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Motivational Interviewing in Palliative Care?

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We have recently published data from a prospective clinical intervention study comprising 195 patients in end of life care at the Iceland University Hospital, using evocation intervention methods to facilitate death talk with a hospital Chaplain specialized in terminal care [1].

The intervention significantly increased open discussions regarding own impending death, especially in men. The intervention protocol was inspired by Motivational Interviewing [2] but the method was adapted for palliative end of life care. The main aim was to facilitate open discussions regarding the patients impending death to enable open communication between the health care personnel and the patients significant others.

Early practices in Western countries frequently withheld information from terminal patients, but there has been a shift in Western medical ethics towards conditional disclosure [3,4]. Conditional disclosure may be described as a trade-off dilemma between the patients's right to be informed versus the right to hold on to hope, or not to know. Modern day health service providers struggle to balance these scales.

It is currently widely recommended that discussions about end-of-life care begin early in the terminal care process [5-8]. Health care professionals, faced with terminal patients are managing as best they can to live up to these and other recommendations, drawing on clinical and personal experience.

Another growing ethical concern is the trade-off dilemma between the patients immediate psychological distress versus their significant others long-term well-being. Research on patients significant others shows that the long-term benefits of receiving information and insight regarding a loved one's impending death may significantly decreases psychological trauma during bereavement [9,10]. At the same time, generally accepted interpretations of laws protecting patients´ integrity frustrate the health care personnel's role in delivering prognostic information. This is indeed a growing concern in palliative care.

Communication between health care professionals and the dying patient may be a prerequisite for open communication with those patients' significant others since we may have to "go through the patient" to provide significant others with pragmatic information regarding prognosis. This requires a well-established communication to be in place. A well-established communication is based on trust and respect for personal boundaries.

One way to address this problem is to integrate a systematic non-confrontative evidence based communication method into clinical practice. For this purpose, we have tempted

to adapt Motivational Interviewing in end of life care [1]. Motivational Interviewing is a non-confrontative communication method, which opens up ways to give patients an opportunity to enter into death talk with health care professionals without overstepping the patient's personal boundaries. When appropriately applied, the method may create a secure environment to resolve emotional and cognitive discrepancies. One such discrepancy would be the conflict between the patients believe that abstaining from a discussion with significant others regarding impending death may protect the loved one from harm versus the scientifically documented risk for prolonged grief and log-term poor psychological well-being in surviving loved ones in absence of sufficient awareness time.

Motivational Interviewing was originally developed in substance use treatment but has been adapted to other areas, now including end of life care [1]. Motivational Interviewing draws heavily from other methods and by no means have they reinvented the wheel. However, there are several aspects of the Motivational Interviewing method that are novel and the method is relatively well defined and structured. Also, the pioneers in Motivational Interviewing have emphasized that the method should be subject to scientific scrutiny and operationalized as much as possible. Thus relatively objective methods to assess fidelity of the training and counsellor competency in applying the method are in place [11]. This makes the method extra interesting for the scientific community in our view and helps to ensure the quality of the clinical intervention.

References

1. Skulason B, Hauksdottir A, Ahcic K, Helgason AR. Death talk: Gender differences in talking about one´s own impending death. BMC Palliative Care. 2014 Mar 11;13(1):8. doi: 10.1186/1472-684X-13-8.
2. Miller WR, Rollnick S. Motivational Interviewing Helping People Change. Third edition. Guilford Press. New York 2012.
3. Gorer G. Death, grief and mourning in contemporary Britain. London, Cresset Press. 1965.
4. Field D & Copp G. Communication and awareness about dying in the 1990´s. Palliative Medicine 1999; 13: 459-468.
5. National Consensus Project for Quality Palliative Care. Clinical practice guidelines for quality palliative care: http://www.nationalconsensusproject.org/Guidelines_Download2.aspx.
6. Smith TJ, Temin S, Alesi ER, et al. American Society of Clinical Oncology provisional clinical opinion: The integration of palliative care into standard oncology care. J Clin Oncol 2012; 30*:* 880–887.
7. Mack, J W, Cronin A, Keating NL, Taback N, Huskamp HA, Malin JL, Earle CC and Weeks JC. Associations Between End-of-Life Discussions Characteristics and Care Received Near Death: A Prospective Cohort Study. J of Clin Onc December 10, 2012 vol. 30 no. 35: 4387-4395.
8. Quill TE. Perspectives on care at the close of life: Initiating end-of-life discussions with seriously ill patients—Addressing the "elephant in the room." JAMA 2000; 284*:* 2502–2507.
9. Valdimarsdottir U, Helgason AR, Fürst CJ et al. Awareness of husband's impending death from cancer and long-term anxiety in widowhood: a nationwide follow-up. Palliat Med 2004; 18: 432-443.
10. Hauksdottir A, Steineck G, Fürst CJ et al. Long-term Harm of Low Preparedness for a Wife's Death to Cancer – A Population-based Study of Widowers 4-5 Years After the Loss. Am J of Epidem 2010; 172: 389-396.
11. Forsberg L, Forsberg LG, Lindquist H et al. Clinician acquisition and retention of Motivational Interviewing skills: a two-and-a-half-year exploratory study. Substance Abuse Treatment, Prevention and Policy 2010; 5:8.