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Communication in palliative care

Abstract

Communication consists in an intentional exchange of verbal and non-verbal signs (symbols) undertaken in order to improve cooperation or share meanings among partners. The communication occurs on many levels, from the intrapersonal through interpersonal (involving a group), to the public level.

In the context of palliative care, special importance is gained by the basic social behaviours, such as the ability to conduct a conversation. Communicativeness is a skill that is not only acquired through experience, but also through professional training. The interest of the interdisciplinary team requires improvement of the qualifications of its members in this respect. Only through full cooperation with the patient and the family, which will take into account the emotions and needs, can one negotiate common goals concerning care. Interdisciplinary team members should ensure proper communication in order to ensure the provision of optimal support to the patient and the family.

Key words: communication, interdisciplinary team, truth telling

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Introduction

Communication consists in an intentional exchange of verbal and non-verbal signs (symbols) undertaken in order to improve cooperation or share meanings among partners. The communication occurs on many levels, from the intrapersonal through interpersonal (involving a group), to the public level. The most important function of communication is to coordinate the activities of all participants in this process. In order to ensure that interpersonal interactions run unobstructed, it is not enough to use the same language, but it is necessary to include the experience, values and emotions contributed by each side [1].

Good communication skills also constitute the basis for a good cooperation among the interdisciplinary team, the terminally ill patient and his/her family. Without mutual respect, it is impossible to achieve mutual understanding and effect a good and satisfying cooperation. Without offering holis-

tic care to the patient and his/her family, we are not in a position to provide support even at the most basic level. Only by constantly improving communicative competence can the physician achieve genuine contact with the patient and respond as far as possible to all his needs, including emotional and spiritual ones. Interdisciplinary team members should understand the principles that govern group dynamics. Every individual contributes his/her own values, convictions and experiences. The ability to cooperate as a team is also subject to rules of communication and thereby demands training. In its broader context, palliative care constitutes a part of medicine that developed in response to the need to provide the terminally person with special concern and care. Therefore, one needs to ensure that the idea of the hospice movement is constantly alive and present in the public eye. To that end, it is necessary to inform the public about the values of palliative care, about the demand for this kind of centres and progress in this specialty of medicine.

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Physician – patient communication

Research demonstrates that communicativeness is a skill that one can and ought to practise. Experience alone will not suffice. It turns out that professional practice of such skills permits the individual talking with the patient to work out an approach that offers an opportunity for a better evaluation of the influence of emotional, social and spiritual factors on the patient's well-being. Through special training, the team learns how to better respond to verbal and non-verbal cues concerning emotions, to ask more relevant questions and express empathy to a greater extent [2].

Special communication skills are necessary when new information becomes available about the worsening condition of the patient. The ability to convey unfavourable information is an art, but also a controversial matter. Quite a few physicians are afraid of facing a situation in which they will be obliged to convey unfavourable news to their patients. They fear that taking away their faith in recuperation, they will consequently worsen the physical and mental condition of the patient [3]. Paradoxically, research results show that it is precisely a heart-to-heart conversation, taking into account the sensibility of the patient, helps him to maintain hope despite an unfavourable prognosis. Such a conversation need not necessarily be accompanied by violent emotional outbursts; a lot depends on the manner in which the physician adjusts to the patient's reaction and reacts to them on an ongoing basis. The patient, aware of his own condition is more satisfied with palliative care provided to him/her. Good communication should underlie cooperation between the physician and the patient since it brings about mutual benefits. The physician gains a sense of satisfaction from mutual trust, while the patient benefits from a sense of security. If a successful relationship starts between the patient and the physician, there will be room for expressing emotions on both sides. The contact with the patient should not be a one-off occurrence, but should happen regularly. During such meetings there should be time to express feelings. Showing empathy to the patient causes him to shed much of his/her irritation and anger. In the case of palliative patients, this acquires special significance, because strong emotions tend to become suppressed.

It turns out that if, when taking a patient's history, the interview includes not just the health condition of the patient, but also its psychosocial determinants, it will, paradoxically, be shorter by about

15–20%. The physician capable of conducting an appropriate conversation with the patient and to deal with difficult emotions that accompany a serious illness will more quickly succeed in winning his/her confidence. The patient, who is certain that the physician takes into account all his difficulties and needs related to his state of health, will be more ready to disclose the real reason behind his difficulties. Such attitude favours better cooperation and offers to the patient a sense of security, which cannot be overrated at this difficult time. In this way, the interview is shorter and permits better planning of cooperation with the patient achieve common objectives. Naturally, the conversation skill does not result only from such predispositions as empathy or inborn sensitivity, but, first of all, from experience.

Conveying new unfavourable information concerning the state of health demands not only intuition, but also the use of a suitable strategy during the conversation with the patient. By learning this difficult information, the patient and his/her family can set themselves realistic targets and establish new priorities in view of the inevitable death. It is important to find out before such conversation what the patient really wants to know about his/her health condition. Such information should be gleaned during previous consultations. If they are not encouraged to share their own doubts, the patients' doubts will not be revealed. The same should be remembered about the way bad news is communicated to the family.

It is advisable to observe a certain pattern of conversation; on the other hand, it should not be applied rigidly, but adapted to the changing situation with a degree of flexibility. The conversation should start with the patient's condition. Then, the physician should find out to what extent the family are aware of how advanced the disease is and attempt to deliver the most reliable information. During such a conversation, it is a good idea to touch upon such issues as symptoms, which the patient will have to face, and remedial options that can be proposed by the physician. One ought ask the patient about his/her preferences regarding care and his wishes concerning what should happen after his/her departure. After the delivery of such difficult information, the physician should try to display compassion and empathy, and then wait for the reaction on the part of the patient, try to read his/her emotions and to find out to what extent the message was understood [2].

One of the aspects of conveying unfavourable news concerning health involves coping with strong

negative emotions. The NURSE method serves to overcome these (the acronym stands for name, understand, respect, support, explore). The physician should show the patient that s/he is aware of his/her emotions, should try to name them, but one should not impose this on the patient. The physician should show that s/he understands the patient's feelings and respect in the face of this difficult situation. Demonstrating support helps to improve the patient's sense of security. Most importantly, the physician needs to recognize the reasons for all the mental difficulties experienced by the patient, such as depression. One cannot overrate the skill of speaking with the patient. It is necessary if we want the patient to be able to maintain realistic hope that his life could be happy despite his illness.

In the context of a serious illness, patients are often full of very conflicting and suppressed emotions. Cooperation with such a patient in this stressful situation may lead to increased tension. It is best to resolve conflicts in an open manner. Emotions should find their relief in a balanced way. It is worth to sum up individual stages of the conversation and try to adopt the patient's perspective showing understanding for their feelings. A terminal illness threatens the patient's identity, makes identification difficult and lowers self-esteem. Therefore it is necessary to recognize the needs of the patient and to help to try to him to regain a favourable image of himself [4].

The terminally ill patient should be offered psychological care when he needs support. The psychologist can suggest appropriate psychotherapeutic interventions, which will permit the patient to better manage his/her own feelings. In this way, the patient obtains additional support besides pharmacotherapy, which will improve his/her locus of control. The patient who copes better with his own fears, improves his/her communication skills, both with the family and with the medical staff. The most important therapeutic aims at this time involve the provision of social support. At this difficult time, the patient should not be isolated. A support network should be organised for him/her. In this way, the sense of anxiety and the sense of loneliness are reduced. Therapeutic interventions are also aimed at the abreaction of difficult emotions and also showing the patient that being ill causes feelings such as irritation and anger. This is absolutely normal at that time and should not provoke a sense of guilt. Psychological assistance at this time should focus on helping the patient to confront approach-

ing death and the consequences of this event in all dimensions, including the patient's family. The psychologist tries to help the patient to find a new sense of life and to accept a new temporary perspective, more focussed on the present. The terminally ill patient should focus on being here and now, instead of turning his thoughts to the future. At that time, family relations need to be worked on, because the progress of a serious illness tends to disrupt them. Family members have been forced to accept new roles and learn new responsibilities. It is necessary to try to resolve all family conflicts so that they do not cause unnecessary suffering to the patient [5].

Physician – family communication

One may not plan good patient care without taking the family into account. Holistic palliative care consists in supporting the family, in communicating the necessary information concerning the patient's condition, help in providing nursing care to the patient. It is essential matter to prepare the family to the departure of their relative and ensure support after the patient's death.

In planning optimal palliative care in the terminal stage of the disease, one ought to take into account the most important relationships of the patient with close relatives. The patient, the family and the interdisciplinary team should set common objectives via mutual agreement. The family needs to be updated on the changing health condition and the prognosis. The relationship between the physician and the family should include room for an expression of feelings and the provision of support. In order to ensure that the family and the patient can make the best decisions, they ought to be informed about all the advantages and disadvantages of proposed treatment. Breaking bad news to the family requires prior preparation in order to be able to answer all the questions. The physician needs to find out what the family already know about the condition of the patient, and then brief them on the current state of health. The family needs to be helped to show feelings, before setting common objectives and ways to achieve them. It is a mistake to delay such a conversation when it is already known that the disease is terminal.

In patient-oriented medicine, paramount importance is attached to patient values and relationships with the next of kin. In such a context, the physician ceases to be the person who can make the best decisions concerning the choice of treat-

ment of the patient [6]. One must remember that family members do not have full insight into the medical condition of the patient. Strong emotions impact the manner of information processing, the perception and the decision making. Not only the patient, but also his family use defence mechanisms in order to reduce emotional tension. In order to understand the patient better, proposed was the model in which the conversation occurs at different levels. Key to the good and successful communication is the understanding of how the other side perceives the problem subjectively. The interpretation of conversation does not consist in the understanding of facts, but in the way in which they are perceived. What is important is to recognise the value and experiences represented by the family in order to improve communication with them. The physician should be aware of his/her own contribution to this relationship, own emotions and experiences, which can influence mutual interactions. The most serious communication problems arise when one denies affective influence on the relationship between the patient, the physician, and the family [4].

Directing attention to emotions felt by the family allows one to identify defence mechanisms triggered by them. Denial by the family may lead to a conspiracy of silence around the patient. Ignoring psychological problems, which the family must face when one of its members is dying, causes patient isolation, forces, him/her to cope with own fears alone, deprived of support [7].

Interdisciplinary team communication

The team working in hospices and palliative care units is exposed to a special emotional load. The continual confrontation with suffering and death and special responsibility for decisions, often of ethical nature, may lead to the emergence of the burn out syndrome. In such teams, cooperation and good communication and the most important assets. Mutual agreement and clarity of goals are necessary. Unfortunately, the nature of palliative care work causes often gives rise to circumstances that may lead to tensions and misunderstandings. A certain model for the resolution of such conflicts should be in place in order to minimize the their emotional costs and negative impact that affects not only the staff members, but also the patient and his/her family. It is recommended that, in such situations, strong feelings, which may at first arise in such a situation, should not guide the actions. One needs to discuss

matters with the other side presenting one's own point of view, and then listen calmly to the arguments of the other side. One should underline the achievement of a common goal for the sake of the patient. Opening oneself to somebody else's opinions and readiness to compromise may help find shared solutions to the problem at hand as opposed to the unnecessary criticism and aggressive attitudes [2].

Members of the interdisciplinary team need mutual support and confidence, because decisions concerning patient care have a special significance. Sharing responsibilities may improve satisfaction with results achieved and reduce the sense of helplessness. The art of making good decisions is a skill that needs to be developed. Palliative medicine faces physicians on an everyday basis with peculiar ethical dilemmas.

Despite the understanding that the most important objective is to relieve suffering, quite often the choice of the proper way to treat is burdened four basic difficulties. Firstly, it involves clinical inertia, which consist in the habitual implementation of outdated medical procedures, despite the fact that clinical trials indicate their ineffectiveness. In such a situation, what is necessary is not only flexibility and openness to novelty on the part of the medical staff, but also readiness to explain to the patient and to the family, why a particular manner of assistance has been chosen, other than the traditional one. Another obstacle is scepticism, whose source is the sense of helplessness. Quite frequently it comes across as conflicts within the team. The sense of frustration needs to be prevented by constant improvement of one's own qualifications, better awareness of oneself and the recognition of the source of internal helplessness. A passive attitude, lack of initiative and avoidance of difficulties cause that the most important goal, which is the good of the patient, is lost. It is necessary to involve the whole team in the tasks at hand and in making joint decisions actively. The last trap is failure in self-criticism. When palliative care team members demonstrate recklessness, lack of compassion and overconfidence in the decision-making process, the tension and number of conflicts increase [8].

It appears that the crucial idea that should constitute the focus of the interdisciplinary team work is patient autonomy and respect for his/her dignity.

Team cooperation is influenced not only by conscious factors, but also by defence mechanisms that

can be triggered in the context of stress by every team member. First of all, they include denial. The threat that comes from such an attitude causes a delay in the decision to pass from causal to symptomatic treatment. The physician who fails to perceive exacerbated symptoms in the patient will be unable to help him/her not only from the medical point of view, but will also fail to provide the necessary emotional support. Mental problems that may arise while working with the terminally ill patient may prevent the patient from receiving proper help, while the intensification of his symptoms may be iatrogenic in nature [7].

The goal of the interdisciplinary team is to coordinate patient care and respond to his/her social, emotional and spiritual needs of the terminally ill patient, as well as his/her family. Communication takes place on several different levels. One ought to remember that we all are subject to its rules and we must observe the rules which it governs. A principal idea of the philosophy behind palliative medicine is respect toward patient autonomy and patient's suffering.

Social communication

Communication processes permeate all social interactions. They also occur among organizations. Different types of institutions dealing with palliative care should propagate the idea of the hospice movement. We live in a culture that keeps denying the ageing process and dying. It is dominated by the cult of youth, with the fear of death being pushed out to the sphere of public unawareness. Therefore advocacy and protection of the rights of terminally ill patients is especially important. The part played by non-profit organizations and volunteer work organisations cannot be overstated. Their contribution to public awareness bring about changes in the mentality and the death-negating culture as well as raises the awareness of the necessity to provide competent and compassionate care to incurably ill patients [9].

Conclusion

The process of communication involves not just single individuals, but also groups of people. In the context of palliative care, special importance is gained by the basic social behaviours, such as the ability to conduct a conversation. Communicativeness is a skill that is not only acquired through experience, but also through professional training. The interest of the interdisciplinary team requires improvement of the qualifications of its members in this respect. Only through full cooperation with the patient and the family, which will take into account the emotions and needs, can one negotiate common goals concerning care. Interdisciplinary team members should ensure proper communication in order to ensure the provision of optimal support to the patient and the family. At the top level of communication among organizations, ways should be sought in which to propagate the idea of the hospice and palliative care movement to the public.

References

1. Nęcki Z. Komunikacja interpersonalna. In: Szewczuk W. *Encyklopedia psychologii*. Fundacja INNOWACJA, Warszawa 1998; 149–154.
2. Heaven C., Green C. Good Communication: Patients, Families and Professionals. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 613–619.
3. Clayton J.B. Telling the Truth: Bad News. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 620–625.
4. Elbert-Avila K.T. Problems in Communication. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 625–629.
5. Spiegel D. Counseling. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 630–634.
6. Marchand L.R. The Plan of Care. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 662–665.
7. Arranz P., Barreto P. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 647–650.
8. Altisent R., Torrubia M. Making Good Decisions. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 643–647.
9. Floriani F.C. Public Advocacy and Community Outreach. In: Walsh D. *Palliative Medicine. Expert Consult*. Elsevier Health Sciences 2009; 635–637.

