Palliative Care Rounds

Contradictions and Dialectics in the Palliative Dialogue: Enhancing the Palliative Dialogue by Dialectical Principles

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Abstract

The application of required communication skills in the palliative dialogue necessitates a significant transition from the paternalistic medical approach to the holistic psychosocial approach that focuses on the patient and views the individual as a whole entity. Understanding the evolution of a therapeutic relationship in terms of entrance into the relationship, development, maintenance, and leave taking as well as the adoption of dialectical ideas gives palliative caregivers flexibility in the dialogue with patients and families. Accepting the principles of dialectics, in which the existence of contradictions is seen as an inherent part of a reality that is undergoing constant change, gives the caregiver the flexibility to interpret dichotomic thoughts and emotions as a dialectic failure and, in accordance, to move toward a synthesis of the ideas of living and dying. This approach provides caregivers the means to promote the palliative dialogue, implement varied communication skills to clarify the patient's goals, and implement a therapeutic plan to realize them. J Pain Symptom Manage 2014;48:992–997. *© 2014 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Professional quality of life, palliative dialogue, therapeutic relationship evolution, dialectical approaches, coping strategies

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Introduction

Quality communication is an essential element in the optimal care of dying patients and their families. Patients' attitudes and partnership in the decision-making process are key elements in treatment planning, alongside attention to their physical, emotional, and social needs.[1] Providing bad news, truth telling, planning treatment, and advance directives are among the central issues cited in the literature as barriers to quality communication.[2,3]

Oncologists who incorporated both medical and psychosocial aspects into communication with patients perceived themselves as having a positive influence on the flexibility of patients and families in coping with the process leading

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up to the acceptance of death[4] and derived greater satisfaction from their work. Supportive behavior on the part of the physician, as well as active participation of the patient and family in the dialogue, was associated with greater patient and family satisfaction.[5]

Poor communication skills and lack of time to communicate with patients were associated with high levels of stress, burnout, compassion fatigue, and lack of work satisfaction.[1,6] Additional issues reported by physicians included a low level of confidence in their ability to apply complex communication skills, such as providing bad news, encouraging communication within the family, helping in situations that entail uncertainty and coping with denial,[1] avoiding providing patients a honest prognosis even when they express readiness to accept it,[7,8] and handling moral dilemmas related to concern and anxiety when patients have dashed hopes.[9]

When patients and families present extreme emotions such as denial, anger, aggression, and despair during the dying process, the caregiving team has no choice but to respect this attitude and adjust the goals of therapy and intervention modalities. Understanding the evolution of a therapeutic relationship as an ongoing process in terms of entrance into the relationship, development, maintenance, and leave taking as well as adopting the dialectical approach might expand our ability to deal with these thoughts, behavior, and extreme emotions and recommend effective techniques to avoid the described barriers.[10] This article describes an intervention used with a terminal patient in a home-based hospice. For better understanding of the implementation of these strategies, we choose to present the development of the relationship according to the phases described by Baxter.[11] At each stage, we emphasize the inherent significance in the text and the main dilemmas that the caregivers confronted because of that message, with recommendations for how application of the dialectical approach could influence the interventions and allow better management of the palliative dialogue.

Case Description

Ronen, a 62-year-old man, is married and the father of three children. He was diagnosed with leukemia three and a half years ago. After a prolonged period of treatment, his condition slowly deteriorated. At the last follow-up appointment in the hospital, his oncologist raised the issue of referral to a community hospice as an option for support in between courses of chemotherapy. Ronen gave his consent, and the hospice team scheduled their first home visit. On the referral application, the oncologist recommended a nutritional consultation before beginning total parenteral nutrition (TPN) in the hospital. Because TPN is a life-sustaining intervention, the hospice team decides to reconsider the issue after clarifying Ronen's treatment goals. After the first visit, Ronen's preferences were still ambiguous.

Comment

Dialectical Strategies for Balancing the Tension of the Palliative Dialogue

One of the barriers to quality communication is the constant tension between the role of the hospice caregivers as leaders in their field and the need to allow the patient to take the lead. The members of the palliative care team are knowledgeable experts in the processes of death and dying and the prevention of associated suffering. In contrast, patients and their families are perceived as experts in alleviating their own physical and emotional suffering in a way that is appropriate for them and is supported by the palliative caregivers.

Dialectical approaches focus on the inherent contradictions that exist in social life.[10] One of the fundamental assumptions is the existence of contradictions that exist at all times and are mutually related. In addition, there are ongoing changes that relationships go through over time, alongside turning points.

In light of the dialectical approach, three coping methods have been identified to balance the tension between the patient and palliative caregiver points of view:[12]

1) Selection and denial:[10] A common method to achieve balance is by choosing one role, leader or follower, and behaving as if the alternative does not exist. For