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COMMUNICATION STRATEGIES USED BY HEALTH CARE PROFESSIONALS IN PROVIDING PALLIATIVE CARE TO PATIENTS

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Communication strategies used by health care professionals in providing palliative care to patients*

ESTRATÉGIAS DE COMUNICAÇÃO UTILIZADAS POR PROFISSIONAIS DE SAÚDE NA ATENÇÃO À PACIENTES SOB CUIDADOS PALIATIVOS

ESTRATEGIAS DE COMUNICACIÓN UTILIZADAS POR PROFESIONALES DE SALUD EN LA ATENCIÓN A PACIENTES BAJO CUIDADOS PALIATIVOS

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ABSTRACT

The objective of this study is to verify the relevance and utilization of communication strategies in palliative care. This is a multicenter qualitative study using a questionnaire, performed from August of2008 to July of2009 with 303 health care professionals who worked with patients receiving palliative care. Data were subjected to descriptive statistical analysis. Most participants (57.7%) were unable to state at least one verbal communication strategy, and only 15.2% were able to describe five signs or non-verbal communication strategies. The verbal strategies most commonly mentioned were those related to answering questions about the disease/treatment. Among the non-verbal strategies used, the most common were affective touch, looking, smiling, physical proximity, and careful listening. Though professionals have assigned a high degree of importance to communication in palliative care, they showed poor knowledge regarding communication strategies. Final considerations include the necessity of training professionals to communicate effectively in palliative care.

DESCRIPTORS

Communication
Palliative care
Patient care team
Interpersonal relations

RESUMO

O presente estudo objetivou verificar a relevância e a utilização de estratégias de comunicação em cuidados paliativos. Estudo quantitativo multicêntrico, realizado entre agosto/2008 e julho/2009, junto a 303 profissionais de saúde que trabalhavam com pacientes sob cuidados paliativos, por meio da aplicação de questionário. Os dados sofreram tratamento estatístico descritivo. A maioria (57,7%) não foi capaz de citar ao menos uma estratégia de comunicação verbal e apenas 15,2% mencionaram 5 sinais ou estratégias não verbais. As estratégias verbais mais citadas foram as de cunho interrogativo sobre a doença/tratamento e, dentre as não verbais, destacaram-se o toque afetivo, olhar, sorriso, proximidade física e escuta ativa. Embora os profissionais tenham atribuído alto grau de relevância para a comunicação em cuidados paliativos, evidenciaram escasso conhecimento de estratégias de comunicação. Faz-se necessária a capacitação dos profissionais no que tange à comunicação em cuidados paliativos.

DESCRITORES

Comunicação
Cuidados paliativos
Equipe de assistência ao paciente
Relações interpessoais

RESUMEN

Verificar la relevancia y la utilización de estrategias de comunicación en cuidados paliativos. Estudio cuantitativo multicéntrico, realizado entre agosto/2008 y julio/2009, con 303 profesionales de salud que trabajaban con pacientes bajo cuidados paliativos, mediante aplicación de cuestionario. Los datos recibieron análisis estadístico descriptivo. La mayoría (57,7% no fue capaz de citar al menos una estrategia de comunicación verbal, y apenas 15,2% mencionó 5 señales o estrategias no verbales. Las estrategias verbales más nombradas fueron las de cuño interrogativo acerca de la enfermedad/tratamiento, y entre las no verbales se destacaron caricias afectivas, miradas, sonrisas, proximidad física y escucha activa. Aunque los profesionales hayan atribuido alto grado de relevancia a la comunicación en cuidados paliativos, evidenciaron escaso conocimiento de estrategias de comunicación. Resulta necesaria la capacitación de los profesionales en lo atinente a comunicación en cuidados paliativos.

DESCRIPTORES

Comunicación
Cuidados paliativos
Grupo de atención al paciente
Relaciones interpersonales

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INTRODUCTION

Along with the proficient control of pain and symptoms, and interdisciplinary teamwork, the adequate use of communication skills and interpersonal relationships constitutes the triad foundation that sustains palliative care. In situations of uncertainty, pain and suffering, relationships are re-signified and contact with people, either with relatives or healthcare professionals, starts to represent the essence of care that sustains faith and hope, supporting the experience of difficult moments.

Since a means of communication occurs in this human contact, through speech or nonverbal cues, knowledge of interpersonal communication techniques or strategies that facilitate the interaction and can transmit care, compassion and comfort is of paramount importance. Regardless of the basic formation area or professional category, all healthcare professionals need this knowledge, since they work in their quotidian with people who are experiencing the end of their lives, in the most varied scenarios. In this sense, the question is: do the healthcare professionals who work or have frequent contact with patients under palliative care value communication as an essential dimension of palliative care? Do they know interpersonal communication strategies in the context of terminality? Thus, it necessary is for this study to investigate these questions.

OBJECTIVE

• To investigate whether healthcare professionals who work or have frequent contact with patients under palliative care value interpersonal communication in the context of terminality.

• To ascertain whether they know interpersonal communication strategies or techniques that facilitate the interaction with patients in palliative care.

• To identify which communication strategies are used by these professionals to facilitate the interaction with people living in the final stage of life.

LITERATURE REVIEW

Palliative care is active and total care for the patient whose disease no longer responds to curative treatment. It is a differentiated care approach which aims to improve the quality of life of patients and their families, through appropriate evaluation and treatment to relieve the pain and symptoms, and to provide psychosocial and spiritual support[1]. Palliative care is directed towards the relief of suffering, focusing on the sick person and not the illness of the person[2], recovering and revalorizing the interpersonal relationships in the process of dying, using compassion, empathy, humility and honesty as key elements[3].

Although many educational institutions have opened up space to discuss the theme of death and care at the end of life in some disciplines, the teaching is fragmented and superficial in its content, especially regarding interpersonal communication in palliative care. Thus, healthcare professionals who work caring for people experiencing the end of life consider communication in the process of dying a sore point in their practice, avoiding contact and conversation with these patients, pointing out that they do not receive theoretical preparation nor emotional support to deal with the suffering and death of their terminal patients[4-5].

Interpersonal communication in the area of health and palliative care is understood as a complex process that involves the perception, comprehension and transmission of messages in the interaction between patients and healthcare professionals. It is a process that has two dimensions: the verbal, which occurs through the expression of spoken or written words, and the nonverbal, characterized by the manner and tone of voice with which words are said, by gestures that accompany the speech, by looks and facial expressions, by the body posture, and by the physical distance that people maintain with each other[6].

Although many educational institutions have opened up space to discuss the theme of death and care at the end of life in some disciplines, the teaching is fragmented and superficial in its content, especially regarding interpersonal communication in palliative care.

Internationally, there are numerous studies that investigate communication in the process of dying. Although it is valued in the care process for the patient at the end of life, many of the studies comprehend communication in a reductionist way, characterizing it as a synonym for information regarding the diagnosis and prognosis and/or communication of difficult news[7-8]. Of the studies that approach communication as a broad process, as an instrument of the interpersonal relationship between patient and healthcare professional, and characterize it as an essential attribute of quality care at the end of life, the ones that stand out are those that propose and/or evaluate training programs for the healthcare professionals in communication with terminal patients, aiming to improve their communication skills[9-11].

An English study conducted with 110 palliative care nurses showed that communication skills seem to be determining factors for them feeling more confident and secure when dealing with difficult situations in their quotidian work with terminal patients[12]. A group of researchers[11], through a randomized study involving 160 oncologists of the UK filmed during their interactions with 2407 patients, demonstrated that the length of practice and amount of experience as an oncology physician was not related to the acquisition of communication skills. That is, more experienced professionals are not necessarily more

able to deal with the problems related to communication with their patients because communication skills are not acquired over time, but with adequate training. Studies that investigate training in communication skills in oncology/palliative care nurses showed an improvement in these skills and in the attention to the emotional dimension of the care provided by the nurses, as they often used more emotional and affectionate words after the educational intervention[13-15].

The national literature is lacking in studies that address the communication process with patients without a prognosis of a cure, despite being well structured in other healthcare practices. The few studies that can be found on the theme deal with three aspects: communication as information requested by the patients[16-18]; empirical recommendations on how the communication process with people experiencing terminality should be[19-20]; or reflections on the communication of difficult news[21].

It is essential for the care of the patient undergoing the process of dying that healthcare professionals adequately perceive, comprehend and employ verbal and nonverbal communication. The latter makes it crucial in the context of terminality because it allows the perception and comprehension of the feelings, doubts and anxieties of the patient, as well as the understanding and clarification of gestures, expressions, looks and symbolic language typical of someone who is experiencing a phase in which a cure for their disease is no longer possible[19].

Fear of the unknown faced with death, of the intense suffering at the time of death and of being alone when all of this is happening, as well as concern about the family members left behind, are common and generate severe psychological distress for the patient. Reflections on the process of re-examining their lives are also frequently performed and may bring anguish to the patient who has unfinished business or conflicts to be resolved. In making appropriate use of interpersonal communication, it is often possible to decipher essential information and to help reduce the anxiety and distress of those who are experiencing the threat of terminality, providing higher quality care and achieving greater personal satisfaction[3,5,19-20].

METHOD

Type of study: This is a multicenter, descriptive, exploratory, cross-sectional, field study with a quantitative approach.

Place of study: Four health institutions and a higher education institution located within the city of São Paulo were the study sites. Among the health institutions, three were large general hospitals (two public and one private) and one a small private hospital specializing in care for elderly long-stay patients. These institutions were selected for their different approaches (outpatient, home and hospital palliative care) and representativity in relation to the palliative care movement in Brazil. In all there were active members of the bodies representing the healthcare professionals who work with patients undergoing palliative care.

Sample: A non-random, convenience sample was used, according to the number of healthcare professionals who voluntarily enrolled on the training course of communication in palliative care offered in the five institutions, as part of the doctoral research conducted by the first author and supervised by the second. The sample consisted of 303 healthcare professionals, according to the following inclusion criteria: aged 18 years or over; linked through employment, academic work, as a service provider or as a volunteer to healthcare institutions that possess structured services, and/or a team, of palliative care; expressions of interest and availability of time to attend on the days and times scheduled for participation in the course; to have made a prior registration to undertake the course offered.

Data collection procedures: The research project was submitted to the Research Ethics Committee (REC) of the educational institution (process No. 705/2007/CEP-EEUSP) and to three of the four health institutions (process No. 33/08/CER-IIER; 821/08/CER-HU/USP and 08/927/CER-Einstein) that possessed their own RECs and requested a new submission. Due to not having its own REC, the small private hospital considered the submission and approval of the research project by the Committee of the educational institution. Upon approval, the subjects were recruited through posters fixed to the walls of the institutions advertising the training course offered to the employees on pre-determined days and times between August 2008 and July 2009. Those who showed interest in the proposal contacted the researcher to enroll.

On the first day of the course, before its start, in each of the institutions, the proposal was presented and the Terms of Free Prior Informed Consent (TFPIC) delivered. All 303 subjects agreed to voluntarily participate in the study, signing the TFPIC. This was followed by the application of a questionnaire that included questions that aimed to identify the profile of the subjects regarding gender, age, religious beliefs, professional category and the completion of previous training in palliative care. Together with this questionnaire, the data collection instrument of the doctoral study was applied, of which three questions were used for this study. The first asked the subjects to score the importance they attached to communication in the care of people who have serious illnesses with no possibility of a cure, considering zero as no importance and five as the highest possible importance. The second question asked the subjects to cite two verbal communication strategies they would use to talk to patients undergoing palliative care. The third required the subject to cite five signals or nonverbal strategies that they would use to demonstrate empathy in the interaction with these patients.

Data analysis: Zero was assigned as the minimum score and 1 as the maximum score for the second and third questions. Thus, the score was assigned according to the number of adequate communication strategies mentioned by the subjects. In the second question the citation of two inappropriate strategies provided a score of zero, one appropriate strategy mentioned gave a score of 0.5 and citing two appropriate strategies received a score of 1.0. Regarding the third question, each citation of an appropriate nonverbal signal gave a score of 0.2, therefore, citing no adequate signal gave a score of 0 and mentioning 5 adequate signals scored 1.0. The communication strategies were considered adequate when they were consistent with the interpersonal communication(6) and palliative care(1) theoretical frameworks adopted in the study. This was followed by the statistical analysis of the data, using the software SAS version 9.1.3. The qualitative variables were analyzed by grouping by similarity and expressed according to their absolute and relative frequency, by number and percentage. For the analysis of quantitative variables means were used to summarize the information and standard deviations, minimum and maximum, to show the variability of the data. These data were then presented in tables.

RESULTS

The sample was composed predominantly of professionals of the nursing team (127 - 41.9% registered nurses, 89 - 29.4% auxiliary nurses or nursing technicians), of females (261 - 86.1%) and Catholics (160 - 52. 8%). The mean age of the subjects was 39.3 ±10.2 years and only 79 professionals (26.1%) reported ever having participated in any type of palliative care educational activity.

The professionals assigned a high value to communication in the care of people who have serious illnesses without the possibility of a cure, as the mean score assigned by them to the relevance of communication in palliative care was 4.6 ± 0.8 on a scale 0-5, considering 0 as no importance and 5 as the maximum possible importance.With regard to knowledge of communication strategies in the context of terminality, the professionals obtained a mean score of 0.3 ±0.3 in the second question. That is, when asked to cite two verbal communication strategies they would use to communicate with patients undergoing palliative care, the majority (175 subjects - 57.7%) did not mention any appropriate strategy. Table 1 shows these data.

Table 1 - Sample distribution for the answer to the question of verbal strategies for dialogue with patient in palliative care - São Paulo, 2011

Response (n=303)	N	%
Two incorrect strategies mentioned	164	54.1
One incorrect and one correct strategy mentioned	92	30.4
Two correct strategies mentioned	36	11.9
Did not respond	11	3.6
Total	303	100.0

A total of 128 subjects (42.2%) indicated at least one appropriate verbal communication strategy that they use in the interaction with the patient undergoing palliative care. Thus, 164 appropriate verbal communication strategies were cited, largely expressing similar meanings. After grouping by thematic similarity the strategies were presented according to their frequency, as shown in Table 2.

Table 2 - Sample distribution of appropriate verbal communicate strategies for interaction with patients in palliative care mentioned - São Paulo, 2011

Verbal strategy mentioned (n=128)*	N	%
To ask what the patients know about their condition/ disease	29	22.7
To ask the patients how they feel, to encourage them to talk about their feelings	29	22.7
To verbalize willingness to help, to talk and/or clarify doubts	26	20.3
To ask about the expectations of the patients regarding the treatment	25	19.5
To ask about the interests and preferences of the patients in order to establish pleasant conversations	22	17.9
Clarity (objectivity/colloquial language)	19	14.8
Prudente sincerity (incremental information)	16	12.5
To verbalize comprehension of their emotions/ feelings	7	5.5

*Many of the subjects cited more than one appropriate strategy.

In the third question, which asked the professionals to cite five nonverbal signals or strategies they would use to demonstrate empathy in the interaction with the patient undergoing palliative care, the mean score obtained by the sample was 0.6 ± 0.3. Thus, of the five nonverbal signals requested, the majority (143 - 47.2%) were able to name three or four. A total of 36 subjects (11.9%) did not indicate any appropriate nonverbal signal and only 46 subjects (15.2%) answered the question in full, citing five nonverbal signals they would use to establish an empathic bond with people experiencing the end of life, as asked in the question. These data are shown in Table 3.

Table 3 - Sample distribution for the response to the question regarding the nonverbal signals used to demonstrate empathy in the interaction with patients in palliative care - São Paulo, 2011

Response (n=303)	N	%
Incorrect	24	7.9
1 correct signal mentioned	25	8.3
2 correct signals mentioned	53	17.5
3 correct signals mentioned	73	24.1
4 correct signals mentioned	70	23.1
5 correct signals mentioned	46	15.2
Did not respond	12	3.9
Total	**303**	**100**

The subjects mentioned 860 appropriate nonverbal signals, which were grouped according to thematic similarity and presented in Table 4, according to the frequency of citation. The affectionate touch, the look, the smile,

and physical proximity were the nonverbal strategies more mentioned by the professionals as those used for the establishment of an empathic bond.

Table 4 - Sample distribution of appropriate nonverbal communication strategies which demonstrate empathy with patients in palliative care mentioned - São Paulo, 2011

Nonverbal strategy cited (n=267)*	N	%
Affectionate touch	262	98.1
Establish/maintain eye contact	163	61
Smile	149	55.8
Physical proximity/presence	140	52.4
Active listening	31	11.6
Positive nod of the head	28	10.5
Ben/lean the body toward the patient	19	7.1
Positive/interested/encouraging facial expression	18	6.7
Positive gestures/waving hands	17	6.4
Respect the personal space of the patient/remove physical obstacles	17	6.4
Share silence	12	4.5
Caring/soft/low tone of voice	12	4.5

*Many of the subjects cited more than one nonverbal signal.

DISCUSSION

The fact that less than a third of the subjects had participated in any palliative care educational activity validated the initial perception of this study, regarding the lack of specific palliative training for those who work in their quotidian with people experiencing the end of their lives. The high value attributed by the subjects to communication in the context of terminality confirms the literature consulted on communication in palliative care[3-5,7-15]. This is estimated as an important attribute of the care at end of the life, either due to the care with which news is communicated, or the emotional support that communication allows to be offered to the patient who is suffering, or even an instrument that allows the identification of the multidimensional needs of the patient and family.

Both in the question relative to the verbal strategies, as well as in the question that refers to the nonverbal actions, there were a large number of subjects who answered incorrectly, citing inappropriate communication strategies for the palliative context (to use a white lie or to avoid eye contact, for example) or even subjective expressions such as solidarity, compassion, support, attention, affection, among others. While they defined or described feelings, these expressions are not characterized as communication strategies. This information proves to be relevant, because it indicates that the professionals found it difficult to differentiate between feelings and concrete actions in the context of communication.

Coupled with the limited knowledge about communication with terminal patients demonstrated, this apparent inability to solidify therapeutic actions of the end of life care through verbal expressions and nonverbal actions configures an obstacle for the performance of quality palliative care, which considers the multiple dimensions and the different needs of the human beings in a situation of advanced disease. These findings are consistent with the perception that the professionals had about their own poor knowledge regarding communication in the context of care to the patient without the possibility of a cure, as well as their unpreparedness to deal with situations of suffering of their patients[3-5,14].

Concerning the knowledge/use of verbal communication strategies in the context of terminality, the majority of the professionals showed a lack of knowledge regarding verbal communication strategies. Among the five most frequently mentioned strategies were questions of an interrogative character, aimed at the investigation of disease/treatment and at the knowledge and expectations of the patients about their condition. The strategies or techniques of verbal communication can be classified into three groups: expression, clarification and validation. The strategies allocated to the expression group were those that the allow verbal expression of thoughts and feelings, facilitating their description and enabling the exploration of problematic areas for the patient[6,22].

In the clarification group were the strategies that help to comprehend or clarify the messages received, enabling the correction of inaccurate or ambiguous information. Finally, the validation group contained the expressions that make the ordinary meaning of what is expressed, certifying the accuracy of the comprehension of the message received[6,22]. Of the eight verbal strategies mentioned by the subjects, six were in the expression group. These techniques offer, in a sense, more security for the professional, since they do not imply decision making or problem solving[22]. While they should be used in all the phases of the interaction with the patients, the strategies of expression are most useful for the initial approach, to establish a climate conducive to interaction. For the continuity of the interaction, formation of bonds of trust and identification of the multidimensional needs it is necessary to make more use of the clarification and validation strategies, associated with those of expression.

Regarding the nonverbal signals mentioned, although the affectionate touch was the strategy most frequently cited, there was also a predominance of strategies mentioned of the kinesics, or body language category. It is noteworthy that among the body signals mentioned, the face (eyes and smile) were most often mentioned, as they are more easily remembered and recognized. The more subtle signals, such as paraverbal (tone of voice) and the use of silence, were the least cited. The affectionate touch refers to the physical contact that conveys messages of an emotional nature[6]. Several actions mentioned by the professionals that were grouped under this denomination were: a hug, a kiss on the cheek, a caress of the hair, a firm handshake, touching hands, arms and shoulders and greeting with physical contact.

Physical contact alone is not configured as an emotional event, however, it stimulates sensory nerve endings and triggers neuronal and mental alterations, the emotions. In this sense, it can be said that the touch arouses emotions and therefore is very welcome when greeting the patient at the beginning of the interaction or at or at the end, when the patient is depressed, sad, feels alone, is in pain, has diminished self-esteem and self-image, or is dying[6,22]. The use of the affectionate touch is very important in the context of palliative care, as it relates to the emotional dimension of the care. Eye contact and smiling are facial signals that denote interest and, therefore, facilitate the interaction with the patients. In addition to portraying emotions, the look has an important function: to regulate the flow of the conversation[6]. The interruption of eye contact may denote a lack of interest in continuing the conversation, causing the interaction to be interrupted or impaired. Thus, both show essential signals for the approach and establishment of a bond of trust with the patients.

The distance that people maintain with each other during the interaction also transmits messages. This distance between people can be classified into: public, when greater than 360 centimeters; social, when between 125 and 360 cm, personnel, between 45 and 125 cm, and intimate if less than 45 cm[6]. Physical proximity with the patient at a personal distance level, a nonverbal strategy cited by many professionals, allows close contact without being intrusive. This enables the patient to hear what is being said without the professional changing the tone of their voice and to understand the signals of the face of the professional. Approaching the people at this distance can convey the message of interest, necessary for the establishment of the empathic bond.

It should also be noted that in Table 4 the fifth most mentioned strategy is not actually a strategy of nonverbal communication in itself but a set of verbal and nonverbal signals: active listening. In this study, it was decided to cite it in the same way as presented by the professionals due to its frequency of being mentioned and its importance in the palliative context: it is through its use that the needs of people experiencing the end of life can be identified in their different dimensions.

Active listening involves the therapeutic use of silence, the conscious emission of nonverbal facial signals that denote interest in what is being said (maintaining eye contact, positive head nods), the physical proximity and orientation of the body with the trunk facing toward the person, and the use of short verbal phrases that encourage continuation of the speech, such as: *and then...*, *carry on ...*, and *I hear you ...*, among others[22]. It is a process that requires concentration and energy on behalf of the professional for its use. This is because it is necessary to try to comprehend the common points to which the patient relates or repeats frequently, since they may offer clues to identify the area of their concerns or requirements. It can be metaphorically compared to reading a complex text, in which it is necessary to comprehend the message transmitted between the lines[22].

CONCLUSION

The healthcare professionals who participated in this study showed that they greatly valued interpersonal communication in the context of terminality, as they attributed a score very close to the maximum possible to this. However, in general, they showed little knowledge of communication strategies for interacting with patients in palliative care: the majority of the subjects (57.7%) were not able to cite one appropriate verbal communication strategy and only 15.2% mentioned five nonverbal signals or strategies that were requested. The verbal strategies most cited by the healthcare professionals were of an interrogative nature and were related to the expectations and knowledge of the patients about their disease and treatment, as well as statements of concern and interest in the multidimensional aspects of the patient. Included among the nonverbal signals or strategies mentioned were the affective touch, the look, the smile, physical proximity and active listening.

The data evidenced by this study are consistent with those identified in previous studies and with what the literature highlights and shows concern about. If these subjects do not correctly use strategies to express their ideas, to clarify and validate information in the interaction with their patients, then the way in which the individualized care they provide is directed is called into question, since needs are identified and validated primarily through appropriate questioning and the use/understanding of nonverbal cues. Considering that the literature also shows that communication skills are not acquired over time, but with adequate training, there is an urgent need for the education of these professionals regarding the use of communication strategies for interaction and inter-relationships with the terminal patients.

The limitations of this study relate to not considering the statistical correlation between the variables professional category, gender, age and previous knowledge about palliative care, in a sample composed of professionals from different disciplines and with different career paths and work contexts. The use of only one instrument proposed to measure the knowledge of professionals regarding communication strategies in palliative care was also considered a limiting factor in the study, in view of the subjectivity and complexity of the communication process with terminal patients. Further studies are necessary, performed from various methodological perspectives, in order to deepen the understanding of the theme.

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