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How a Model of Communication Can Assist Nurses to Foster Hope When Communicating with Patients Living with a Terminal Prognosis

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Abstract: Nurses play a central role in joint decision-making and person-centred care, whereby care is focused on the needs of an individual patient. A key part of person-centred care is the way nurses engage with patients because good communication can impact on a person's spiritual wellbeing, particularly in relation to their ability to have hope. The way nurses communicate can be even more pertinent for people living with a terminal prognosis as the issues discussed can in themselves significantly influence a person's spiritual wellbeing. This paper combines contemporary research on how health professionals can foster hope in patients living with a terminal prognosis with The Awareness Context Theory described by Glaser and Strauss in 1965. A model of communication is then used to demonstrate how the research on hope and The Awareness Context Theory can be applied to practice.

Keywords: spirituality; health; healthcare

1. Introduction

Nurses have an ethical and legal obligation to engage in person-centred care, whereby a partnership model is adopted and care is focused on the needs of the individual person (Nursing Midwifery Council [NMC] 2015). A key component of person-centred care is joint decision making, whereby patients who have capacity are fully informed of their condition along with the options available and the decision they make is respected (Coulter and Collins 2011; HM Government 2005). Handled effectively this leads to positive outcomes such as increased autonomy, however if too much information is given at the wrong time or in the wrong way hopelessness may result, reducing a person's spiritual wellbeing and quality of life (Clayton et al. 2008). The impact of communication between a patient and a nurse may be even more significant for those living with a terminal prognosis as during illness a person may have to deal with significant news, make important decisions and redefine what their own spirituality means (Baldacchino 2006). This paper will propose that by promoting hope through the use of a model of communication, nurses can care for the spiritual needs of a person living with a terminal prognosis and therefore improve their quality of life.

2. Spirituality and Information Giving

Spirituality is a broad term encompassing a person finding meaning and purpose and believing in themselves, others or a figure of religion (Weathers et al. 2015; Lepherd 2015). A healthy spiritual wellbeing has been associated with better mental and physical health outcomes, demonstrating the need for competent delivery of spiritual care by health professionals (Wilson et al. 2017). Despite this, some nurses still feel unsure of how to recognise and respond to the spiritual needs of those in their care, which may be more apparent when communicating with patients living with a terminal prognosis than in other settings (Royal College of Nursing 2010; Holloway et al. 2011). Nurses may

be concerned of the impact that giving information has on a patient and this cautious approach may result in ineffective communication, for example too little or too much information being given in the wrong way (Reinke et al. 2010). This can influence a person's ability to have hope, which may lead to a reduction in their spiritual wellbeing (Buckley and Herth 2004).

2.1. Hope

Hope is defined as an inner strength that helps a person look beyond their current situation (Buckley and Herth 2004). Hope can mean different things to different people and can be relative to a person's situation, for example in a biomedical model it is strongly associated with 'cure' and 'treatment', whereas in end of life care hope can be present even when a person is approaching death (Broadhurst and Harrington 2016). Different people may adopt different coping strategies in order to preserve hope, for example hope for a good day or hope to achieve a goal such as attending a specific event (Buckley and Herth 2004; Reinke et al. 2010; Schofield et al. 2015). Hope has significance as it is a form of strength for a person and supports them in living the remainder of their life to the full and can protect against depression (Broadhurst and Harrington 2016). Both the significance and individuality of hope highlight the need for a professional to have an awareness of spirituality when communicating with people who are living with a terminal prognosis (Clayton et al. 2008).

2.2. The Awareness Context Theory

In relation to receiving significant news, hope may be defined as the ability to accept difficult information without being controlled by despair or relying on denial of the reality of the situation (Clayton et al. 2008; Borneman et al. 2014). This indicates that there may be a relationship between hope and the way information is communicated, highlighting the benefit of professionals understanding a patient's level of knowledge and understanding (Clayton et al. 2008). The awareness context theory created by Glaser and Strauss (1965) and subsequently adapted to the current healthcare system by modern authors provides a framework to explore this relationship (Borneman et al. 2014). Glaser and Strauss (1965) describe how there are four contexts of patient awareness of a terminal prognosis. If a patient is unaware of their prognosis but their family and the health professionals involved in their care are aware this is classed as closed awareness. If the patient suspects their prognosis but has not had it confirmed this is suspicion awareness. If all those involved with a patient are aware but do not discuss it openly this is classed as mutual pretence awareness. When the patient, their family and the health professionals involved with a patient are all aware and discuss the situation openly this is termed open awareness.

Taking into consideration the emotional impact of receiving information, the open awareness context was subsequently separated into three separate categories; suspended, uncertain and active (Timmermans 1994). A patient in suspended open awareness, does not accept the diagnosis, either through disbelief or by choosing to ignore it. Uncertain open awareness describes a situation where a patient focuses on the hope of a positive outcome and may dismiss the negative aspects of the information given. In active open awareness full acceptance occurs and the patient and their family can prepare for the prospect of death.

Small and Gott (2012) built on this theory by exploring how a patient may transition between the stages of awareness. At times a patient may be in active open awareness and feel hopeful for the future and able to create goals for the time they have left. At other times active open awareness may involve acceptance of their prognosis but feelings of hopelessness. A patient may then transition into suspended open awareness where they cannot accept the prognosis but are focusing on the hope for a cure. Furthermore opposing emotions can co-exist when a patient is living with a terminal prognosis as they may feel they are living and dying, indicating that denial and acceptance can both be present (Borneman et al. 2014). Despite the patient's awareness context, hope may be used as a coping strategy, whether this is hope for symptom control, hope for a peaceful death or hope for a cure (Broadhurst and Harrington 2016). Therefore by being aware of the impact that awareness has on a person's level

of hope, professionals can ensure patients receive appropriate support as they engage in difficult conversations and transition between contexts (Borneman et al. 2014).

3. The Use of the SAGE and THYME Model

Although a terminal prognosis is often given within an interdisciplinary team, during the time following the discussion nurses often support the person who has received the significant news and their family and this may involve continuing the conversation or providing comfort as they process the information (Reinke et al. 2010). During this time a person may transition through different stages of processing and also be seeking information in order to manage their uncertainty and determine which behaviours they adopt (McCaughan and McKenna 2007). One way to promote hope in a person during this interaction is through the use of a communication model that focuses on empowering patients and giving them some control over the way professionals communicate, such as 'SAGE and THYME' (Connolly et al. 2010; Griffiths et al. 2015). SAGE is an acronym for Setting (creating an appropriate physical environment), Ask (enquiring about the person's concerns), Gather (allowing the person to disclose all concerns rather than providing advice immediately) and Empathy (displaying signs of empathy). THYME is an acronym for Talk (enquiring if the person has any friends/families who they could talk to), Help (asking about who has helped the person before), You (asking what the person thinks would help), Me (asking if the care provider can do anything to help) and End (draw the conversation to a close).

One advantage of using the SAGE and THYME model when communicating with people living with a terminal prognosis is that it may overcome the barrier of professionals feeling unconfident within the area of spiritual care (Candy et al. 2012). It may take great courage for a professional to enquire about a person's spirituality as they may think they do not know how they are expected to respond (Holloway et al. 2011). By having a model such as SAGE and THYME to provide a structure, professionals may feel more confident in exploring this aspect of patient care, which may subsequently help foster feelings of hope for the patient (Broadhurst and Harrington 2016).

The SAGE and THYME model begins with the nurse creating an appropriate physical environment, demonstrating that they have time for the person and they acknowledge their distress (Connolly et al. 2010). The next two steps, 'Ask' and ' Gather', then provide an opportunity for a nurse to enquire about a person's concerns and a question such as 'Can I ask what is concerning you?' may be useful (Connolly et al. 2010). This indicates to the person that their involvement in the discussion is voluntary and this may foster hope by encouraging the person to take the lead on the direction of the discussion (Parry et al. 2014). By allowing a person to express their concerns, nurses may be able to identify which awareness context a person is in and avoid wrong assumptions being made or unwanted advice being forced (Clayton et al. 2008).

The nurse should be aware that a person may give indirect clues as to which awareness context they are in, for example the use of euphemisms has linked to an avoidance of information and this may require a different form of support (Clayton et al. 2008). This will be explored later in this paper. In addition, as the manifestation of hope varies between people, the 'Ask' and 'Gather' stages may identify what is important to a person, for example any cultural or religious beliefs that may influence their spiritual wellbeing (Broadhurst and Harrington 2016).

The final step in SAGE is 'Empathy' and this can be demonstrated in various ways including eye contact, active listening and audibly reflecting on what a person has said (Parry et al. 2014). Multiple studies have found nurses who are attentive, compassionate, non-judgemental and caring foster feelings of hope by demonstrating to the person that they are respected and supported (Broadhurst and Harrington 2016; Borneman et al. 2014). Furthermore, patients who value honesty also identified that they appreciate a lack of 'bluntness' and being treated as a 'whole' and this may highlight the value of empathy when delivering significant news (Clayton et al. 2008).

The first two steps of THYME involve asking a person who they can talk to and what has been helpful in the past (Connolly et al. 2010). Support from family and friends, including giving and

receiving love, can lead to feelings of being valued and optimism, which may provide a form of hope (Broadhurst and Harrington 2016). However some people may find that their social support reduces their level of hope as the pressure to remain positive may decrease their ability to accept their prognosis and transform their goals (Sachs et al. 2013). Therefore this provides an opportunity for a person to explore who they feel they can be honest with and how they can manage any pressure they feel to be constantly optimistic (Connolly et al. 2010).

This conversation may naturally progress into the 'You' step of THYME, which explores what a person feels they can do to help themselves (Connolly et al. 2010). An element of this may be encouraging a person to create realistic goals leading to feelings of empowerment, providing a way for open awareness to promote hope rather than reduce it (Clayton et al. 2008; Batho 2015). This form of empowerment can be seen as more than 'regaining control' as it is a transformation that reconciles holding on to previous identities, while letting go of previous areas of control (Aujoulat et al. 2008). By focusing on what people can achieve in the context of their current level of ability and highlighting an aim for them to work towards, a form of strength may be developed and this is in line with the definition of hope previously described (Buckley and Herth 2004).

A further way to support the creation of realistic goals is for a nurse to ask a person if there is anything they can do to help, as promoted through the 'Me' stage of THYME (Connolly et al. 2010). A key part of this may be in relation to the support available and symptom management as unmanaged pain and isolation have been associated with despair and hopelessness (Reinke et al. 2010; Sachs et al. 2013). Some people may transition their goal into enjoying the time they have left or having a 'peaceful death' and by helping to manage a person's symptoms, a nurse can foster hope by helping to facilitate these aims (Broadhurst and Harrington 2016).

The 'Me' stage may also provide the opportunity for a nurse to manage the delivery of information, clarify any queries and address any indirect ques, such as the use of euphemisms, that may have been disclosed during 'Ask' and 'Gather' (Connolly et al. 2010). A nurse could link back to a statement a person previously said or note what they haven't stated and ask if they would like the nurse to explain or clarify any issues (Parry et al. 2014). This may prevent forcing unwanted information, such as statistics, without supporting false hope, as both denial and unwanted clarification may lead to a person loosing hope (Clayton et al. 2008). This offer of clarification may also build a trusting relationship and encourage a person to feel that they are working in partnership with a nurse (Clayton et al. 2008). If achieved successfully, a person living with a terminal prognosis may be able to hold onto their hope despite being in the open awareness context and therefore be able to make fully informed decisions without risking their spiritual wellbeing (Borneman et al. 2014).

4. Conclusions

Hope can be a powerful and vital coping mechanism for a person who is nearing the end of their life. When engaging in person-centred care and promoting autonomy, health professionals must recognise the need to care for this aspect of spiritual wellbeing. By using a partnership model of communication that does not force information but allows patients to explain their own level of understanding, express concerns and explore solutions, health professionals can help foster hope and promote a good quality of life.

This paper has focused largely on the use of communication tools to promote feelings of hope within a patient, however these tools could also be applied to help handle the wider needs of a patient's family, though this requires further exploration. The information discussed in this paper has also been concentrated in the context of end of life care, whereas these tools may be of equal importance in other situations requiring sensitivity in the delivery of information, such as giving the news of a cancer diagnosis.

In order to ensure that patients receive optimum spiritual care, further research is needed to explore how person-centred care and a person's awareness of their prognosis impacts on spirituality,

especially in relation to hope. There is also the need to explore whether using a communication model such as SAGE and THYME is a successful way to transition these ideas into practice.

Conflicts of Interest: The authors declare no conflict of interest.

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