



Transitioning out of prognostic talk in discussions with families of hospice patients at the end of life: A conversation analytic study



Rebecca J. Anderson^{a,*}, Patrick C. Stone^a, Joseph T.S. Low^a, Steven Bloch^b

^a Marie Curie Palliative Care Research Department, Division of Psychiatry, UCL, London, UK

^b Department of Language and Cognition, Division of Psychology and Language Sciences, UCL, London, UK

ARTICLE INFO

Article history:

Received 4 June 2020

Received in revised form 5 October 2020

Accepted 6 October 2020

Keywords:

Communication

Conversation analysis

End of life

Palliative care

Hospice

Uncertainty

Prognosis

ABSTRACT

Objective: To examine transitions out of prognostic talk in interactions between clinicians and the relatives and friends of imminently dying hospice patients.

Methods: Conversation analysis of 20 conversations between specialist palliative care clinicians and the families of imminently dying patients in a hospice.

Results: Following the provision and acknowledgement of a prognostic estimate, clinicians were able to transition gradually towards making assurances about actions that could be taken to ensure patient comfort. When families raised concerns or questions, this transition sequence was extended. Clinicians addressed these questions or concerns and then pivoted to action-oriented talk, most often relating to patient comfort.

Conclusion: In conversations at the end of life, families and clinicians used practices to transition from the uncertainty of prognosis to more certain, controllable topics including comfort care.

Practice Implications: In a context in which there is a great deal of uncertainty, transitioning towards talk on comfort care can emphasise action and the continued care of the patient and their family.

© 2020 The Author(s). Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

1. Introduction

Communication is a key element of compassionate, palliative care [1,2]. Prognostic discussions can be especially important, as patients who have end-of-life discussions and are informed of their prognosis are more likely to die in their preferred place and less likely to have aggressive treatments in the last week of life [3,4]. For families, being told their relative is imminently dying allows them to prepare for the death, both emotionally and practically.

Recent research has examined the ways end-of-life issues are addressed by clinicians, patients and families. Conversation analytic studies across different settings have shown how clinicians provide opportunities for patients and families to raise topics related to the end of life [5–9]. Our study of conversations with families of imminently dying patients showed that clinicians provided a categorical prognosis (e.g. hours or days), explained how they reached that prognosis, and made clear that they could not predict exact timelines [10]. Other studies of communication with families have shown that clinicians use strategies such as

highlighting patients' deterioration to cultivate prognostic awareness and tailor their communication to individual families [11].

Clinicians describe a lack of time and worries about losing control as reasons for not discussing prognosis [12,13]. They sometimes avoid discussing prognosis or can rush past prognostic talk to focus instead on treatments [14,15], while others can give the impression that once life-sustaining treatments stop, care staff would “not do anything” for the patient [16]. Interview studies have also found that some families felt abandoned at the end of life [17,18]. If prognostic discussions are moved on abruptly, families may feel they have not fully discussed prognosis and may not be prepared for the patient's death. Such communication can have lasting impacts on families' impressions of patients' care and their adjustment to bereavement [19–21].

Despite increasing research on how prognostication is initiated and discussed with patients and families, there is little evidence about how conversations move on following a prognostic estimate. Existing literature shows that topic transitions are delicate, interactively managed points in conversations that can cause problems if too disjunctive rather than being gradual ‘stepwise’ transitions [22–24]. The interactional delicacy of topic transitions, combined with the importance of ensuring families feel they have been listened to, suggest that transitions out of prognostic talk need to be handled sensitively. This paper therefore aims to examine the structure of transitions out of prognostic talk and the

* Corresponding author at: Marie Curie Palliative Care Research Department, Division of Psychiatry, University College London, 6th Floor, Maple House, 149 Tottenham Court Road, London, W1T 7NF, UK.

E-mail address: rebecca.anderson.16@ucl.ac.uk (R.J. Anderson).

practices used by experienced palliative care clinicians during these transitions in conversations with families of imminently dying patients. The findings from this paper can provide evidence-based recommendations for strategies to aid clinicians in transitioning to other conversational topics following prognostic discussions.

2. Method

Conversations between senior, experienced clinicians and families of hospice inpatients were audio-recorded at one UK hospice. Family members were eligible to participate if they were over 18, could engage in conversational English, and were close relatives or friends of a patient who was judged by clinicians to be imminently dying and lacking capacity. Clinicians were eligible if they were palliative care consultants, specialist registrars with at least three months' experience in the role, or clinical nurse specialists. Recordings were analysed using conversation analysis, an approach which uses recordings of naturally occurring conversations to examine the interactional practices used by participants in conversations [25]. Recordings were transcribed using Jeffersonian transcription; used as standard in conversation analysis [26,27] (see Appendix A for a table of all transcription symbols used in this paper).

The analysis focuses on how prognostic talk is exited. We identified a collection of all instances of prognostic talk, and examined how this was exited so that other aspects of care could be discussed. For the purposes of this analysis, we define prognostic talk as discussions about the expected time to the patient's death, the related uncertainty, and the family's responses to this information. The analysis presented does not address the prognostic estimate itself, but in some cases, we include the delivery of a prognosis in the extracts to provide the context of the transition. An analysis of the prognostic talk itself, alongside a detailed description of the methods used in this study, can be found elsewhere [10]. This study received ethical approval from the University College London Research Ethics Committee on 17th July 2017 (ref 11519/001).

3. Results

Consent was obtained for 29 recorded conversations, 23 of which included prognostic talk. The analysis describes transition

sequences that were identified in 20 of the 23 conversations in which prognostic talk occurred. In two of the remaining three cases, family members displayed that they were already aware of the short prognosis, therefore not treating the prognostic statement as newsworthy, and moved the conversation onto another topic. In the final case, the son of a patient had made a time estimate request at a point which interrupted his mother trying to raise another, unrelated concern. Once the clinician provided a prognosis, his mother moved the conversation back to her previous concern.

The characteristics of the participants in the 20 conversations included in this analysis are provided in Table 1. Clinicians included two consultants, two registrars and one clinical nurse specialist, and the majority of relatives were either the adult child or spouse of a patient.

Across the 20 conversations included in this analysis, there was a pattern in which clinicians and family members transitioned from the uncertainty of prognosis to more certain, controllable topics, particularly comfort care. In the analysis below, we outline the structure of these transitions, describe cases in which this transition is extended by families' responses to receiving a prognosis, and present a deviant case in which the transition sequence takes a different course.

3.1. The structure of transitions out of prognostic talk

In eleven cases, once a prognostic estimate has been provided, transition sequences include the following three actions:

- 1 A family member provides acceptance or acknowledgement of the prognosis. This takes various forms including acknowledgement tokens (e.g. "okay", "right", "yeah"), partial repetitions or summing up the prognostic statement (e.g. "she's too far gone"), and descriptions of changes the family member has seen which convey agreement with the short prognosis (e.g. "she's been breathing at this rate for definitely twenty-four hours"): This acknowledgement of the prognosis is a preferred response [28], allowing the clinician to move to the second action:
- 2 The clinician makes assurances about the patient's comfort. This is mostly through describing the comfort care that care team will provide, but there are also cases where clinicians describe the role families can play to increase patients' comfort and wellbeing.

Table 1
Participant characteristics.

	Clinicians (N = 5)	Family members (N = 32)
Female, N (%)	3 (60)	24 (75.0)
Mean age, years (range)	40.8 (31-53)	49.7 (24-86)
Ethnicity		
White British or Irish, N (%)	2 (40)	21 (65.6)
White Other, N (%)	1 (20)	3 (9.4)
Mixed White/Asian, N (%)	2 (40)	2 (6.3)
Black African, N (%)	0	4 (12.5)
Black Caribbean, N (%)	0	1 (3.1)
Indian, N (%)	0	1(3.1)
Mean years in palliative care (range)	9.4 (1.7-19)	-
Job title		
Consultant, N (%)	2 (40)	-
Specialist registrar, N (%)	2 (40)	-
Clinical nurse specialist, N (%)	1 (20)	-
Relation to patient		
Adult child, N (%)	-	18 (56.3)
Partner/Spouse, N (%)	-	7 (21.9)
Friend, N (%)	-	2 (6.3)
Sibling, N (%)	-	1 (3.1)
Cousin, N (%)	-	2 (6.3)
Son-in-law, N (%)	-	2 (6.3)

3 A family member affiliates with the clinician’s descriptions of the need and/or plan for comfort care. These affiliations include acknowledgement tokens (e.g. “okay”, “yeah”) and more explicit displays of agreement (e.g. “okay that’s fine”, “make her comfortable yeah”).

These three actions are mapped onto the extracts in Tables 2 and 3 below. Table 2 is an extract of a conversation between a doctor (DOC) and the friend of a patient (FRI). Prior to this extract they had discussed the patient’s confusion and pain.

In line 3, the friend displays some awareness of the length of the prognosis by asking “you mean like days?”. After confirming this the doctor pursues a more explicit acknowledgement of the prognosis by soliciting the friend’s view (lines 6–7). This elicits the preferred response from the friend [28] of displaying acceptance of the prognosis, giving her own account of the patient’s deterioration (lines 8–10).

Eliciting this acceptance from the friend enables the doctor to begin to transition away from prognostic talk. At this point, there are several markers of upcoming topic change. Firstly, the doctor affiliates with the friend’s account (line 12), providing a summary statement that displays their shared perspective. This elicits further agreement from the friend which is followed by the doctor’s acknowledgement token “yeah” (lines 14–15). Finally, when the doctor produces the statement which transitions away

from prognostic talk in line 17, this is preceded by “so”. Acknowledgement tokens, summary statements and the marker “so” are all common precursors to topic change [22,29,30].

Over lines 17–25, the doctor successfully transitions to the topic of comfort care. This is fitted to the friend’s previously expressed concerns, as prior to this extract, the doctor and friend had discussed the patient’s wish for no further treatment and their priority of avoiding pain. The multiple references to “we” when describing not prolonging life on lines 17–20 therefore invoke the whole care team, but also the collaboration between the care team and the friend. The doctor then provides a ‘bright-side’ perspective, often associated with closing a bad news sequence [31]. In this case, the ‘bright-side’ is that there are actions they can take to avoid pain (lines 22–25). When providing the prognosis, the doctor had used qualifying language such as “think” (lines 1, 4 & 6) or “probably” (line 1) [10]. In contrast, when transitioning to talk on comfort care, the doctor changes to more certain, action-oriented language such as “definitely” (line 24) and clearly listing what will be done.

The friend displays approval for both parts of the proposed plan. In line 21, in overlap with the doctor completing the description of not taking steps to prolong life, the friend displays agreement. She then provides a positive assessment of the plan at line 26, and orients to her perspective being acknowledged by thanking the clinician at line 28. Following this extract the doctor goes into

Table 2
Recording 05_42, 05:13–05:44.

<p>01 DOC: °I <u>think</u>° (0.9) °he probably has a limited amount 02 of time now.° 03 FRI: You mean like (0.3) <u>days</u> [or, 04 DOC: [°I think <u>days</u> yes.°</p>	<p>Prognostic statement</p>
<p>05 (0.7) 06 HCP: °°I think <u>days</u>.°° (0.4) Is that (0.4) what you’ve 07 been expect[ing.</p>	
<p>08 FRI: [shhh ~Yeah.~ hhh (0.3) ↑Jus:t 09 from (.) my own like (.)<u>seeing</u> how he is and how 10 quickly he’s going (0.4) downhill.</p>	<p>1. Family member provides acceptance / acknowledgement</p>
<p>11 (0.4) 12 DOC: °That’s what you see as well° 13 (0.3) 14 FRI: [°Yeah°] 15 DOC: [°Yeah°] °yeh° 16 (0.4)</p>	
<p>17 DOC: .hhh So we’ll (.) we <u>won’t</u> do anything (.) to 18 <u>prolong</u> his life, .hh So we won’t to >anything< 19 (0.3) °as° (.) we already said no blood 20 [tests no other <u>treatment</u> of the] calcium, .h but 21 FRI: [Yea:h yea:h yeah] 22 DOC: what we’ll be <u>really</u> (0.2) <u>really</u> careful about is 23 °that he° .hh to (0.9) avoid any (0.2) unnecessarily 24 (0.4) u unnecessary dis↑tress and <u>definitely</u> avoid 25 any pain.</p>	<p>2. Clinician makes assurances about the patient’s comfort</p>
<p>26 FRI: .hhh Yeh (.) that would be <u>great</u>. 27 DOC: °Yeh° 28 FRI: ↑Thanks</p>	<p>3. Family member affiliates with plan for comfort care</p>

Table 3
Recording 02_10, 07:00-07:35.

01 DOC: I <u>think</u> if you look back (0.5) over the last (1.0)	Prognostic statement
02 <u>few days</u> and then <u>before</u> what happened, (0.6) um	
03 I think it would um be <u>days</u> ,	
04 (0.3)	1. Family member provides acceptance/ acknowledgement
05 DAU: Right.	
06 (1.0)	
07 DOC: Over which time he would become (0.9) increasingly	2. Clinician makes assurances about the patient's comfort 3. Family member affiliates with plan for comfort care
08 (0.2) I think disorientate:d more sleepy, (0.2)	
09 .hhh and at some stage I think he would be more or	
10 less (0.8) asleep all the <u>ti:me</u> . Now if he's	
11 agitated <u>with tha:t</u>	
12 DAU: You can (.)	
13 DOC: we can [give him medication] yes. O:r subcutaneous	
14 DAU: [do <u>intravenous</u>]	
15 DOC: usually.	
16 DAU: <u>Right</u> .	
17 (0.7)	
18 DOC: To:: help him to relax .hhh [um]	
19 DAU: [Yeh.]	
20 (0.9)	
21 DAU: Cause that (.) I mean <u>that's one</u> thing. (1.4) No	
22 one wants him to be ↑anxious=	
23 DOC: =No.	

further detail about how the team would treat anxiety and pain, further consolidating the topic change to comfort care.

Table 3 is a further example of this transition sequence. This is a conversation between a doctor (DOC) and the daughter of a patient (DAU). Much of the conversation prior to this extract had focused on the patient's disorientation, which is raised once again during this extract.

Following the prognostic estimate of days, the daughter provides a preferred response by acknowledging of the prognosis (line 5). Again this enables a transition from prognosis. In this case there were fewer topic change markers than in the Table 2 conversation, and the transition more clearly resembles a stepwise topic transition [22,32]. Following the daughter's acknowledgement of the time estimate, the doctor provides further prognostic information by describing the patient's likely disorientation and sleepiness. This leads to the doctor's pivotal utterance [32], "now if he's more agitated with that we can give him medication" (lines 10-13). This statement links the previous prognostic talk about the patient's likely decline, with assurances about what can be done to address the daughter's previously stated concerns about disorientation and agitation.

The daughter completes the doctor's suggestion in partial overlap, displaying recognition and affiliation with the doctor's suggestion of medication to treat disorientation and agitation, and her own independent knowledge of treatment options (lines 12-14) [28,33-35]. The doctor confirms the daughter's suggestion (while correcting "intravenous" to "subcutaneous"), stating that this would help the patient to relax. The daughter endorses this plan by once again stating that her father's anxiety is the main concern (lines 21-22), to which the doctor agrees (line 23).

While there are small differences in the ways in which they are expressed, both of these extracts demonstrate the same structure and actions. Acknowledgement of the short prognosis is a preferred response to a prognostic statement [28] (or to the elicitation of the friend's view of this prognosis as in Table 2), enabling the doctor to start a new action in the next turn by beginning the transition out of prognostic talk and towards comfort care. Discussing comfort at the end of life is linked with prognosis and so could be gradually transitioned to from prognostic talk in an unproblematic fashion [22,32]. In both cases, the family member's response was to display approval of the suggested comfort care measures, therefore consolidating this topic change.

3.2. Extended transition sequences

In eight cases, the transition sequence described above is extended as, having received an uncertain prognosis, family members raise other questions or concerns. Such transition sequences include the following actions once a prognostic estimate has been provided:

- 1 A family member raises a concern or question. These mostly relate to the patient's physical condition, but in two cases concern the impact of the prognosis on the family (see supplementary material for an example). These questions or concerns begin to move the conversation away from time estimates, but put the clinician in a position where they must respond to the question or concern and therefore cannot immediately transition towards making assurances about the patient's comfort.

- 2 The clinician addresses the concern or question raised by the family. This is done by answering a question or concern, or affiliating with a troubles telling.
- 3 In responding to concerns and questions, the clinician then pivots towards making assurances about actions that can be taken, mostly regarding the patient’s comfort. However, when the stated concerns relate to the impact on the family, the suggested actions address these concerns instead (e.g. offering counselling or suggesting ways the family can look after their own wellbeing).
- 4 A family member affiliates with the clinician’s suggestion.

body (lines 5-7). The relevant next turn after a question is an answer [36], and so the doctor is obliged to provide this and therefore unable to immediately transition to assurances about the patient’s comfort. The question does however begin to move the conversation away from time estimates and towards a topic about which the doctor can be more certain. The language in the doctor’s description of what is happening inside the patient’s body is more equivocal than the previous talk on prognosis (not shown here), as fewer qualifying terms such as “probably” or “I think” are used. However, this description does not convey complete certainty and does not orient to action. The doctor uses terms such as “kind of”, “sort’ve” and “essentially”, and these turns at talk include several disfluencies including pauses and “erm”s (lines 11-17), suggesting some remaining difficulty in responding to the daughter’s question. While the physical process of dying is more objective than predicting time to death, it remains difficult to know exactly what is happening to a person’s body at this time. At line 21, the doctor therefore pivots towards talk about comfort care, using “and then” to link it with the previous talk. This allows more certain

Table 4 is a conversation between a registrar (DOC) and the daughter (DAU) and wife (WIF) of a patient. Prior to this extract, the doctor provided a prognostic estimate of “days”.

Following the doctor’s statement of uncertainty in line 1, the wife displays acceptance of the uncertainty of the prognosis (lines 2, 4 & 6). However, in overlap with the wife and doctor, the daughter then asks about what was happening to the patient’s

Table 4
Recording 07_17, 04:33-05:10.

<p>01 DOC: [↑It’s <u>difficult</u> to] <u>be</u> more [precise] 02 WIF: [because I find] [I know] 03 DOC: [than that] 04 WIF: [I know]</p>	<p>Uncertainty expressed following prognostic statement</p>
<p>05 DAU: [Is it more] a [question not <u>merely</u> a question of] 06 WIF: [It’s fine it’s fine.] 07 DAU: his hear[t or is that the wrong thing.]</p>	<p>1. Family member raises a concern or question</p>
<p>08 DOC: [tch .hh ↑<u>Well</u> it’s often the] <u>cancer</u> making 09 the body <u>so</u> weak, 10 DAU: Yes 11 DOC: Y’know kind of as <u>well</u> [because it’s often that .hh] 12 DAU: [That’s what I thought yeh] 13 DOC: and then obviously <u>with</u> that then th- the body 14 being able <u>cope</u> with (0.2) er:m (.) things and 15 then [.hh] essentially, (0.2) er::m the cancer’s 16 DAU: [Mmm] 17 DOC: sort’ve <u>overwhelming</u> the body [and the] hear:t and 18 WIF: [yeh mm] 19 DOC: [other] vital or[gans] can’t <u>cope</u> anymore. .hh 20 DAU: [Mmm] [mm]</p>	<p>2. Clinician addresses concern or question</p>
<p>21 DOC: And then our <u>focus</u> now is ↑very much on keeping 22 Simon as <u>comfortable</u> as pos[sible, .hh] 23 WIF: [<u>Yes yes</u>] 24 DOC: and not doing things unneces[sari]=now the nurses 25 DAU: [yes] 26 DOC: <u>will</u> have to position, 27 DAU: Yeh 28 DOC: and help him, (.) to be comfortable, .hh If 29 <u>necessary</u> they will give extra <u>injections</u> prior 30 WIF: Y:eh 31 DOC: to <u>move</u>[ment and things] too. 32 DAU: [Y:eh yeh]</p>	<p>3. Clinician pivots towards action 4. Family members affiliate with clinician’s suggestion</p>

Table 5
Recording 02_52, 07:11-10:05.

<p>01 DOC: I think that <u>rate</u> of change means that that he 02 he may (0.3) <u>sadly</u> he may only have some <u>days</u> 03 left. 04 DAU: °Mmm°</p>	<p>Prognostic statement</p>
<p>05 SON: Yeh <u>yesterday</u> he coughed up I've got a picture of 06 it I'll <u>show</u> you. (0.2) He <u>coughed</u> up (0.5) d'er::m 07 (0.5) 08 DAU: M:ucus, 09 HCP: [Y:ea:h] 10 SON: [Mucus,] [Blood.] 11 DAU: [Really] 12 HCP: Okay:, 13 (0.2) 14 SON: Like <u>stale</u> blood. 15 HCP: °Mm↓mmm° 16 SON: °Ye:s° [Quite a] <u>lot</u> of it, 17 HCP: [Y:eah.] 18 (0.5) 19 HCP: Yeh. 20 SON: #Er:# I <u>took</u> a picture of it, 21 HCP: Okay. 22 SON: Which I can show you, 23 (0.3) 24 HCP: >Yeh< 25 DAU: Mmm 26 HCP: <u>Fair</u> enough. 27 SON: Yeh. 28 HCP: .hhhhhhh 29 DAU: I'm sure you've seen that before=</p>	<p>1. Family member raises a concern or question</p>

language as the doctor sets out comfort as a priority (lines 21-22) and emphasises actions the care team will take to ensure this (lines 24-31).

In addition to action-orientation in talk about comfort care, the doctor also uses more personalised language. In Table 4, when talking about the impact of the cancer on the body, the doctor uses depersonalised terms such as “the body” and “the heart” (lines 9, 13, & 17). In contrast, when talking about comfort care, her language becomes more personalised, using the patient’s name (line 22). Here, the doctor portrays a situation in which the body is dying, but the person is comfortable. Depersonalisation to separate the person and their body when discussing sensitive topics has been found elsewhere, including discussing sexuality in gynaecological consultations [37], and physiotherapists using depersonalisation for negative assessments and personalised language for positive assessments [38].

The doctor’s suggestions receive affiliation from the family in the form of several “yes” and “yeh”s (lines 23, 25, 27, 30 & 32), and following this extract when the wife states “I think that it’s best”.

A further example of an extended transition sequence is presented in Table 5, a conversation between a doctor (DOC) and the daughter (DAU) and son (SON) of a patient. Prior to this extract, they had discussed how the patient had been asleep for the past few days and the impact of disease on his body.

Following the doctor’s prognostic statement, the son reports that his father had coughed up blood and mucus (lines 5-22). This moves the conversation away from talk on time estimates and raises a concern which the doctor must address. The doctor does so by explaining that they may not know where the mucus has come

from and that they would not do anything “traumatic” (presumably referring to any investigations into the source of the mucus; lines 32-45). This explanation of what will not be done allows further topic transition (preceded by the transition marker “so”; [30]) from line 48 to talk on comfort care. Over 67 omitted lines, the doctor explains mouthcare, receiving some displays of agreement, and then the patient’s confusion. In lines 124-131, the doctor explains what the family can do to help with this confusion. Following a 1.7 second silence, at lines 132-134 the son provides affiliation with this suggestion. Following this extract, they go on to talk about practical arrangements in the coming days.

The cases in Tables 4 and 5 demonstrate what happens when, in response to receiving a prognostic estimate, the family raise other concerns. This makes the first step away from talk of time estimates, but places the doctor in a position where they must first address the concern before moving to action-oriented talk. The analysis shows how doctors use their responses to these questions and concerns to pivot towards the type of action-oriented talk we saw in the earlier examples.

3.3. A deviant case

The cases above have demonstrated that the normative action following prognostic talk is for the clinicians to transition into action-oriented talk, usually making assurances about the patient’s comfort. However, in this section we present a case in which a doctor moves to close the conversation immediately following prognostic talk, therefore deviating from the normative actions seen in previous examples.

<p>30 HCP: =Y:e:s[: 31 DAU: [mhuh ↑hm hm 32 HCP: an:d and <u>sometimes</u> wel- I think at (.) at this 33 <u>stage</u> (0.5) w-<u>obviously</u> we're not going to do 34 anything <u>to</u> him 35 DAU: Mmm 36 HCP: e:rm 37 (0.6) 38 HCP: that's (0.2) <u>traumatic</u>. 39 DAU: M↑hm 40 (0.8) 41 HCP: We may not ever know where that (.) <u>came</u> from 42 whether it <u>came</u> from within his ↓lungs 43 DAU: °Mmm° 44 HCP: or from the (0.7) um: (0.4) tch.h the <u>oesophagus</u> or 45 or (0.2) even his: <u>throat</u>. 46 SON: Okay. 47 (0.3)</p>	<p>2. Clinician addresses concern or question</p>
<p>48 HCP: Um: (0.5) .hh So ↑everything that we do now, (0.5) 49 is aimed at <u>comfort</u>. 50 (0.5) 51 HCP: And that means, (0.7) um:: all the really 52 fundamental things that we should be doi:ng looking 53 after his <u>skin</u> (0.2) .hh I know he's got that (0.4) 54 that little <u>sore</u> on his bottom, 55 (0.9) 56 HCP: u:m making sure that he's in a (0.2) <u>good</u> position.</p>	<p>3. Clinician pivots towards action</p>
<p><i>67 lines omitted in which they discuss mouthcare and the patient's confusion</i></p>	
<p>124 HCP: When you're <u>with</u> him if you ↑see it I think 125 it's okay to say Daddy what you (0.3) what are 126 you <u>talking</u> about. 127 DAU: °Mmm° 128 HCP: It's <u>me</u> (0.3) I'm here. 129 (0.6) 130 HCP: And it might just (0.2) switch him back. 131 (1.7)</p>	<p>3. Clinician pivots towards action</p>
<p>132 SON: °Yeah.° .hhh It's <u>fine</u>. 133 (0.7) 134 SON: ↑Okay.</p>	<p>4. Family members affiliate with clinician's suggestion</p>

Table 6 presents a conversation between a registrar (DOC) and close family friend of a patient (FRI), with a consultant (CON) also present. Earlier in the conversation they had discussed sedative medications and not giving food and fluids. The extract begins with the doctor's prognostic statement.

At lines 4 and 8, the friend provides displays of acknowledgement by repeating “days” and saying “okay”. At this point there is a silence for seven seconds, followed by an “okay” from the doctor and a further 3.2 second silence at line 11. The average gap between turns at talk in conversations is approximately 0.2 seconds [39], with a gap becoming a ‘lapse’ at around 0.5-0.7 seconds [40,41]. The lapses at lines 9 and 11 are not necessarily problematic and indeed “compassionate silence” is often recommended in consultations [42,43]. However, it does pose the question of how to continue the conversation following these lapses. One response to

lapses that has been identified in prior research, especially following a longer duration of lapse, is to move to end the interaction [40]. This is what we see at line 12 as the doctor offers for the friend to stay in the room for a while, indicating a move towards conversational closure.

Over lines 12–41 a closing section takes place, culminating in a possible terminal exchange at lines 39–41 [44]. However at line 44, the consultant, who had been merely an observer for most of the conversation, moves out of the closing section to “promise” they will make sure the patient “settles down”. The closing section that is disrupted here (lines 12–41) occurs following neither party taking a turn to introduce a new topic and includes arrangement-making (an offer to call the patient’s daughter), therefore resembling standard closing procedures that have been identified in everyday conversations and medical interactions [44–46]. That

Table 6
Recording 09_13, 07:41-08:51.

01 DOC: I think we need to be prepared that it i-it 02 °could be as short as days.°	Prognostic statement
03 (0.6) 04 FRI: °°Days°° 05 (0.4) 06 DOC: °°Could be.°° 07 (2.4) 08 FRI: ↑Okay.	1. Family member provides acceptance/ acknowledgement
09 (7.0) 10 DOC: Okay, 11 (3.2)	
12 DOC: D'you wanna a minute just to stay <u>here</u> : I can make 13 you a cup of <u>tea</u> , 14 (0.8) 15 FRI: °I'm al[r]right.° 16 DOC: [You can just (0.7) use this room to m (0.6) 17 just re↓lax for a moment? 18 (3.9) 19 DOC: Yeah? 20 (1.2) 21 DOC: If you wanna ask me any ↑questions? 22 (0.6) 23 DOC: you know you can just grab me any time. 24 (0.6) 25 DOC: Just see me in the corridor or I'll be in the 26 office at the end. Just come get me. 27 (0.5) 28 FRI: Okay <u>thank</u> you.= 29 DOC: =Yeh, 30 (1.3) 31 DOC: And now shall I give Amanda a call, 32 (1.1) 33 FRI: Yeh. 34 (2.5) 35 DOC: Kay. 36 (2.5) 37 DOC: Kay. 38 ((noise of packing stuff away for 3.8)) 39 FRI: ↑Thank you 40 (0.7) 41 DOC: °°It's [okay°°] 42 CON: [°Okay] Maggie° 43 () (take care)	Deviant case: Move towards conversational closure
44 CON: W- (. we <u>promise</u> we'll do ((noise of DVR being 45 moved)) (1.1) we'll see that (0.5) he just settles 46 down.	2. Clinician makes assurances about the patient's comfort
47 FRI: Thanks	3. Family member affiliates with plan for comfort care

the consultant intervenes here when the conversation is all but complete suggests that it is the registrar's move straight from prognostic talk into closings that is being treated as irregular. She uses "we" to promise on behalf of both herself and the registrar, suggesting that this is something the registrar should have been

communicating. This intervention further supports the case that 'bright-side' type [31] assurances about patients' comfort following prognostic talk, seen in prior examples, are the norm. Following these assurances, the daughter thanks the consultant (line 47) and the registrar moves back into the closing section (not shown here).

4. Discussion and conclusion

4.1. Discussion

This paper examined how clinicians and families of imminently dying patients in a hospice transitioned out of prognostic talk. Following an acknowledgement of the short prognosis, clinicians were able to transition in an unproblematic, stepwise fashion [22,32], towards making assurances about actions that could be taken to ensure patients' comfort. When families raised other questions and concerns, the transition was extended but ultimately had the same outcome. Clinicians addressed these questions or concerns and used their turn at talk to pivot towards action-oriented talk, usually related to patient comfort. Through these transition sequences, clinicians and families moved collaboratively from the uncertain, uncontrollable topic of prognostic estimates, to action-oriented talk about more certain and controllable topics.

This action-orientation has been found elsewhere in institutional encounters, during which talk about troubles is organised in a way to move towards solutions [47,48]. In most medical settings there is a clear link between the trouble and the solution (e.g. in primary care, medical problems lead to treatment advice [49,50]), but here there was no clear solution for a short prognosis or prognostic uncertainty. Clinicians therefore transitioned to other, more 'doctorable' issues (issues for which they could provide a solution [51]). Talk became action-oriented as clinicians described steps they could take to ensure patients' comfort and relatives' wellbeing. This move towards action-oriented talk on 'doctorable' issues had multiple functions. Firstly, it covered important aspects of care that needed to be discussed, such as which treatments would be used under which circumstances. In addition, the sequential placement following prognostic talk meant that it had the benefit of moving the conversation forward out of the difficult topic of prognosis, but also provided some hope in what may be considered by many, a hopeless situation.

This provision of hope when transitioning out of prognostic talk is often seen following breaking bad news, and is referred to as 'bright-siding' [31]. In the current study, clinicians moved from prognostic estimates to give a more positive perspective, demonstrating there was much that could be done to improve patients' comfort and families' wellbeing. A previous conversation analytic study showed an oncologist making similar moves from discussing scan results towards describing treatment options [14]. However in that study, bright-siding was done at the expense of prognostic talk, whereas in our dataset, prognosis had been discussed before moving the conversation on. This difference likely reflects the hospice setting compared to oncology clinics earlier in the disease trajectory. Fear of removing hope has been stated as a reason for avoiding prognostic talk in oncology settings [52,53], whereas the families in this study had displayed an awareness that the prognosis was likely to be short and uncertain [10], meaning hope had to be found in factors beyond length of life. The use of bright-siding in this way fits with previous studies which have suggested that emphasising symptom control can provide hope to terminally ill patients and their families, and that nurses redirect hope towards symptom control when shifting from curative to palliative care [54,55]. Such alternative ways to provide hope may be important in helping clinicians in different settings feel more comfortable discussing prognosis [54,56].

4.1.1. Limitations and future research

This study took place in a hospice with relatives of imminently dying patients and senior clinicians. However, many prognostic conversations happen in acute settings where families may have less prognostic awareness and clinicians may have less time to

speaking with families. Further, while senior clinicians usually take responsibility for discussing prognosis with families, when patients deteriorate rapidly, junior clinicians sometimes need to have these conversations. Therefore, future research should examine similar conversations in other settings and with a broader range of healthcare staff.

To reduce the intrusiveness of recordings, audio- rather than video-recording was used, meaning non-verbal practices were missed. For instance, non-verbal practices may be important for demonstrating empathy [57] in response to families' concerns, before transitioning out of prognostic talk. Future research could therefore video-record consultations, where appropriate, to capture additional non-verbal details.

4.2. Conclusion

Discussing prognosis in the final days of life presents difficulties for clinicians and families. Prognostic uncertainty can be a barrier to open discussions about prognosis for some clinicians, and a source of distress for families. Moves out of prognostic talk must be done in ways which do not shut down discussions in a blunt or disjunctive manner. This paper has demonstrated how unproblematic topic transitions were made by moving gradually towards certainty and action. Describing steps to ensure patients' comfort emphasised the ongoing relationship between clinicians, patients, and families. These practices moved the conversations towards more certain topics while providing reassurance to families that they would continue to receive a high level of care.

4.3. Practice implications

This study provides potential strategies for clinicians working with families of imminently dying patients. Making assurances about steps to improve patients' comfort can transition out of prognostic talk and highlight clinicians' ongoing care for patients and families. Compared to the uncertainty of prognosis, discussing comfort care is an opportunity for clinicians to use more certain, personalised language and clearly explain what can be done to help the patient and family. However, it is important that these transitions are not made too early at the expense of prognostic discussions.

Funding sources

This study was part of a PhD funded by the Marie Curie Chair in Palliative and End of Life Care grant (grant MCCC-FCH-13-U). PS and RA's posts are supported by the Marie Curie Chair in Palliative and End of Life Care grant funding; JL's post is supported by the Marie Curie core and programme grant funding (grants MCCC-FCO-16-U and MCCC-FPO-16-U). The Division of Psychiatry is supported by the UCLH NIHR Biomedical Research Centre.

Data statement

The primary data for this study cannot be shared as it would compromise the confidentiality of research participants. A further data extract has however been provided as e-only supplementary material.

CRedit authorship contribution statement

Rebecca J. Anderson: Conceptualization, Methodology, Formal analysis, Investigation, Writing - original draft, Writing - review & editing, Project administration. **Patrick C. Stone:** Conceptualization, Methodology, Writing - review & editing, Supervision, Project administration, Funding acquisition. **Joseph T.S. Low:**

Conceptualization, Methodology, Writing - review & editing, Supervision, Project administration, Funding acquisition. **Steven Bloch:** Conceptualization, Methodology, Formal analysis, Writing - review & editing, Supervision, Project administration, Funding acquisition.

Declaration of Competing Interest

None.

Acknowledgements

We would like to thank all relatives, friends and clinicians who took part in the study. We would also like to thank our co-investigators for their valuable input: Adrian Tookman, Philip Lodge, Ruth Parry, Barbara Wood and Dori-Anne Finlay. We are particularly grateful to Marco Pino for his helpful suggestions and comments on an earlier version of this manuscript. We would like to thank Marie Curie for funding this project.

Appendix A. Transcription symbols (adapted from Jefferson [26] and Hepburn & Bolden [27])

Symbol	Explanation
[word]	Overlapping speech
[_word_]	Overlapping speech
(0.4)	Silence in seconds
(.)	Micro-pause (under 0.2 seconds)
<u>word</u>	Emphasis
wo::rd	Elongation of prior sound
wor:rd	Rising intonation contour
worrd	Falling intonation contour
↑ ↓	Marked pitch change
WORD	Speech that is louder than surrounding speech
°word°	Speech that is quieter than surrounding speech
word=	Latching of successive speech (no silence between turns/ parts of one turn)
=word	Latching of successive speech (no silence between turns/ parts of one turn)
hhh	Out-breath
.hhh	In-breath
,	Slightly rising intonation
?	Strongly rising intonation
.	Falling intonation
>word<	Speeded up talk
<word>	Slowed down talk
word-	Cut-off of preceding sound
~word	Wobbly voice

Appendix B. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:<https://doi.org/10.1016/j.pec.2020.10.009>.

References

[1] P.J. Larkin, *Compassion: The Essence of Palliative and End-of-Life Care*, Oxford University Press, UK, 2016.
 [2] K. Pfaff, A. Markaki, Compassionate collaborative care: an integrative review of quality indicators in end-of-life care, *BMC Palliat. Care* 16 (2017) 1–24.
 [3] G. Lundquist, B.H. Rasmussen, B. Axelsson, Information of Imminent Death or Not: Does It Make a Difference? *J. Clin. Oncol.* 29 (2011) 3927–3931.
 [4] A.A. Wright, et al., Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment, *JAMA J. Am. Med. Assoc.* 300 (2008) 1665–1673.
 [5] S. Ekberg, et al., Affording Opportunities to Discuss Deterioration in Paediatric Palliative Care Consultations: A Conversation Analytic Study, *BMJ Support. Palliat. Care* (2017).

[6] M. Pino, R. Parry, How and when do patients request life-expectancy estimates? Evidence from hospice medical consultations and insights for practice, *Patient Educ. Couns.* 102 (2018) 223–237.
 [7] C. Shaw, et al., Inviting end-of-life talk in initial CALM therapy sessions: A conversation analytic study, *Patient Educ. Couns.* 100 (2017) 259–266.
 [8] M. Pino, et al., Engaging terminally ill patients in end of life talk: How experienced palliative medicine doctors navigate the dilemma of promoting discussions about dying, *PLoS One* 11 (2016)e0156174.
 [9] A. Peräkylä, *AIDS Counselling: Institutional Interaction and Clinical Practice. Studies in Interactional Sociolinguistics.*, Cambridge University Press, Cambridge, 1995.
 [10] R.J. Anderson, et al., Managing uncertainty and references to time in prognostic conversations with family members at the end of life: a conversation analytic study, *Palliat. Med.* 34 (2020) 896–905.
 [11] R.J. Anderson, et al., Communication between healthcare professionals and relatives of patients approaching the end-of-life: A systematic review of qualitative evidence, *Palliat. Med.* 33 (2019) 926–941.
 [12] M. Friedrichsen, A. Milberg, Concerns about Losing Control When Breaking Bad News to Terminally Ill Patients with Cancer: Physicians' Perspective, *J. Palliat. Med.* 9 (2006) 673–682.
 [13] A. Travers, V. Taylor, What are the barriers to initiating end-of-life conversations with patients in the last year of life? *Int. J. Palliat. Nurs.* 22 (2016) 454–462.
 [14] D. Cortez, D.W. Maynard, T.C. Campbell, Creating space to discuss end-of-life issues in cancer care, *Patient Educ. Couns.* 102 (2019) 216–222.
 [15] S. Singh, et al., Characterizing the Nature of Scan Results Discussions: Insights Into Why Patients Misunderstand Their Prognosis, *J. Oncol. Pract.* 13 (2017) e231–e9.
 [16] H.F. West, et al., Expressions of nonabandonment during the intensive care unit family conference, *J. Palliat. Med.* 8 (2005) 797–807.
 [17] Abib El, G.M.C. Halal, et al., Parents' perspectives on the deaths of their children in two Brazilian paediatric intensive care units, *Int. J. Palliat. Nurs.* 19 (2013) 495–502.
 [18] G. Caswell, et al., Communication between family carers and health professionals about end-of-life care for older people in the acute hospital setting: a qualitative study, *BMC Palliat. Care* 14 (2015) 35.
 [19] B. Wendlandt, et al., Modifiable elements of ICU supportive care and communication are associated with surrogates' PTSD symptoms, *Intensive Care Med.* 45 (2019) 619–626.
 [20] L.J. Hinkle, G.T. Bosslet, A.M. Torke, Factors associated with family satisfaction with end-of-life care in the ICU: A systematic review, *Chest* 147 (2015) 82–93.
 [21] R. Royak-Schaler, et al., Family perspectives on communication with healthcare providers during end-of-life cancer care, *Oncol. Nurs. Forum* 33 (2006) 753–760.
 [22] G. Jefferson, On stepwise transition from talk about a trouble to inappropriately next-positioned matters, in: J.M. Atkinson (Ed.), *Structures of Social Action*, Cambridge University Press, Cambridge, 1984, pp. 191–222.
 [23] D.W. Maynard, Placement of topic changes in conversation, *Semiotica* 30 (1980) 263–290.
 [24] E.A. Schegloff, The Relevance of Repair to Syntax-for-Conversation, in *Syntax and semantics Vol.12*, in: T. Givón (Ed.), *Discourse and syntax*, 1979, pp. 261–286 New York, London.
 [25] J. Sidnell, *Conversation analysis : an introduction*, Wiley-Blackwell, Chichester, 2010.
 [26] G. Jefferson, Glossary of transcript symbols with an introduction, in: G.H. Lerner (Ed.), *Conversation analysis : studies from the first generation*, John Benjamins Pub., Amsterdam, Philadelphia, 2004, pp. 13–31.
 [27] A. Hepburn, G.B. Bolden, *Transcribing for social research*, SAGE publications., London, 2017.
 [28] A. Pomerantz, Agreeing and disagreeing with assessments: Some features of preferred/dispreferred turn shapes, in: J.M. Atkinson, J. Heritage (Eds.), *Structures of Social Action: Studies in Conversation Analysis*, Cambridge University Press, Cambridge, 1984, pp. 57–101.
 [29] G. Jefferson, Caveat Speaker, Preliminary Notes on Recipient Topic-Shift Implicature, *Res. Lang. Soc. Interaction* 26 (1993) 1–30.
 [30] G.B. Bolden, Implementing incipient actions: The discourse marker 'so' in English conversation, *J. Pragmatics* 41 (2009) 974–998.
 [31] E. Holt, The structure of death announcements: Looking on the bright side of death, *Text-Interdiscip. J. Study Discourse* 13 (1993) 189–212.
 [32] H. Sacks, *Lectures on conversation: Volumes I and II*, Blackwell, Oxford, 1992.
 [33] A. Vatanen, Responding in Early Overlap: Recognition Onsets in Assertion Sequences, *Res. Lang. Soc. Interaction* 51 (2018) 107–126.
 [34] C. Goodwin, M.H. Goodwin, Assessments and the construction of context. Rethinking context: Language as an interactive phenomenon, (1992), pp. 147–190 11.
 [35] G. Jefferson, Notes on some orderlinesses of overlap onset, *Discourse Anal. Nat. Rhetoric* 500 (1984) 11–38.
 [36] E.A. Schegloff, Sequencing in Conversational Openings, *Am. Anthropologist* 70 (1968) 1075–1095.
 [37] W. Weijts, H. Houtkoop, P. Mullen, Talking delicacy: speaking about sexuality during gynaecological consultations, *Soc. Health Illn.* 15 (1993) 295–314.
 [38] R. Parry, A video analysis of how physiotherapists communicate with patients about errors of performance: insights for practice and policy, *Physiotherapy* 91 (2005) 204–214.
 [39] T. Stivers, et al., Universals and cultural variation in turn-taking in conversation, *Proc. Natl. Acad. Sci.* 106 (2009) 10587.

- [40] E.M. Hoey, How Speakers Continue with Talk After a Lapse in Conversation, *Res. Lang. Soc. Interaction* 51 (2018) 329–346.
- [41] H. Sacks, E.A. Schegloff, G. Jefferson, A Simplest Systematics for the Organization of Turn-Taking for Conversation, *Language* 50 (1974) 696–735.
- [42] A.L. Back, Compassionate Silence in the Patient–Clinician Encounter: A Contemplative Approach, *J. Palliat. Med.* 12 (2009) 1113–1117.
- [43] R.E. Bernacki, S.D. Block, Communication About Serious Illness Care Goals, *JAMA Internal Medicine* 174 (2014) 1994–2003.
- [44] E.A. Schegloff, H. Sacks, Opening up Closings, *Semiotica* 8 (1973) 289–327.
- [45] J.D. Robinson, Closing medical encounters: two physician practices and their implications for the expression of patients' unstated concerns, *Soc. Sci. Med.* 53 (2001) 639–656.
- [46] J. White, W. Levinson, D. Roter, Oh, by the way . . . , *J. Gen. Intern. Med.* 9 (1994) 24–28.
- [47] M. Ekström, A. Lindström, S. Karlsson, Managing troubles-talk in the renegotiation of a loan contract, *Discourse Studies* 15 (2013) 371–394.
- [48] G. Jefferson, J.R.E. Lee, The rejection of advice: Managing the problematic convergence of a 'troubles-telling' and a 'service encounter', *J. Pragmatics* 5 (1981) 399–422.
- [49] J. Heritage, A. Lindstrom, Motherhood, Medicine, and Morality: Scenes From a Medical Encounter, *Res. Lang. Soc. Interaction* 31 (1998) 397–438.
- [50] J. Ruusuvuori, Managing affect: Integration of empathy and problem-solving in health care encounters, *Discourse Studies* 9 (2007) 597–622.
- [51] J. Heritage, J.D. Robinson, Accounting for the visit: giving reasons for seeking medical care, in: D.W. Maynard, J. Heritage (Eds.), *Communication in Medical Care: Interaction between Primary Care Physicians and Patients*, Cambridge University Press, Cambridge, 2006, pp. 48–85.
- [52] H.M. Buiting, et al., Understanding provision of chemotherapy to patients with end stage cancer: qualitative interview study, *BMJ* 342 (2011) d1933.
- [53] C.D. Prouty, et al., Providers' Perceptions of Communication Breakdowns in Cancer Care, *J. Gen. Intern. Med.* 29 (2014) 1122–1130.
- [54] J.M. Clayton, et al., Sustaining hope when communicating with terminally ill patients and their families: a systematic review, *Psychooncology* 17 (2008) 641–659.
- [55] S.A. Norton, B.J. Bowers, Working toward consensus: Providers' strategies to shift patients from curative to palliative treatment choices, *Res. Nurs. Health* 24 (2001) 258–269.
- [56] J.W. Mack, T.J. Smith, Reasons why physicians do not have discussions about poor prognosis, why it matters, and what can be improved, *J. Clin. Oncol.* 30 (2012) 2715–2717.
- [57] R. Wynn, M. Wynn, Empathy as an interactionally achieved phenomenon in psychotherapy: Characteristics of some conversational resources, *J. Pragmatics* 38 (2006) 1385–1397.