer care.

Results: Patients and families do not generally seek explicit emotional engagement from their practitioners; nor does such engagement consistently improve patient outcomes. Instead some evidence indicates that anxious patients and families can be comforted by clinicians' focus on instrumental care.

Conclusions: Such findings can be interpreted according to the view that clinical relationships evoke attachment processes. In the context of mortal illness, patients are comforted by being able to trust clinicians whom they regard as having the expertise to look after them. From this perspective, instrumental and emotional care are inseparable. Clinicians' clinical authority and expertise is the basis for the emotional comfort they can provide.

Practice implications: For researchers and educators, a consequence of appreciating the inseparability of emotional and instrumental care will be greater emphasis on learning from, and collaborating with, clinicians. Clinicians, in turn, can benefit by communication scientists developing new approaches to supporting their communication. These approaches will need to recognize that clinicians' emphasis on their authority and clinical expertise in communicating with patients can be central to providing emotional comfort, and not necessarily a way to avoid doing so.

1 Introduction: revisiting the axiomatic importance of explicit emotional engagement in clinical communication research and education

Clinicians' explicit emotional engagement with their patients has long been a pivotal interest of clinical communication research and education in cancer care. This interest centres on emotional transactions around patients' expression of emotional concerns, or 'cues' to those concerns, and specifically on whether and how clinicians explicitly acknowledge and explore concerns and empathize with them. Literature around this subject has both empirical and normative dimensions. Empirical papers report how many cues or concerns arise in consultations and whether, and how, clinicians respond to them. Normative expectations are seen in criticisms of clinicians for insufficient engagement and in descriptions of cues that go unexplored, or concerns that elicit no empathic response, as missed 'empathic opportunities'. These criticisms are made freely, even in papers that do not show that engagement is associated with any other outcomes. That is, clinicians' explicit engagement with patients' emotional cues is a 'good' in its own right; it has acquired the status of an outcome that needs no further justification as a route to other outcomes.

Against a historical background of the criticism of medical practice as often dehumanizing and devaluing patients, the call for emotional engagement from clinicians has been a defining element of the drive for more compassionate care. However, moral calls to action can obscure scientific arguments and, for its future scientific credibility, clinical communication research needs to revisit the axiomatic importance attached to explicit emotional engagement.

2 Methods

We draw on empirical evidence and recent reviews and critiques focusing on cancer care, taking our recent critical review as a starting point[1].

3 Results and Discussion

3.1 Patients do not necessarily value clinicians' overt emotional engagement

At first sight, the view that patients are emotionally needy and rely on clinicians' explicit emotional support sits awkwardly with a second influential principle in communication literature – that patients are fundamentally autonomous in the sense that they can take responsibility for decisions about their care, and need to be empowered by information and choice to be participants in decision-making[1]. It also merits scrutiny because of continued

criticisms from clinicians about over-emphasis on the value of overt emotional engagement[2] and the continued absence of evidence from randomized controlled trials that, in the context of attentive and authoritative clinical care, clinicians' overt emotional engagement with patients' emotional cues or concerns improves patient outcomes. However, the critical reason to question the assumption that patients need clinicians' explicit emotional engagement is the evidence that this view is, at best, too simplistic and, at worst, misguided. Finset's group has, over many years of careful quantitative research, uncovered complexity around practitioners' overt emotional engagement, finding that psychosocial communication is not consistently related to patients' satisfaction or emotional outcomes and that psychosocial talk is less comforting than biomedical talk for some groups of patients, in particular anxious ones[3, 4], or at some stages of a consultation[5]. Similarly, qualitative research, while exposing patients' and families' despair in the context of cancer care, also shows that many patients (or, where patients are children, their parents) want practitioners to avoid explicit emotional engagement. Instead, they prioritise doctors' clinical care over counselling, and nurses' conversation about daily life rather than about emotional feelings[1].

3.2 The importance of the clinical context for communication

The priority attached to explicit emotional engagement in communication literature, particularly in serious illness such as cancer, cannot therefore be attributed to the strength of empirical evidence that patients seek it or that it improves other outcomes. Instead, it probably reflects the mental health background of the research and educational pioneers who drew on psychiatry, psychology and counselling to bring patients' emotional needs into a culture of medical care that seemed to place diseases, and not patients, at its centre. However, the context of medical care is very different from that of a mental health clinic, particularly when patients face mortal illness. Emotion is the starting point for mental health care, so a practitioner who wants to engage with the patient must focus on emotional feelings and processes, and build a relationship in which the patient is comfortable disclosing concerns that are normally private. By contrast, the starting point for understanding medical care for potentially serious illness is mortal vulnerability – patients have a disease that might be lethal, maiming or disabling, and hope that their clinicians can protect them [6]. There is a further, crucial contrast. In the mental health clinic, physical contact between patient and clinician would normally be censured, but the medical clinician has to touch patients to examine or treat them. Patients are aware of the difference, too – they expect the psychiatrist

or counsellor to engage with them emotionally, while they expect the surgeon or oncologist to treat them. A psychologist who often touches a patient would probably be seen as alarming, as would a surgeon who never did.

In this context, empirical findings on the kinds of clinician behaviours that do help comfort parents and families facing cancer or other mortal illness are not surprising – even though they diverge from the emphasis on explicit emotional engagement. Clinicians are comforting to the extent that they remain calm and focused on clinical care (even in the face of patients’ or parents’ flagrant emotional distress), show their expertise and authority, perform a careful physical examination, eschew distractions from focusing on the patient who is with them, and help patients to feel in a relationship of individuals by showing something of their own personality and by indicating that they recognize patients’ individuality[1]. Patients have a strong sense of the roles of those who surround them, so they can look to specialist nurses or their own family for more explicitly emotional support, and some will seek counselling or psychotherapy from psychologically trained practitioners; but they look to surgeons and physicians for treatment[7].

3.3 An integrative approach to instrumental and affective care

Recognising the fundamental asymmetry of clinical relationships in areas, such as cancer, where vulnerable patients consult experts who might be able to help them, educators and researchers have recently drawn on attachment theory to understand these relationships, and to understand what can go wrong in them[1]. For this theory, emotional comfort and instrumental care are not distinct domains. Rather, instrumental care is the key to emotional comfort because vulnerable people form emotional bonds with those to whom they attribute power to help them feel safe. First applied to parent-infant relationships, the theory has been extended to adult relationships including clinical relationships, and there is some evidence that patients can see efficient health-care teams and systems as a ‘secure base’, not just individual clinicians[6]. There are undoubtedly differences between adult and child attachments. In particular, whereas an infant who feels in danger is reassured by a parent’s embrace, adults are more likely to need evidence that the attachment figure can, indeed, protect them. Nevertheless, patients’ relationships with clinicians can resemble attachment, in that they build an image of their clinician that centres on the clinician’s expertise and authority and provides a secure base when facing the threat of serious illness[8].

This theory helps to explain other evidence that diverges from assumptions that have long shaped clinical communication literature and guidance[1]. Contrary to the view that clinical relationships are gradually built by clinicians' deployment of communication skills, patients can experience an intense sense of relationship the first time they meet a clinician who offers a 'safe haven' during the emotional turmoil of diagnosis of cancer[9]. That sense of relationship can be understood as a product of patients' own attachment needs, which motivate and shape the patients' projection of their fears and hopes onto the clinician. Similarly, contrary to the influential view that patients' sense of security and autonomy in the face of serious illness normally arises from their participation in decision-making, most patients facing cancer seem to gain their sense of autonomy from being able to depend on clinicians' decisions or recommendations[1]. Recent evidence diverges from long-standing guidance in a third, related area – patients' information needs. Despite the widespread emphasis on patients' needing information from clinicians so as to understand their disease and participate in treatment decision-making, research consistently emphasizes patients' and families' need for clinicians to constrain information[1]. While they want honesty, patients need clinicians to be selective so as not to overburden them with clinical details they do not understand, and in order to foster hope. For clinicians to take this role, patients have to feel that they are in a relationship within which they can hand over the responsibility to manage information for them – that is, an attachment relationship[10].

3.4 Towards a more powerful paradigm for clinical communication

The approach we outline here challenges a defining element of the architecture of clinical communication theory – the distinction between affective communication and instrumental care – seen, for example, in communication coding procedures that seek to separate affective and biomedical talk[4, 5, 11]. In the evidence that informs our approach, these two domains of communication, previously regarded as distinct, are seen to be inseparable, or interchangeable. Although anxiety about symptoms is a powerful driver to consulting a doctor, patients typically want the symptoms addressed, not their anxiety. Conversely, Finset's group recently described how, when patients in cancer consultations ask ostensibly biomedical questions, they can be voicing emotional needs[11]. When clinicians talk about biomedical aspects of treatment in the face of patients' distress, it can be a way, not to *evade* responsibility to provide emotional comfort, as is widely asserted, but to *meet* that responsibility[12]. Similarly, a clinician who provides clinical information to a frightened

patient demonstrates the expertise that might help the patient form an attachment to the clinician. That is, the act of receiving the information can be more important than remembering its content[10]. Analogue studies, in which patients or healthy participants rate videos of clinical consultations about cancer have suggested that clinicians' explicit assurance that they will not abandon patients reduces patients' anxiety and improves their recall of the consultation[13, 14]. In the context of expert and attentive instrumental care, reassurance of non-abandonment would explicitly signal the clinician's availability as an attachment figure. The inseparability of instrumental and emotional domains means that problems in one domain can become manifest in the other, too. For instance, when a patient seeks more information, it might indicate an emotional need to be able to trust the clinician, that is, a problem to be addressed in the clinical relationship rather than by providing more information[10, 11].

The natural sciences escaped the constraints of Newtonian physics, and entered the nuclear age, by learning that the previously distinct concepts of energy and mass are interchangeable. For communication scientists the comparable transition is to appreciate the connection of emotional and instrumental care. The reward will be a theory that can engage more powerfully with the dilemmas of practice than do current approaches, and that might thereby enhance the help that communication scientists can offer clinicians. Many of these dilemmas result from the interdependence of clinicians' exercise of their clinical authority and their provision of emotional care; for example, how to avoid misusing instrumental care to provide emotional comfort by sustaining illusory hope in cure, or how to meet cultural and legal expectations around informed consent when patients want to transfer responsibility to the clinician so they can feel freed to focus on living day-to-day.

4 Practice implications: who are the communication experts?

Adopting the dualist view, whereby emotional comfort and biomedically oriented care and communication are distinct, communication researchers and educators concerned with patients' emotional needs have tended to focus on the emotional domain, to which many can bring particular expertise reflecting their psychological backgrounds. In an integrative view, in which emotional and instrumental communication are inseparable, this 'comfort zone' is not available; a broader perspective on emotional care is needed which encompasses the emotional properties of instrumental care. This challenge presages, however, a more exciting and influential field of clinical communication, one in which communication research and

education will need to be much more collaborative with practitioners than hitherto[2] because, without them, communication scientists cannot understand, or seek to influence, instrumental elements of communication. Indeed, there is potentially much more to learn from practitioners – by collaboration and also by making their communication the subject of research – than has been generally appreciated. Practitioners necessarily work at the interface of emotional and instrumental care and so find solutions to dilemmas that this interface creates. These solutions are a vast, and still barely explored, resource for researchers and educators. The challenge for researchers will be to identify the good solutions and to expose the tacit knowledge on which these are based so that this can inform communication education in future. The challenge for educators will then be to find new ways to support and enhance practitioners' communication that respect the emotional, as well as instrumental, expertise that clinicians already bring[2, 15].

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