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The "Time Factor" and Communication in Oncology and Palliative Care

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Abstract

In the field of medicine, the acquisition of communication skills is essential for an effective, complete and personalized treatment. This is particularly true for delicate fields such as incurable diseases, palliative care (PC) and end-of-life (EOL) care. The *time-factor* is an important concept in the communication process, meaning here not only "the time spent in communication", often scarce in healthcare systems, but also a multiform existential dimension involving all the different figures present in the treatment process (patient-time; physician-time; family-time; institution-time).

The perception of time as an existential explanation for the dimension that the patient is living in can have an individual psychological equivalent that must be acknowledged in order to obtain truly individualized communication and a personalized approach in the doctor-patient relationship.

Keywords: Palliative care, Communication skills, Medical ethics

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Introduction

Communication skills are fundamental for effective and complete care, especially with incurable diseases. These skills are an integral part of the process of human and clinical support and cannot be considered only at the end of the doctor-patient relationship [1].

It is a question of entering and sharing a new dimension of caring, more existential and less technical. The doctor is asked to stand by the patient and help him or her cope with the sadness and loss related to the deeply disturbing news of a serious and incurable disease [2, 3].

Treating means interacting with the patient; in this relation, the knowledge and understanding of the patient gained through dialogue and constant communication is essential. This dialogue should be realistic and in direct correlation to each single step and passage of the patient's case history.

Treatment requires dialogue to help remove elements of disagreement, and language as a means of acquiring knowledge [4]. Indeed, there is a word dimension enveloping the entire treatment, concerning both the work done on oneself as well as in the communication with others [5].

The *time factor* is part of this communication process. When talking about communication, we do not always consider time in all its aspects, we often think of it simply as the duration of

the communication moment, reducing it to a mere professional task to be viewed and resolved as "monetization": a different distribution of resources that attempts to avoid encouraging solely direct treatment and actions, favoring instead greater time devoted to communication [2].

In reality, this solution does not seem to be thorough when we look more deeply at the meaning of time. Time is also a prognostic concept; the moment when information is given; a dynamic phenomenon associated with the development of the disease; one of the multiform existential dimensions directly concerning all the health professionals involved in the process of healthcare. It would therefore seem opportune to make an analytic consideration which, starting from full comprehension of the word, leads us to the substance of the concept of time and on to its pertinence to the study of personalized communication.

What does *time mean*?

The analysis of the three principal conceptual definitions of *time* is functional to the individualization of these dimensions within the relation between the doctor – providing information as part of the treatment – and the patient-family who need to understand and cope with the information received. We will here consider three main conceptions of *time*:

1) **Classic theorization**: Time is conceived as a *measurable order* and thus refers to a system of cause-and-effect; it is a *linear order*. Kant and Newton are amongst the main leading exponents [6].
2) ***Subjective* perception of time**: the sense of time passing is directly linked to the emotional/mental/physical state of the individual when a particular moment is experienced. Time is seen as qualitative and not measurable. The main expression of this concept is time as a *phenomenological condition*: it is "reduced" to consciousness and occurs as a kind of "never-ending stream of life experiences" [7]. In this sense, "time is not a line, but rather a network of intentionality" [8].
3) **Time as a *structure of possibilities***: unlike the two previous concepts where, though starting from different points, time is interpreted as giving precedence to the present; here what prevails is the "becoming". Time as possibility or planning being the only "authentic" perception, as we formulate our own path and possibilities. According to this concept, temporality is fundamental to our way of being; our "project" being the dimension of the future, the most concrete element of which is our eventual death [9].

Each of these concepts concerning *time* can be applied in both a relational and clinical context. The philosophic conception, i.e., the existential explanation of the subjective dimension experienced by the patient, has corresponding personal psychology to consider in order to enable a tailored approach in the relationship between doctor and patient.

What is the *time factor* in communication with cancer patients?

The inclusion of the *time factor* in the communication process with cancer patients and the conscious definition of the other aspects of temporality involved, constitute then a significant element in the course of treatment. Considering time as a multiform existential dimension is of great importance; a lack of such consideration could become a potential obstacle to personalised care [2].

In a healthcare relationship, the comparison of "subjective time" becomes important: first and foremost patient-time, then physician-time, family-time and finally, what is known as "disease time".

These time factors can give a deep complexity to the vast kaleidoscope of the healthcare relationship:

Firstly, it is necessary to underline the possible risk of conflict between physician-time and patient-time, respectively governed by different necessities: the former is characterized by little nursing and relational time, diagnostic-therapeutic objectives and numerous patients to be cared for; the latter is a process of awareness, coping strategies and the replanning and rebuilding of the patient's everyday life.

The issue of subjective and objective time is well highlighted by a study reporting on doctors who then became patients themselves and how they realized that the "suffering" experienced is deeply entwined with many individual and subjective aspects which can potentially impede a therapeutic alliance [10].

Within the different meetings (doctor-patient and also the Healthcare Clinic providing the service) it seems more than ever necessary for the doctor to recognize those parts of the patient's past that can be "modified" so as to find those points of contact useful in optimizing the treatment times, relational moments and medical and clinical-nursing passages, with awareness of all the different dimensions involved: biomedical, existential, psychological and spiritual [11-13].

We speak of temporal experiences which can be "modified", since there is a part of time experienced during illness that belongs to the patient alone and in which there can be no intervention by the practitioner.

How does the perception of time change when a disease such as cancer occurs in one's life? Many studies show that people in their end-of-life experience have an altered time perception and relation: they listen to the rhythm of their body and care less about time; it is the body and not the clock that dictates their daily activities [14].

No doubt that a cancer diagnosis forces one to reconsider the fundamental elements of life and different studies have shown that time perception is dramatically altered.

What has been suddenly lost, and what the patient and doctor must come to terms with, is the dimension of planning and future projections, to be replaced by the value of the present time still available [15].

With reference to this concept of time just described, the appreciation of the present could represent not only a way to qualify each day and give it value, but also a way to ease a passage to death by "erasing time".

According to some philosophers, in the "caring for death" as an integral part of life, the only valid notion of time is that in which past and future are somehow "erased"by"a freezing of the temporal flow" in a continuous present [16].

A study conducted in 2006 regarding the experience of time described by cancer survivors showed that patients talked about time on different levels: the loss of future; time as an assumption of responsibility; the "end of time" and its reappropriation [17].

A second point we should seriously consider is the evaluation of the family's time expectations, above all in contexts such as in Italy where the family represents a key element in the treatment process [18]. Consequently, the time devoted to both patient and family must be well evaluated, as the latter cannot be excluded from the treatment relationship.

When family members actively share the treatment process (or even play the role of protagonists, when the "conspiracy of silence" occurs) then an allotment of "extra time" must be considered for these additional figures. Such extra time could then be a tactic to further optimize the synthesis between the temporal subjectiveness of doctor and patient.

Finally the "disease time", which corresponds to the skill the physician has in the patient treatment relationship, and cannot fail to take into account all the different passages in the treatment process. What emerges is a substantially stable setting (doctor-patient/treatment relationship) though always resting on the "background" of the course of a dynamic disease.

For this reason, it is necessary to adapt the doctor's communication skills and the patient's coping strategies according to the treatment phase [3] and, in the case of cancer, the different roles: general practitioner (GP), oncologist, palliative care provider and psychologist.

In order to achieve continuous care [2], each of these specialists should play an active part in the communicative process, with a specific and well contextualized role.

A communication model should allow for a rotation of "communication leadership", precisely because each stage in the course of the illness has information, objectives and periods for the patient to listen.

In this articulated communication process proper to the cancer care relationship, we should also carefully consider the extreme heterogeneity of viewpoints which are often dependant on the specialty of the doctor, since it is frequently not only the oncologist who must manage issues such as treatment interruption, palliative care and end-of-life care [19].

It is usual for several doctors to manage the flow of information between health professional and patient during the different stages of the illness. The solution to keeping the quality of the relationship intact and the communication effective, and avoid reducing it to mere information, is once again the valuation and optimization of time through the actions of being present, listening and questions and answers management as well as the search for an objective perspective which is at the same time comprehensive of the different dimensions of the patient, the doctor and the "illness" and which is realized in a simultaneous and sequential way by each health professional. For example, the oncologist tells the patient that it is necessary to start palliative care and the GP together with the oncologist explain to the patient the meaning of this change in his/her treatment. In this way, they meet the patient's expectations while managing and easing the handover to the Palliative Care team.

Dynamic and realistic communication: time and candor, beyond empathy

Recognizing the risk of conflict between patient-time and doctor-time is the beginning of the fulfillment of a theoretical model of effective communication, whose main tool is the explication of realistic and genuine communication.

By "realistic" we mean the ability to communicate in each moment of the course of the illness, always taking into account the patient's needs and the viable treatment options in that particular stage. The tools to achieve this are identified in being present; the doctor's efforts to maximize the short interactions through a sense of presence; the ability to utilize and manage the time well [15].

The dimension of "here and now" virtuously compels the doctor to concentrate on the patient in that very moment, who can then feel accepted, listened to and adequately cared for.

We should therefore consider cancer, as far as the relationship aspect is concerned, as a "couple issue", involving new energies, emotions and skills that go beyond the usual diagnosis-treatment relationship. The cognitive resources of the receiver must always be kept in consideration in order to avoid misunderstandings that could be potentially damaging to the future therapeutic alliance. In the actualization of the communication context, the production of realistic aims and ideas in such a complex doctor-patient relationship there by necessitates integrity and authenticity on the part of the speaking and listening health professional.

Etymologically, we can define *authenticity* as something related to our real inner being and as such is the "state of being proper to and deeply concerning mankind" [20]. By authenticity in communication, we therefore mean a message spoken by an emotionally proper, constructive and responsible health professional [21].

At the root of these characteristics, there are matters such as human respect for the ill person and their centrality within the program of treatment, as well as the transmission to the patient that the doctor is present and aware of his or her condition, expectations and fears.

We therefore suggest going beyond the concept of empathy, which could somehow be misinterpreted by many doctors and seen as a complex strategy to learn or a relational "stretching" to the detriment of the pressing need to give priority to medical know-how on the patient's path of listening and coping.

Empathy has been, in fact, described as the ability to feel curious about another particular emotional perspective and most studies on it suggest methods to promote empathy in a patient-

doctor relationship [22]. However, this approach runs the risk of facilitating an overly technical and impersonal attitude.

Empathy should rather be seen as an aspect of an authentic doctor-patient relationship, in the perspective of the relational knowledge that should form the cultural background of all healthcare workers.

In this sense, authenticity is not really an ability to teach, rather an attitude that the doctor embraces within an ethical approach to the ill person which is equal and respectful from a human and emotional point of view. Empathy is the realization of this attitude which must then in turn be inserted into a wider range of views.

The proposal: "Now, Here, Openly, Together" (NHOT)

There exist some prejudices concerning the communication of a bad prognosis to cancer patients, though in practice, an open, realistic and sincere form of communication, while causing drastic changes in the patient's perspective of quality of life and feelings of hope, seems necessary for effective management of the total evolutionary process of cancer [23].

The patient should be properly and fully informed of diagnosis, prognosis and treatment options, enabling him or her to express feelings and preferences [24].

In a dynamic communication model, it seems then clear that *realistic communication* is at the starting point of the illness course, where each treatment option can be openly discussed so as to constantly maintain the best possible quality of life for the patient.

This process requires a continuous modulation of the *consonance between the time needed by the doctor and that needed by the patient* and *between the time perceived by the patient and that perceived by the doctor and the patient's family.*

In this way, the decision is arrived upon for Palliative Care, where the doctor(s) caring for the patient and family acts as a "personal trainer" through an ethical and authentic approach.

It is therefore essential for doctors to be properly trained and have good communication skills to be able to effectively resolve possible conflict between the "therapeutic-nursing pressure" of health professionals and the patient's slowdown in his/her life planning [13].

Attention given to being aware of the "difference between the times" should avoid generating those "tensions" between doctor and patient that could slow down or make harder the relationship, causing frustrations on both sides.

The recourse to "minimal advice about time" can reposition the focus of the relationship onto a more human level, both in a more strictly communicative sense as well as a clinical-diagnostic one, leading the doctor to a better assessment of the patient's clinical objectivity and reducing the use of overly pragmatic methods.

We therefore suggest a short and simple to use method that, through the synthesis between becoming conscious of "different" times (minimal advice about time) and the need for realistic and effective communication, can prepare the ground for a beneficial doctor-patient relationship, having as its main purpose the best possible quality of life for the patient.

By the acronym **NHOT** we identified those steps useful in the building of communication that can positively affect the doctor-patient "couple", specifying not only feasible objectives but also a way to make effective the synthesis between the different moments, which are so often faced in too brief a time.

Now and Here: the use of "emotional angles", otherwise described as "empathic opportunities", in a doctor/cancer patient meeting seems to be of crucial importance - as has been underlined by several authors.

These communication moments, when the patient more or less clearly communicates his/her wish, or need, to talk about something other than the clinical-therapeutic decisions should be faced in that moment and in that room ("now and here").

Importance to consider in the opening of emotional angles:

- The possibility to help the patient to express emotions, expectations and fears within the therapeutic alliance
- The possibility to confront these feelings in the moment allows the patient to later decide on his/her treatment and quality of life in a more conscious way.

Openly: the discussion "now and here" should not leave issues unexplored or let pass misunderstandings which could compromise the opening of communication both in that instant as well as in the future. Clearly, communication should then be "open and candid" from the very beginning of the illness and in regard to the patient's questions.

Together: as stated previously, illness in the doctor/cancer patient relationship can be considered as a "couple issue" (without forgetting the starting point of physiologic asymmetry) and as such, it is a professional relationship involving relational, emotional and psycho-existential variables.

The relationship is at the core of this approach, therefore the doctor, while forming the therapeutic alliance and deciding upon the treatment schedule and objectives, will reinforce the patient's sense of being involved in a shared decision-making process, where the know-how and authenticity of the care provider represents *de facto* the partner in a couple. A couple in which the patient is one of the two protagonists and is vulnerable and needs to be protected.

In our opinion, this "strategic" approach could not only represent a valid means to make difficult conversations with patients easier, but could also become a real program for patient *empowerment* which, starting from feelings of woe and vulnerability with the diagnosis of cancer, becomes more and more *competent* over the course of the illness and treatment, using cognitive, emotional and relational resources to help the patient achieve the best possible quality of life (Table 1 and 2).

Table 1: Division of time-illness in two essential stages, having different subjects as help for dynamic communication [25]

Stage	Subject
I : Beginning of the illness history	**Diagnosis and active treatment**
	Fewor no symptoms
	The doctor has much to explain; the patient has much to decide
	Doctor and patient have many issues to discuss together
II : Last phase of the illness history	**Advanced cancer**
	Many symptoms
	"Nothing left to do"
	Great need for treatments
	Final decisions to make, both for the doctor and patient

Table 2: Requirements of the "patient and time-centered"proposed model of communication

Moroni, De Panfilis, Biasco (2012)	**Patient**	**Doctor**	**Focus**	**Requirements**
Patient		1. Necessity "meeting" of different times 2. Ability to communicate needs (**NOW AND HERE**)	1. Time: a dimension not only chronological but also existential and phenomenological 2. Patient: an ill person who must "accept and plan"(**OPENLY**)	1. The listening to and trusting of the healthcare professional 2. The ability to take advantage of "empathic opportunities" (**TOGETHER**)
Doctor	1. Analysis of priorities ("therapeutic pressure" vs "patient's adaptation") creates a common agenda **(NOW AND HERE)**		Patient-centered approach: 1. Encourage moments of openess and communication 2. Harmonize the different times (**OPENLY**)	1. Realistic and candid communication: communicative techniques and a sincere rapport 2.Transcultural competence 3. Minimal advice about time **(TOGETHER)**

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