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Designing a truth-based communication model in patient ethical care process

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Abstract:

INTRODUCTION: Providing information based on truth is very important in patients' treatment-related decisions and reduces emotional and physical sufferings as well as patient costs. The aim of this study was to design a model that is based on the culture and health-care context of Iran in order to establish a truth-based communication and provide accurate information to patient.

MATERIALS AND METHODS: This qualitative study was conducted in 2019. Data were collected through semi-structured interviews with 18 nurses who had been selected by purposeful sampling method. Data analysis was performed in two steps. In the first step, the participants' experiences were determined using the grounded theory approach. In the next step, using Walker and Evant's (2011) method, the concepts and statements were combined and presented in a central concept.

RESULTS: The central concept in this study was "an attempt to establish a truth-based communication with patient," and then, a truth-based communication model was presented. The components of the model were presented in three parts: improving patient communication skills, managing the situation in which the truth is presented, and the patient's participation in decision-making.

CONCLUSION: To present the truth of the treatment, which can sometimes be unpleasant and bitter, it is very important to improve communication skills and choose an effective communication strategy. To establish a truth-based communication, it is necessary to create a suitable ground for communication, which should be provided in clinical setting and community.

Keywords:

Care, ethics, grounded theory, model, truth-telling

Introduction

One of the most important principles in providing ethical care is to provide patients with the facts about their treatment. Attitudes and methods used to tell the truth and how and when to provide information to patient and his/her family have changed significantly over time.^[1] However, physicians are usually the first to communicate the information to patients and their families.^[2-5] However, presenting the facts about treatment requires the cooperation of all members of the treatment

team, including nurses.^[6] It is inevitable that nurses will have to provide information or disclose the truth to patients.^[7] In Valizadeh *et al.*'s study in Iran (2014), nurses stated that they preferred not to disclose the truth to patients.^[8] In another study, nurses believed that disclosing the truth causes stress and negative emotions in patients.^[9] In a study by Rejnö *et al.*, nurses manipulated the truth or concealed information from patients.^[10] Atrak's study found that telling the truth to patients increases their anxiety, frustration, sadness, depression, and fear and sometimes can lead to suicide.^[11]

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In contrast, other studies have shown that patients like to know the truth about their diagnosis and treatment, even if it is not good news.^[12] Providing accurate information while making decision about patients' treatment is important and leads to reduced emotional and physical sufferings as well as patient costs.^[13] Providing information based on truth, even unpleasant facts, neither diminishes hope nor creates lasting psychological problems.^[14] The patient's distress caused by the disclosure of information is not related to the content of information, and in fact, it is related to the way the information is presented and poor communication skills.^[15,16] With respect to moral attitudes and acknowledging the patients' right to know what is relevant to their conditions, the treatment team members have agreed that by improving their communication skills, they should bring the truth to the point where it causes the least harm to patient.^[17]

Many of the patients' emotional reactions when hearing the truth are closely related to their environment, culture, and religious beliefs, which must be carefully considered.^[18] According to a research by Culley *et al.*, there are currently no official guidelines for presenting truth to patients.^[19] Mahasti-Jouybari *et al.* also showed that nurses use indirect methods to present information to patients and their families and do not have specific guidelines in this regard, and also each nurse behaves according to his/her particular style based on the culture context.^[20] Therefore, the process of presenting the truth of treatment to patients is multidimensional and influenced by cultural and social factors. To achieve the goal of effective communication based on culture and religious beliefs, having a model can act as a guide. Therefore, the present study was conducted with the aim of designing a guide model in presenting the truth in Iran.

Materials and Methods

The present study was conducted in 2019 with a qualitative method and a grounded theory approach. This research has been carried out in two stages: constructing a descriptive theory and synthesizing a prescriptive model.

At the first stage, 18 nurses working in teaching hospitals affiliated to Tehran University of Medical Sciences participated in the study using purposeful sampling. The criteria for entering the study were as follows: having at least 1 year of patient care experience and willing to share experiences. The criteria for leaving the study included providing nursing service in managerial and administrative positions and not having direct communication with patients and patient care. Data collection was done with inductive approach through

semi-structured interviews, observational notes, field notes, and memo writing, so that observational notes were taken during official observations, field notes were taken during interviews, and memos were taken during data analysis. In some cases, after implementing the interviews and reviewing manuscripts in cases where further clarification was needed, second interviews were conducted. Consequently, 32 interviews were conducted with 18 participants. The interview began with a general question: "Based on your experiences during patient care, in what situations did you fail to or did not want to present the truth to the patient?" Based on the responses of the participants, the next questions of the interview were asked according to the interview guide. The interviews lasted between 30 and 45 min each. The main criteria for the number of interviews were the use of key informant, the quality of data, emerging category and theory, and reaching data saturation.^[21]

At the end of each interview, it was typed verbatim. The analysis began after the first interview was completed. Data analysis was performed using Corbin and Strauss method at open coding levels to identify and develop concepts, data analysis for context, and entry of process in analysis and integration of categories. After reading the text of each interview and obtaining a general sense of understanding, a suitable code was given to the desired phrase or paragraph. Continuous comparative analysis was done through question design, word analysis, interclass and intraclass comparison (flip-flop), sudden flip technique (researcher's sudden sense of data accuracy), and raising the red flag. This method prevented bias in data analysis and increased theoretical sensitivity of the study.^[22] Management of the coded data was done by MAXQDA software 2010 version ((Sony- ICD-UX560F), Tokyo, Japan). Thus, the primary categories and finally the main categories were emerged, and a descriptive theory was formed.

At the second stage, after the formation of descriptive theory, the three-step method of Walker and Evant's (2011) theory synthesis was used.^[23] At the first step of model design, by defining key concepts for constructing and processing the basics of the theory, a concept or set of related concepts for model development was identified and determined. The title, "truth-based communication" derived from descriptive theory, was chosen as the central concept. Then, in addition to the central concept, other related concepts were defined as conceptual framework, so the four meta-paradynamic concepts of the model including human, nursing, environment, and health were selected as the conceptual framework. At the second step, a review of the texts was performed to determine the factors related to the main concepts and the meta-paradynamic concepts

of the model. The purpose of text review is to obtain information and data to complement model elements or prescriptive theory. All available Persian and English texts from 1990 to 2019 on the central concept of the truth-based communication model were reviewed accurately and purposefully to determine the relationships between them and the factors affecting them. In addition, the results of grounded theory were used as one of the cited texts at this stage. At the third step, concepts and statements were organized within a related central concept, and the phenomenon under study was formed using the above findings.

To ensure the accuracy and validity of the data, the criteria of credibility, dependability, confirmability, and transferability introduced by Lincoln and Guba were used in this qualitative study.^[24] This study was carried out with the permission of the Ethics Committee of Tehran University of Medical Sciences with the code: IR.TUMS.VCR.REC.1397.568. All participants signed an informed consent form after learning the objectives of the study. Keeping information confidential and anonymous and giving participants the right to withdraw from the study at any time were among the ethical principles considered in this study.

Results

Eighteen nurses (11 women and 7 men) participated in this study. Nurses were selected from all wards and shifts to participate in the study. The mean age of nurses was 39.38 ± 2.1 years and their mean work experience was 14.66 ± 3.8 years.

In data analysis, in the first phase of the study and the grounded theory section, three main categories, including a defective communication cycle, an attempt to establish and repair truth-based communication bridges,

and patient is part of the treatment family, as well as 11 subcategories were emerged [Table 1].

According to the findings, underlying factors related to concealment of truth were placed in the category of defective communication cycle. In this category, organizational structures such as lack of guidance, lack of support from officials, and lack of sufficient and experienced staff were among organizational factors that affected truth rendering. In addition, individual contributions related to nursing, such as experience, self-confidence, cultural competence, and ethical reasoning, were among factors that negatively affected communication in providing the truth to patient. The patient’s clinical conditions, such as a lack of understanding in pediatric patients or cognitive impairment, were among factors that were cited by the nurses. Furthermore, family resistance toward truth rendering was one of the communication barriers that nurses emphasized on. In some cases, nature of the news and misinformation was the reason for concealment of the truth.

Nurses’ strategies were to try to build and repair communication bridges in response to background problems and to try to improve individual and professional capabilities as well as communication skills. This effort has been aimed at providing information based on ethical and organizational standards.

As a result of this effort, the most obvious concept revealed in the data was to consider patient as a member of the treatment family and the need for patient participation in treatment decision-making. Being aware of all facts in relation to treatment is a necessity for making an informed decision. In this regard, the nurses referred to three outcomes as efforts to continually grow cognitively for patient participation, including a dualist view (having doubt in presenting the truth to patient) and regression (the nurse’s resistance in presenting the truth to patient). According to the analysis of relationship between categories, the central category of “attempting to establish a truth-based communication with the patient” was chosen as the central category. This descriptive theory helps to understand the actions and interactions in the realm of real communication with the patient and shows that the participants were trying to establish a truth-based communication with the patients. However, this theory cannot answer the practical question of how nurses can improve communication honesty by becoming professional in clinical communication. The answer to this question is possible by designing a prescriptive model.^[23]

Accordingly, in the second stage of the study, which is the synthesis of prescriptive model, the results of articles

Table 1: The main categories and subcategories of the central concept of attempting to build a truth-based communication with patient

	Categories	Subcategories
Attempting to build a truth-based communication with patient	A defective communication cycle	Organization structure Nature of the news Individual contributions Special conditions Family norms
	An attempt to establish and repair truth-based communication bridges	Situation management Improving professional empowerment Trying to gain the support of the organization
	Patient is part of the treatment family	Continuous development of cognitive skills Dualist view Regression

and concept reviews in the grounded theory section were explained in a central concept. In the research phase, 6413 articles were found and after being reviewed by two researchers familiar with the systematic review as well as PRISMA, 43 articles related to the central concept of the study were retained. Then, by placing the results of text reviews and categories obtained in the grounded theory section, the concepts and axes of the truth-based communication model were defined.

In this model, human, as a biological, psychological, social, and spiritual being, has different physical and mental needs and behave differently in order to meet his/her needs in different situations. In this model, human beings are involved in establishing a truth-based communication with patient. The nurse in this model is an educated person with sufficient knowledge and scientific ability, who is a responsible and accountable person who uses professional knowledge, competence, and communication skills, and follows professional rules and standards to provide care, make decision, and take measures to improve patient's health. The environment in the present prescriptive model is a set of elements and factors that surround the person (receiver and presenter of truth). The environment must be healthy and motivating so that the nurse can perform her/his duties. Health in this model is equivalent to the consequence and result of the correct and effective communication between the patient and the nurse in challenging situations, and proper performance at the right time and place. Establishing a truth-based communication is also an interaction, in which attention is paid to three axes of managing the situation when presenting the truth, informing the patient to participate in decision-making, and improving patient communication skills [Figure 1].

In the axis of situation management, it is important to pay attention to the individual attitudes and skills of caregivers in providing information to patients and how

much of the facts should be presented to the patient at the right time and place. Managing individual and patient's emotions, having appropriate communication strategies, and predicting the consequences of disclosed information are also very important. Experience, adequate study, and self-management are important factors in increasing the self-confidence of nurses in managing the situation. In addition, according to the study's findings, gaining organizational support, improving professional and interprofessional cooperation in the organization, and getting help from the patient's family play a vital role in helping to balance the situation.

In the axes of informing patient to participate in decision-making, considering the principle of autonomy and avoiding a paternalistic approach, as well as following the principles of patient-centered care, were among issues that nurses mentioned in this regard. The treatment team should consider factors related to the patient, including acceptance of the new role, level of health literacy and awareness, self-confidence, need for the type of decision-making, the illness, age, gender, economic status, ethnicity, culture, and profession.

When it comes to improving patient communication skills, it is important for nurses to first recognize their personal values and, at the same time, respect the personal values and different cultures of patients. In fact, the performance of health-care professionals and service providers must be intertwined with the values and beliefs of patients, and the safety of patients must be ensured without regard to their cultural background. Lack of cultural awareness and competence causes nurses to care for patients without any regard to their culture and not consider the patient's religious and cultural beliefs.

Discussion

In the present study, the truth-based communication model was explained. According to the findings, if the situation is suitable for rendering the truth, presenting the truth to patient will be facilitated. The findings of grounded theory section showed that defective communication cycle is one of the reasons for why the situation of presenting the truth to patient is not suitable. The defective communication cycle is due to the ineffective communication between treatment team members, between the treatment team and patient's family, and finally, ineffective communication with the patient. The truth-based communication model recommends the participation of an interprofessional team, including health-care providers, patients, and their families. These findings are consistent with the perceptual model of professional and interprofessional decision-making presented by Légaré et al.^[25] This

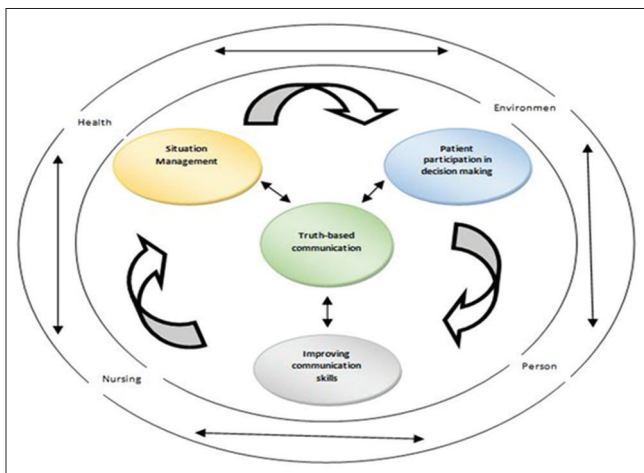


Figure 1: Components of the truth-based communication model

model emphasizes the need for situation management to provide facts and complies with the SPIKES,^[26] PEWTER,^[27] BREAKS,^[28] and ABCDE^[29] models. In all of these models, the situation is first evaluated, the patient's previous knowledge is examined, and then, information is rendered to patient in the appropriate place and time and in the presence of appropriate person.

In this proposed model, it is necessary to inform patients about the information related to their condition in order to take part in decision-making. This model is in line with the patient participation model in decision-making presented by Elwyn *et al.* In their model, if patients are informed about the choices and different options are expressed, we can be confident that right decisions will be made.^[30] The truth-based communication model is similar to Longtin *et al.*'s model. In both models, it is important to pay attention to patient-related factors, service-related factors, responsibility and power-sharing, the use of communication strategies that make decisions effectively, and the role of feedback.^[31]

In the truth-based communication model, the patient is a member of the treatment family. This approach is consistent with the Hollender and Szasz's model of bilateral partnership with the patient (1956). In this approach, the relationship between the patient and the treatment team is based on equal power, mutual independence, and equal satisfaction. In the truth-based communication model, as in the Ozar's interactive communication model (1984), the treatment team and the patient both have equal moral significance. In this model, the treatment team has a primary ethical commitment to meet the patient's needs.^[32]

This model, however, is in contrast with the Hollender and Szasz's active-passive communication model, which is essentially patriarchal and very similar to the parent-child communication. In this model, the patient is like a lonely person who wants specialized knowledge. Treatment is separate from the patient and his/her role and is done according to the patient's wishes. This model can only be justified in acute or emergency cases.^[33,34] In the truth-based model of communication, the patient is respected as a member of the treatment family, unlike the instrumental model, in which patient's values are irrelevant and the goal of treatment is to get beyond the patient and sometimes the patient is sacrificed for that purpose. In the instrumental model, the patient is assumed to have no autonomy. In this communication model, the patient does not have the right to choose and should only accept the treatment that has been chosen for him/her.^[35,36]

The truth-based communication model and most of the similar communication models that were compared with

this model depend on culture and history. Therefore, these communication models should be considered as dynamic models that are related to the culture and conditions of the society that produced them. Therefore, it can be concluded that they will not be easily globalized.

In the present study, only the perspectives and experiences of nurses were considered, so it is recommended that in further studies, the opinions and experiences of other members of the treatment team, the patients, and their families would be examined.

Conclusion

It is important to have communication skills and to choose an effective communication strategy to present the truth of the treatment to patient, which can sometimes be unpleasant and bitter. In this regard, it is necessary to teach communication skills to physicians and nurses, so that they can present the truth to patients in the most appropriate way. Considering the patient's preferences, empowering patients, and considering the patient's and family's beliefs and values are important issues that have been considered in the truth-based communication model. It is necessary to establish a truth-based communication with the patient in the context that should be provided in medical settings and society.

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Conflicts of interest

There are no conflicts of interest.

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