Pain talk in palliative care: A qualitative analysis

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Research article

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Abstract

Aim Using the method of Conversation Analysis (CA), this study aims to demonstrate how the palliative care provider uses different types of interactional practices to address patient's pain concerns. Background The delivery of palliative care services could be facilitated through effective communication. The method of conversation analysis is effective in improving communication skills. Conversation analysis, used in other healthcare settings, also is a useful way to explore the interactional details between palliative care providers and terminally ill patients. Method The data showed in this study are obtained from 2 videotapes of provider-patient interaction in palliative care settings. The videos and the initial transcript of them are collected from the Alexander St website http://ctiv.alexanderstreet.com, an educational resource presenting a large collection of psycho-therapeutic videos. The data is analyzed using the method of conversation analysis. Results In this study, an illustrative analysis is demonstrated to show the potential of conversation analysis for research on pain talk in palliative care. It has been shown that conversation analysis could contribute to unfolding the interactional details regarding "pain talk" in palliative care settings. Specifically, CA could provide a detailed a description and interpretation of the conversational practices used to construct palliative care provider participation in delivering pain talk. In addition, CA could also demonstrate the interactional resources by which patients disclose their experiences of physical and spiritual pain to the palliative care provider and the way how the palliative care provider responds to patient's problematic experiences. Conclusion This study identifies five types of interactional resources which are used to deal with patient's pain concerns in palliative care setting. A conversation analytical study of pain talk in palliative care could provide a turn-by-turn description of how the palliative care provider communicates with the terminally ill patient in terms of pain concerns. The findings in this study could inform how the palliative care provider initiates, delivers and develops a pain talk with the terminally ill patient effectively.

Introduction

Palliative care consists of a holistic and interdisciplinary approach to care that seeks to improve the quality of life of patients and their families when confronted with a life-threatening illness.[1,2] Healthcare providers in hospice and palliative care work to relieve the physical, psychological, social, cultural and spiritual concerns and suffering of persons with life-limiting illness, and they assist patients to maintain an acceptable quality of life.[3] The delivery of hospice and palliative care services could be facilitated through effective communication.[4] One of the key elements of physician-patient communication in any type of medical consultation (e.g., palliative care, acute care, primary care) is the solicitation of information from patients about their immediate concerns (Boyd & Heritage, 2006; Heritage, 2010; Robinson, 2006; Stivers & Heritage, 2001).[5,6,7,8] Pain is a major problem and primary concern of patients in palliative care.[3] Based on the method of conversation analysis, a number of studies have been conducted to examine doctor-patient interaction in palliative care setting.[9,10] Asking for information from patients about their concerns could contribute to a good understanding of their emotional, physical and psychological state in palliative care.[1] The type and amount of the patient's concerns the palliative care

provider could obtain has a strong influence on the quality of care received by the patient.[11] If a palliative care provider obtains only minimal information about a patient's concerns, it is likely that the palliative care provider will not make an effective patient care plan.[12] Although Conversation Analysis (CA) is a very useful method for examining the patient's concerns in palliative care, few studies has examined the ways in which the palliative care provider addresses the patient's pain concerns in palliative care. In this study, using the method of CA, we aim to examine the conversational practices used by the palliative care provider to deliver pain talk. This study provides a detailed description and interpretation of the conversational practices used to construct the palliative care provider participation in delivering pain talk.

Methods

Patient and Public Involvement

The transcribed data showed in this study was obtained from one videotape of doctor-patient interaction in palliative care setting. The recorded data and its initial transcript were collected from the Alexander St website http://ctiv.alexanderstreet.com, an educational resource presenting a large collection of psycho-therapeutic videos. The data were re-transcribed using Jefferson's system.[13] In this study, the data consists of two palliative care sessions lasting about 50 minutes. A palliative care provider and two terminal cancer patients are involved. Study into two palliative care sessions can, by no means, tell the whole picture of medical interaction in palliative care setting but might motivate palliative care providers' reflection on their communicative skills and shed some light on how to communicate with terminal patients in palliative care setting.

Data analysis

Conversation analysis is the study of'talk-in-interaction'. The general aim of CA studies is to show how conversation is sequentially organised, turn-by-turn and action-by-action, and how this sequence organisation in interaction enables interlocutors to manage intersubjectivity and communicate with each other smoothly.[14,15,16] The central claim of CA is that the current turn is not only shaped by the preceding turn, but also influence what the next speaker is going to say in the subsequent turn. Conversation analysts qualitatively examine recordings of naturally occurring interactions to unravel the reoccurring interactional practices through which social actions (such as complaining or advising) are constructed in moment-by-moment processes.[17]

CA offers a rigorous method (applicable to large data sets) to the study of interaction in health settings.[18] In CA studies in medical settings, a key focus is how the doctor's turn arises from the patient's previous turn and how the doctor's turn controls the patient's subsequent turns (or vice-versa). As is pointed out by Peräkylä et al. (2008), CA provides a new way for observing and understanding medical interaction.[19] CA unfolds the sequential organization in the medical consultation in detail and explicates the practices and patterns through which the consultation is performed.[20]

Results

In this study, we focus mainly on the palliative care provider's interactional practices which work to deal with the patient's pain concerns. By examining the provider's interactional practices as they unfold within sequences of talk, we could have a better understanding of how the palliative care provider initiates, develops and completes a palliative care proposal.

Proposing hospice in an implicit way

Conversations about end-of-life decisions and the transition toward palliative care remain among the most challenging communication tasks for palliative care providers (Back et al., 2008, Fallowfield & Jenkins, 2004, Galushko et al., 2012),[21,22,23] as initiating palliative care decisions often entails addressing a patient's impending death. Consequently, the ability to initiate timely conversations about end-of-life decisions is considered a fundamental skill for palliative care providers (Bakitas et al., 2011).[24] Extract 1 shows an instance where the palliative care provider proposes palliative care in an implicit way.

Extract 1

01 D: I think we need to talk about (0.5) what's been going on for the last few days. The fact

02 that you didn't respond to the spinal t*ap*s (.) I wouldn't want to p*ut* you through any more

03 spinal taps. There's going to be a time (.) when we're not going to be able to deal with the

04 pressure (.) with the [steroids.

05 P: [Okay.

06 D:We will be able to help with pain and in making you comfortable.

07 I'm worried that your disease is progressing quickly.

08 We've talked about (.) you know (.) hospice before.

09 And I think this is the time where we need to discuss a bit more about it.

10 P:Well (.)Mary and I have talked many times and my thought again is I'm not afraid to die, but

11 I'm afraid of all the suffering that goes beforehand. So we just-we're trying to find out,

12 you know, when that is going to come to pass just so we can-we can say goodbye to each

13 other.

At the beginning of this extract, the palliative care provider tells the patient that her illness reaches a point where spinal taps is not useful for dealing with her ongoing symptom. In line 5, the patient responds with an agreement token, which indicates that the patient shows an agreement with what the palliative care provider has said. After receipt with the agreement token, the palliative care provider starts to talk about palliative care in lines 6–9, where he first says that they could be able to deal with pain and make the patient feel comfortable and then reports on the degree of her illness, where palliative care need to be considered. Notice that in line 6 an exclusive *we* was used instead of *I* at the beginning of an assertion in the treatment of pain, which permits the doctor to identify with other palliative care providers in his hospitals, thus adding authority to his position (which may reassure the patient as well). In line 7, the palliative care provider says that he is worried that the disease is progressing quickly, which implies that the disease may be out of control and the patient is approaching the end of life. Based on what the palliative care provider has said in lines 6 and7, it can be supposed the patient's illness cannot be cured whereas something could be done to improve her quality of life. It paves the way for the recommendation of palliative care to deal with her illness. In line 8, the palliative care provider initiates the topic "hospice", which indicates there are no clinical methods to cure the patient's disease but could improve her quality of life. It is clear that the direct delivery of "hospice" could make the patient feel sad. Notice that the delivery of hospice is delayed by the use of "we have talked about" and "you know". First, inclusive "we" works to evoke a sense of commonality and rapport between the palliative care provider and the patient. Then, by saying "*you know"* and leaving idea (hospice) less filled out, the palliative care provider can distance himself from potentially face-threatening utterance and invite the patient to participate in the ongoing talk. The palliative care provider begins to propose palliative care to the patient in line 9, where he says that it is time to start a palliative care in an implicit way. First, the provider's claim is prefaced with epistemic marker "I think", which can be seen as the provider's cautiousness in making knowledge claims. Specifically, through downplaying his own source of knowledge, the provider tries to preserve the patient's greater rights to decide whether palliative care should be put into practice. Second, talking about palliative care is quantified by an approximator "a bit more", which can both leave adequate leeway to the patient and take the paint's decision-making into consideration. In this sense, it indicates that the provider wants to involve the patient in the subsequent interaction, which is, hoping to get confirmation from the patient concerning the use of palliative care.

Soliciting the patient's goals on pain management

Discussing goals of care requires a unique combination of good communication skills that should be separated conceptually from talking about prognosis or delivering bad news.[25] Understanding the patient's care goals in the context of a serious illness invites the patient to participate in designing a shared care plan.[25] It is thus significant to understand how to solicit the patient's care goals and how the patient responds to the provider's inquiry. Let's see extract 2 where the palliative care provider asks for the patient's goals on pain management and the patient reports on her detailed goals on pain management.

Extract 2

01D: What should our goals be?

02P: My goals (.) I-I don't-I want to be pain-free. I'll be honest about that (.) I want to be

03 pain-free, I don't like pain. I-I don't-I can't-I can tolerate emotional pain to a certain point,

04 but I cannot tolerate physical pain. I want to have some sort of pain-free living standard

05 where I can go on you know. And I want people to know that aro*und* me that are working

06 with me that this is (.) this is it from me. You know, this is where I am going, this where I'm, 07 and this is where-where I want to be. I don't want to (.) people, I don't want to fool people. 08 I know where I'm going. I'm- I'm in a-I'm in a dangerous situation. You know (.) I may not

09 wake up tomorrow. I may not wake up tomorrow. And my (0.5) and my husband knows that. 10 I know that. Well (.) all of the preparations are done. Everything is ready. And this is the

11 place for us to do it.This is where we get the support that we need.

In line 1, the palliative care provider asks the patient"what should our goals be", soliciting an expectation of the therapeutic goals. By saying "our goals" instead of your goals, both the palliative care provider and the patient are involved in the design of pain management. On the one hand, it suggests that the provider and the patient are going hand in hand to deal with the patient's pain. On the other hand, it offers an opportunity for shared decision-making, which will spark patient engagement in her own care. Here, the palliative care provider's question is designed to communicate that the therapeutic goals being solicited are uncertain or unknown to him, which by their nature call for a response.[15] In response to the physician's new-concern question, the patient: (1) begins her answer with "my goals", then cuts herself off after"my goals-"and finally presents her goal, "I… I don't… I want to be pain-free" where self-repair occurs.[26] (2) offers a detailed description of his goals with emotional disclosures (i.e., I don't like pain, in line 3; I cannot tolerate physical pain, in line 4) and (3) elaborates on her perception and attitude towards her own illness, (i.e., I'm in a dangerous situation, in line 8; everything is ready, in line 10). In sum, the patient displays her orientation to the doctor's "What are our goals"as a solicitation of an expectation of pain management in palliative care.

Soliciting the patient's presenting pain concerns

After visits are opened, physicians typically solicit patients' presenting concerns with questions such as *How are you feelings today?*..[27,28] These questions have an important role to play in maintaining the effective communication between physicians and patients because different question designs/formats (i.e., different wordings) can significantly influence and constrain patients' answers. Extract 2 shows an

instance of how the palliative care provider uses questions to solicit the patient's presenting pain concerns.

Extract 3

01 D: Being in bed as you are right now, sitting quite still, do you have any pain at all right now?

02 P: No, no.

03 D: Oh, no pain right now?

04 P: No.

05 D: So what you are saying is that when your sit in bed as you are, you are comfortable?

06 P: Yes.

07 D: If you get up and try to walk, then your legs are painful?

08 P: Yeah, painful yeah.

At the beginning of this extract, the palliative care provider's question, "do you have any pain at all right now?" solicits an update or evaluation of the patient's current situation. Turn-terminal, temporal modification, " right now", invites the patient to evaluate the current state of his condition relative to its previous state (presumably during the prior visit). Here, the doctor's question prefers a negative response because of the use of the negative polarity term"any…at all".[29] In what follows, the patient's response in a brief and immediate way is aligned to that preference. Notice that the patient's response "no" was repeated twice, which is a report of improvement on her health status and thus demonstrates a positive evaluation of her ongoing physical-heath condition. Subsequently, the palliative care provider's question in line 1 was expressed in an alternative way in line 3, that is, in a negative declarative question, "no pain right now?" The question "no pain right now" is polarized in a negative direction favoring a "no" response. Again, the patient's response is both aligned to the polarity preference expressed in the question, and produced in preferred format, that is, the response is designed briefly and produced without significant delay. In line 5, the palliative care provider initiates a new question, which is prefaced with a "so" positioning it as building on the patient's talk. Here the provider attempts to formulate what the patient has said in the preceding turns and confirm the current state of her body. After getting the patient's confirmatory response, the palliative care provider in line 7 raises a new question, which draws out an implication of what they have talked about in the preceding turns. Notice that in this extract, three close-ended questions are designed to solicit an evaluation of an ongoing physical-health condition. Closed-ended questions communicate that although the palliative care provider has some idea about the nature of patient's concerns, he does not have primary authority including knowledge concerning the sate of the

patient's pain concerns.[30] In other words, the patient has primary access to, and knowledge of, her pain concerns.

Displaying affiliation with the patient's pain concerns

In palliative care, the patient creates empathic opportunities by displaying their affectual stance towards his/her pain symptom. In response, the palliative care provider deals with the patient's pain concerns through affiliative displays. Extract 4 is a case in point.

Extract 4

01 P If I can walk without pain, that will be something fine =

02 D: = Ye:ah

(1.0)

03 P: I have had p*ain* there for-for-for 5 months now.

04 D: Hmm (.) Hmm. Well (.) that's what we're aiming for (.) get r*id* of the pain (.) and get you

05 walking.

06 P: Yeah.

At the beginning of this extract, it can be seen that the paint is afflicted by pain ("If I can walk without pain", line 1and she expects to get rid of pain ("that will be something fine", line 1).The palliative care provider responds to this with an acknowledgement token "yeah". The provider does not continue his turn, and a 1.0 silence ensues, after which the patient says that she suffers pains for 5 months, which suggests the patient has been eager to get the pain away, and thus can be heard to pursue a stronger response from the physician. Proposals of affiliation were usually made after the patient had put some effort into pursuing affiliation from the professional.[31] The provider responds with a twice-repeated acknowledgement token 'hmm', then with a particle "well". Turn-initial *well* functions as an alert that the talk to follow will privilege the speaker's perspectives, experiences or feelings.[32] After the particle "well", the palliative care provider deals with the patient's pain concerns through affiliative displays ("we're aiming for (.) get rid of the pain (.) and get you walking.", lines 4 and 5), which affiliates with the patient's ongoing concerns.

Alleviating the patient's pain concerns

Palliative care providers should actively listen to their patients' pain concerns and deal with them patiently. The palliative care provider will usually tell the patient that they could manage his/her pain

well.[33] For patients, they would find it reassuring to know that their pains can be managed well. Extract 5 is case in point.

Extract 5

01 D:When you wake up l*ike* that, it's because you are worried or because of p*ain,* or you just

02 w*ake* up?

03 P:It-It-It could be pain but no, and I don't worry. Well (.) of course, when here, you (0.5) you

04 don't know how it's going to end and there is always a bit of anxiety against the same for

05 everybody, but it was the same at home, I wouldn't sleep at night (.) it was my night*mare* too.

06D: What do you m*ean* you don't know how it's going to end?

07P: Am I going to s*uff*er? How is it going to (.) Am I going to get into a co*ma?* It's all question

08 that you, we don't know, but there is always, you know (.) you-you ask yourself.

09D: What do you think will ha*ppen?* What do you ima*gine* might happen?

10 P: Well, to me *can*cer, it means it's not curable and you suffer a lot.

11 D: You suffer a lot like from pain.

12 P: Yeah, Yeah (.) Maybe I'm wrong today (.) maybe they've got [medication

13 D: [Yeah.

14 P: but to me, that's the way it is.

15 D: What if I told you that we do have the means and we do have the medi*cation* to control pain

16 in almost all cases, li*ke* almost a hundred percent.

27 P: Yeah.

At the beginning of this extract, the palliative care provider inquires the patient about why she wakes up while other patients sleep. In response, the patient in lines 3–5 reports that she cannot sleep at night because of both anxiety and pain. In lines 12 and 14, the patient says that she wake up mainly because of pain while other patients who sleep may have gotten medication. In what follows, the palliative care provider in lines 15 and 16 switches to talking about non-problematic, positive issues in managing the patient's pain, which is a common way to exit from troubles-telling sequences in ordinary conversation

(Jefferson, 1984). Notice that the palliative care provider uses extreme case formulation like"in almost all cases, a hundred percent" to display an orientation to the fact that the patient's pain could be definitely controlled. In this sense, the provider's presentation of comforting utterances tend to formulate the patient's pain both as common and as basically relivable and manageable.

Conclusion

Using the method of conversation analysis, this study identify five types of interactional resources which are used to deal with the patient's pain concerns in palliative care setting. Conversation analytical studies on pain talk in palliative care provides a turn-by-turn description of how the palliative care provider communicates with the patient in terms of pain concerns. In addition, by examining sequential features of pain talk in palliative care setting, we may get a better understanding of the interactional details in process of achieving palliative care. This study not only enriches studies of palliative care but also helps to improve palliative care providers' communication skills. This is a preliminary study of pain concerns in palliative care, and thorough investigations would be carried out in future studies.

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Ethical approval:

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References

1. Bélanger E, Rodriguez C, Groleau D, Légaré F, Macdonald ME, Marchand R. Patient participation in palliative care decisions:An ethnographic discourse analysis.International Journal of Qualitative studies on Health and Well-being 2016;11:1–15.
2. Wu Y, Li L, Su H, Yao X, Ma W. Hospice and palliative care: development and challenges in China. Clinical Journal of oncology nursing 2016; 20:E16-E19.
3. Twycross, A. Managing pain in children: where to from here? Journal of Clinical Nursing 2010; 19:15-16.
4. Cunningham, S. Physician's questions and a palliative patient's answers regarding physical pain: A conversation analytic approach (Unpublished doctoral dissertation).The University of Guelph, Guelph, 2012.

5. Boyd, E.,Heritage.J. Taking the history: questioning during comprehensive history-taking. In: Heritage, Maynard (Eds.), Communication in Medical Care: Interaction between Primary Care Physicians and Patients(pp.151–184). Cambridge University Press: Cambridge, 2006.
6. Heritage, J. 2010. Questioning in medicine. In:Freed, A., Ehrlich, S.(Eds.),'Why do you ask?': the Functions of Questions in institutional Discourse(pp.42–68). Oxford University Press: Oxford, 2010.
7. Robinson, D. J. Soliciting patients' presenting concerns. In J. Heritage & D.W Maynard. Communication in medical care (pp.23–67). Cambridge: Cambridge University Press, 2006.
8. Stivers T, Heritage J. Breaking the sequential mold: Answering 'more than the question' during comprehensive history taking. Text 2001; 21: 151–185.
9. Arber, A. (2007). "Pain talk" in hospice and palliative care team meetings: An ethnography. International Journal of Nursing Studies 200744, 916–926.
10. Cunningham, S. Physician's questions and palliative patient's answers regarding physical pain: A conversation analytic approachUnpublished doctoral dissertation). The University of Gueph, Guelph, 2012.
11. Beach, W. A. (2012).Handbook of patient provider interactions. New York: Hampton Press, 2012.
12. Granda-Cameron, C, Houldin, A.Concept analysis of good death in terminally ill patients. American Journal of Hospice and Palliative Medicine 2012;29, 632–639.
13. Jefferson, G. Glossary of transcript symbols with an introduction. In G. H. Lerner (ed.) Conversation Analysis: Studies From the First Generation.Amsterdam/ Philadelphia: John Benjamins, 2004.
14. Heritage, J. Garfinkel and ethnomethodology. In I. Hutchby & R.Wooffitt. Conversation analysis: principles, practices and applications (pp.67–88). Cambridge: Polity Press,1984.
15. Sacks, H. Notes on methodology. In J. M. Atkinson & J. C. Heritage (Eds.), Structures of social action: Studies in conversation analysis (pp. 21–27).Cambridge:Cambridge University Press, 1984.
16. Schegloff, E. A. Categories in action: person reference and membership categorization. Discourse Studies 2007;9, 433–461.
17. Schegloff, E. A. Sequence Organization in Interaction: A Primer in Conversation Analysis. Cambridge: Cambridge University Press, 2007.
18. Drew P, John C, Sarah, C.Conversation analysis: a method for research into interactions between patients and health-care professionals. Health Expectations 2001;4:58–70
19. Peräkylä A, Antaki C, Vehvilainen S, Leudar, I. Conversation analysis and psychotherapy. Cambridge: Cambridge University Press,2008.
20. Maynard D. Bad news, good News: Conversational order in everyday talk and clinical settings. Chicago: University of Chicago Press, 2003.
21. Back AL, Anderson WG, Bunch L, Marr LA, Wallace JA, Yang HB, Arnold RM: Communication about cancer near the end of life. Cancer 2008; 11:1897–1910.
22. Fallowfield L, Jenkins V. Communicating sad, bad, and difficult news in medicine. Lancet 2004; 363:312–319.

23. Galushko M, Romotzky V, Voltz R. Challenges in end-of-life communication. Current Opinion Support Palliative Care 2012; 6:355.
24. Bakitas M, Kryworuchko J, Matlock DD, Volandes AE. Palliative medicine and decision science: the critical need for a shared agenda to foster informed patient choice in serious illness. Journal of Palliative Medicine 2011, 14:1109–1116.
25. Flint, H., Meyer, M., Hossain, M. Discussing Serious News: Teaching Communication Skills Through Role Play With Bereaved Parents. American Journal of Hospice and palliative medicine 2015, 34: 254–257.
26. Schegloff E.A, Jefferson G, Sacks H. The preference for self-correction in the organization of repair in conversation. Language 1977,53:361–82.
27. Heath C. The opening sequence in doctor-patient interaction. In P. Atkinson and C. Heath (eds.) Medical Work: Realities and Routines (pp.71–90). Aldershot: Gower,1981.
28. Robinson J.Getting down to business: talk, gaze, and body orientation during openings of doctor-patient consultations. Human Communication Research 1998,25:97–123.
29. Goodwin C. Conversational organization: Interaction Between Speakers and Hearers. New York: Academic Press,1981.
30. Robinson J.Soliciting patient's presenting concerns. In: J.Heritage and Maynard, D.W (eds.).Communication in Medical Care (pp.22–47). Cambridge Press:Cambridge, 2006.
31. Drew, P. The voice of the patient: Non-alignment between patients and doctors in the consultation. In W. A. Beach (Ed.), Handbook of patient-provider interactions: Raising and responding to concerns about life, illness, & disease (pp. 299–306). New York: Hampton Press,2013.
32. Gardner, R. (1997). The conversation object mm: A weak and variable acknowledging token. Research on Language and Social Interaction 1997, 30:131–156.
33. Kehl, K. A.Moving toward peace: An analysis of the concept of a good death. American Journal of Hospice and Palliative Medicine, 2006, 23: 277–286.