Journal of Rural and Community Development

Palliative Care Professionals' Perceptions of Effective Interpersonal Communication in the Context of Caring for Older Adults in Rural Settings

Authors: Kelly Penz, Wendy D. Duggleby, Donna M. Wilson, Allison Williams, Beverly D. Leipert, Denise Marshall, Donna Goodridge, Lori Cooper

Palliative Care Professionals' Perceptions of Effective Interpersonal Communication in the Context of Caring for Older Adults in Rural Settings

Kelly Penz
College of Nursing, University of Saskatchewan
Regina, Saskatchewan, Canada
kelly.penz@usask.ca

Wendy D Duggleby
Faculty of Nursing, University of Alberta
Edmonton, Alberta, Canada
wendy.duggleby@ualberta.ca

Donna M Wilson
Faculty of Nursing, University of Alberta
Edmonton, Alberta, Canada
donna.wilson@ualberta.ca

Allison Williams
School of Geography and Earth Sciences, McMaster University
Hamilton, Ontario, Canada
awill@univmail.cis.mcmaster.ca

Beverly D Leipert
Arthur Labatt Family School of Nursing, University of Western Ontario
London, Ontario, Canada
bleipert@uwo.ca

Denise Marshall
Faculty of Health Sciences, McMaster University
Hamilton, Ontario, Canada
marshald@mcmaster.ca

Donna Goodridge
College of Nursing, University of Saskatchewan
Saskatoon, Saskatchewan, Canada
donna.goodridge@usask.ca

Lori Cooper
College of Nursing, University of Saskatchewan
Saskatoon, Saskatchewan, Canada
ljc552@mail.usask.ca

Abstract

The purpose of this article was to report an in-depth appraisal of palliative care professionals' perceptions of effective interpersonal communication while providing palliative care for older adults in rural settings. A total of four focus group interviews were conducted involving 12 palliative care professionals who

were practicing in rural settings in a Western Canadian province. Data were transcribed verbatim and analyzed using thematic analysis. The findings of this study suggest the importance of: a) understanding the context of aging and dying in rural settings, b) focusing on essential information needs, and c) effective interpersonal communication within this context. The factors related to effective interpersonal communication between professionals and care recipients and their family members could be grouped into three themes: i) rural care 'for your own,' ii) independence and individuality, and iii) timing and early access/rural rapport. Although the challenges of providing integrated palliative care services in rural areas were apparent in this study, from an interpersonal perspective, the participants were connected to their patients/family members. They often viewed their older care recipients as part of their own lives. Having a rural sense of closeness and community connection seemed to have a positive impact on the professional participants. The participants also felt that their sense of closeness also provided a sense of peace for their care recipients.

Keywords: palliative care professionals, interpersonal communications, qualitative study

----

1.0 Introduction

Interpersonal communication is often identified as "the process of message transaction between people (usual two) who work toward creating and sustaining shared meaning" (West, 2006, p. 6). Effective interpersonal communication in health care is reflected in the health care professionals' ability to exchange information, respond to emotions, manage uncertainty, foster relationships, and assist in decision making while acting consistently in a therapeutic fashion (Street & Epstein, 2008). Effective interpersonal communication is influenced by the physiological, psychosocial, and environmental context for both health care professional(s) and the recipients of their care. In the context of palliative and end-of-life (EOL) care, effective interpersonal communication including the provision of needed and timely information have been identified as among the most prominent needs for dying persons and family members (Lowey, 2008). Within this context, interpersonal communication is viewed as the primary foundation from which relationships are established and nurtured, physical and psychosocial assessments are made, and care goals are developed and addressed (Dahlin & Giansiracusa, 2006). With regard to health related outcomes, effective communication has a significant influence on the perceptions of the quality of care that palliative persons and their family members receive (Luker, Austin, Caress, & Hallett, 2000). For example, therapeutic interpersonal communication influences mutual understanding, patient satisfaction, and rapport, as well as, contributes to reducing suffering, adequate pain control, and improved coping and emotional well-being (Street et al., 2008). Quality palliative and EOL care require that health care professionals attend to the sensitive nature of communicating with patients/family members in order to promote trust, alleviate fears, and initiate and then foster therapeutic relationships (von Gunten, Ferris, & Emanuel, 2000; Stajduhar, Thorne, McGuinness, & Kim-Sing, 2010). Although interpersonal communication between patients/family members and health care providers is necessary for positive outcomes, few studies have been reported in the context of older adults receiving palliative care in rural settings. Based on an analysis of a

subset of data from a large qualitative study on transitions in rural palliative care, the research question addressed is: What are palliative care professionals' perceptions of effective interpersonal communication in the context of providing palliative care to older adults living in rural settings?

1.1 Background Literature

Research related to palliative and EOL care delivery has consistently confirmed the importance of effective interpersonal communication between care providers and care recipients including terminally-ill patients and their family members (de Haes & Teunissen, 2005; Johnson et al., 2011; Parker et al., 2007; Stajduhar et al., 2010). A systematic review regarding EOL communication from the perspective of patients, informal caregivers, and formal caregivers outlined several key elements of communication within the palliative/EOL care context. Conclusions from this review are that patients and informal caregivers prefer health care professionals who are empathetic, encourage questions, use honesty in their approach, and clarify individual information needs and level of understanding (Parker et al., 2007). In addition, the findings of a qualitative study which explored helpful communication from the perspective of persons with advanced cancer is also critical to outline as it highlighted the importance of clinicians who treat their patients as people of value while also acknowledging their diverse life histories (Stajduhar et al., 2010). In essence, attention to the manner in which communication occurred was fundamental to the study participants' confidence in their own quality of care (Stajduhar et al., 2010). Although effective interpersonal communication is identified as an important factor in the provision of quality palliative care, barriers to creating a therapeutic environment for communication may exist. From the perspective of formal care providers, examples of these barriers include their potential discomfort with discussing issues of death, dying, and grief (Anselm et al., 2005; Vachon & Sherwood, 2007), lack of knowledge and moral distress surrounding disease progression and palliative care (Brazil, Kassalainen, Ploeg, & Marshall, 2011) and a failure to involve appropriate family members (Johnson et al., 2011). As a result, major concerns facing palliative patients and their family members include a lack of understanding of their conditions, communication breakdowns within families, and 'late' referrals to accessing appropriate levels of palliative and EOL care (Johnson et al., 2011).

There is an urgent need to develop a better understanding of the complexities of effective communication in the context of terminal illness such as advanced cancer, especially what makes communication helpful or unhelpful (Stajduhar et al., 2010). An important aspect of developing this understanding is consideration of the context of caring for older adult populations and the geographical settings in which they live. In a review of the literature regarding the role of communication in palliative cancer care, a concerning finding was the lack of attention in the literature to the growing population of elderly patients (de Haes & Teunissen, 2005). When caring for older adult populations, the ability to communicate and provide information effectively may have its own set of unique challenges for formal health care providers. Receptive communication may become more difficult (e.g., misinterpretation, lack of clarity) when normal age related changes in physiology and cognition have an impact on the sensory, perceptual, and processing abilities of older adults (Antai-Otong, 2006). Thus, understanding age-related barriers to communication is highly complex, as these barriers are often influenced by primary ageing (e.g., hearing loss, vision loss, cognitive decline) and secondary ageing characteristics (e.g., lifestyle,

exercise history, diet), and by historical and contextual life experiences (Sparks & Nussbaum, 2008). The abilities of older adults to express themselves and process information may be even more of a concern if complicated by the experience of chronic and progressive life-limiting illnesses. For example, older adults who are diagnosed with cancer are often confronting a health care system that demands a high level of health literacy. In order to better understand the experience of aging patients and achieve better health outcomes, a key approach is for health care professionals to develop an awareness of the complexities of particular age-related interpersonal communication, with an emphasis on multi-cultural health environments (Sparks et al., 2008).

A demographic characteristic increasingly associated with culture and cultural identity is living in a rural or remote geographical setting. Numerous studies have identified that there is a concerning lack of access to tertiary and secondary palliative care services within rural and remote areas (Burge, Lawson, & Johnston, 2005; Evans, Stone, & Elwyn, 2003; Goodridge, Lawson, Rennie, & Marchiniuk, 2011; Robinson, Pesut, & Bottorff, 2010; Robinson et al., 2009; Wilson et al., 2006). Within the context of rural palliative care delivery, the provision of essential information and timely communication are two key factors that were identified as helping individuals adapt to disruptive changes or transitions (e.g., environmental, roles and relationships, health status, activities of daily living) when dealing with a terminal illness diagnosis (Duggleby et al., 2010). Research related to interpersonal patient/family-professional communication within the context of rural palliative care delivery tends to focus on the challenges of geographically isolated settings. Within these settings, the ability to communicate in an effective manner is often complicated by a sense of isolation of care recipients and professionals (Kenny, Endacott, Botti, & Watts, 2007; McConigley, Kristjanson, & Morgan, 2000), a lack of accessibility to palliative specific resources, and the presence of dual relationships in rural communities (Duggleby et al., 2010; Haxton & Boelk, 2010; Robinson et al., 2010). A lack of rural role preparation for many formal care providers (Kelley, Sellick, & Linkewich, 2003), and the impact of vast geographical distances and resulting time constraints (Rosenberg & Canning, 2004) are additional barriers that may also complicate the development of effective therapeutic relationships. The presence of such barriers not only cause feelings of distress on the part of older rural palliative patients and their family members, but also result in a perceived lack of important information regarding their care (Duggleby et al., 2011).

Although barriers to communication are important considerations in understanding the reality of the limited palliative care resources in many rural areas, knowledge of these barriers does not provide information on the attributes of interpersonal communication in rural settings that are related to improving the quality of care for rural people. In a review of the literature surrounding nurses and palliation in community settings, Rose and Glass (2006) suggested that the healing potential of effective communication has the ability to transcend language and culture, and cross a multitude of barriers associated with limited access to formal palliative care services. Due to the contextual differences between rural and urban areas, there is a need to understand the unique context of effective interpersonal communication with older adults in rural palliative care. Developing an understanding of these unique elements from the perspective of palliative care professionals working within a rural context, has the potential to decrease perceived barriers and guide the development of rural palliative care programs and services.

2.0 Method

2.1 Design

The data for the present analysis were part of a constructivist grounded theory study exploring the transitions experienced by older rural palliative patients and their family members while receiving palliative and EOL care which is reported elsewhere (Duggleby et al., 2010). It was during this transitions study, that it became evident that effective interpersonal communication is critical for older rural adults with palliative and EOL care needs. The original transitions study included in-depth interviews with older adult palliative care patients and informal caregivers living in rural settings, and focus group interviews with rural palliative health care professionals. The focus group data provided the data subset used for the present analysis. A thematic analysis (Patton, 2002) using constant comparative methods was subsequently conducted on the focus group data to explore the participants' perspectives on effective interpersonal communication within the context of rural palliative care for older adults. Thematic analysis is the categorical reduction of qualitative data while developing core consistencies and meanings from the data (Patton, 2002). The study as a whole and including this additional analysis were approved by a university behavioural ethics review board before initiation.

Sample

The sample for the present analysis consisted of rural palliative care professionals who were enrolled in the study using purposeful sampling with the following inclusion criteria: a) 18 years of age and older, b) English speaking, c) providing direct care of older palliative patients and their families in rural settings and, d) may be palliative care coordinators, palliative care nurses or home care aides. Site collaborators from three separate health regions across Saskatchewan, Canada assisted in identifying potential study participants based on the above criteria and provided them with a letter of interest. Those who were interested in the study returned the letter of interest with their contact information, which was forwarded on to the researchers. The study was then explained to the interested participants via telephone, with a research package of study materials being sent to them by mail (e.g., consent forms, demographic form, sample focus group questions). Focus groups interviews were arranged once all participants returned the completed consent forms and demographic forms to the researchers. Participants were recruited for the focus groups (averaging 3-6 participants per group) until saturation was reached, or no new properties of the developing categories were emerging in the data.

2.2 Data Collection

Data collection for the study occurred in the fall of 2007. Four focus group interviews were conducted via telephone (i.e., conference call format) with a total of 12 rural palliative care professionals. Consistent with constructivist grounded theory methods used in the original study, an interview guide was used during the focus group interviews, and was adapted as the study progressed by adding areas to explore which helped define gaps in the emerging data (Charmaz, 2006). The nature of interview questions focused on the most significant transitions experienced by older rural palliative care patients and their families, how they deal with and what helped or hindered the transitions. Group size (3-6 on average) was determined by the availability of participants to call in during the designated

interview time. Telephone interviewing techniques were chosen based on the vast geographical distribution of participants, as well as, the preferences for reduced travel time as indicated by the participants. A particularly useful method of data collection in rural settings, this method provides the advantages of broad geographical coverage and the development of positive relationships (Musselwhite, Cuff, McGregor, & King, 2007), and increased time effectiveness (e.g., less travel time, common time of day accessibility) (Wilson, Roe, & Wright, 1998). The focus groups were audio-taped, with each group being interviewed twice in order to clarify and elaborate on the first focus group interviews. The duration of each focus group interview was approximately 50-70 minutes.

2.3 Data Analysis and Scientific Rigour

The audio-taped focus group interviews were transcribed verbatim immediately after each interview and were checked for accuracy, then coded and analysed using NUD*IST software. Follow-up interviews were conducted in order to elaborate and clarify the data from the initial interviews and establish credibility. The thematic analysis of the focus group data was conducted by using an inductive approach involving the discovery of patterns, categories, and themes within the data (Patton, 2002). As categories emerged in the data, the participants' words were used as much as possible to develop the themes and give meaning to the analysis. Constant comparative methods were used to compare data with data and category with category, and to ensure that a thorough analysis was conducted on all properties of the data.

Attention was also paid to the data quality in terms of trustworthiness and qualitative rigour. Credibility was established by confirming the findings with the follow-up focus group interviews. Auditability was achieved by providing an audit trail beginning with the raw data and interview notes, through to the documentation of the stages of data analysis and interpretation. Fittingness was attained by using the participants' words and language throughout the coding process. In accordance with LoBiondo-Wood and Haber (2002), confirmability is met when auditability, fittingness, and creditability have been established.

3.0 Findings

3.1 Sample

A total of 12 rural palliative care professionals participated in the study. The total sample included one palliative care assessor with a background in social work, and 11 Registered Nurses (RNs) working in various professional roles, including palliative care coordinators and home care RNs. All were female, with a mean age of 48.3 years. Their years of experience in palliative care practice was 11.3 years on average, and ranged from 1.3 to 20 years overall. Their contact with palliative patients averaged 19.7 hours per week, which also included a broad range, from 1 to 40 hours per week.

3.2 Findings and Main Themes

In describing the aspects of effective interpersonal communication, the palliative care professionals indicated specific areas of information or content they felt were the most important in helping older rural palliative care patients and their family members. Essential information needs that were described by the palliative care

professionals included learning the "how to" of basic treatment and caregiving, knowing what to expect as the disease progresses and during the process of dying, and developing an understanding of what services are available and how to best access relevant palliative care services. For example one participant described *"...they want to know, am I going to die in my sleep or what's going to happen... I try to tell them... and I try to explain it... I find it helps to take some of the fear away."* Although not unique to rural area practice, it was the combination of these key pieces of information that the professional participants' felt were crucial to helping geographically isolated families deal with significant or unexpected changes in their lives and to addressing some of the gaps in service that are often present in rural settings. One participant described *"part of what I do is connecting people with resources and, and finding people, finding funding for people who have to travel, ...just finding resources for people. It's hard to piece together everything in the rural areas."* Within the context of providing palliative and EOL care to older adults living in rural settings, the palliative care professionals also indicated the primary importance of effective interpersonal communication within these relationships. The perceptions of the palliative care professionals surrounding interpersonal communication and seen as vital in rural palliative care practice were reflected in three main themes: i) rural care 'for your own,' ii) independence and individuality, and iii) timing and early access/rural rapport.

Rural Care 'for your own'

Within the context of communication in rural palliative care, one of the main themes that the participants focused on was the importance of seeing their older care recipients and others as part of their own lives. In a sense, the participants felt that the lines were often blurred between professional/caregiver, and neighbor/friend in rural settings. Although challenging at times, this often played a positive role in how they interacted with and communicated with their patients and family members. In many cases, the professional participants were living in the small rural settings in which they were working, and knew their patients personally. The resulting bond and close community ties that they felt were evident. When communicating with their patients and patients' family members, they reflected that they were not seen as and did not feel like formal outsiders. They seemed to share a rural closeness and sense of family that had a positive impact on them professionally as well as on the sense of connection and peace felt by their patients. Examples from the data included:

> …they have to trace your lineage...because you already got an automatic in if there's any sort of cultural thing going on. They connect you up and they seem at peace.

> …they're so used to dealing in a rural and small town community and you're a part of that community…and, you're almost like a part of an extended family.

> It's almost like you are taking care of one of your own.

> I have patients that rely on those home care nurses coming in and that they become part of their family…that's how they view you.

Independence and Individuality

Participants focused on the importance of health care professionals attending to the elements of independence and individuality when building relationships and communicating effectively with individuals and families in rural palliative practice. A key aspect of attending to these elements included the inclusion of the older patient and their family members as key players within a health care team that focuses on individual circumstances and preferences. In this way they would recognize the individual strengths of the patient and family, as well as, use a multidisciplinary approach to communication. To create a therapeutic environment, they felt that the health care team should be defined to include the patient, family members, RNs, home health professionals, physicians, volunteers, spiritual care providers, and even important friends and neighbors involved in the day to day care of the older palliative care recipient. It was evident that for the participants, a multidisciplinary philosophy of care was very difficult to create, especially within the smaller rural areas and settings lacking adequate services and resources. However, the drive to work toward creating and sustaining this care mentality or approach was strong. Examples of data reflecting this theme were:

> The best outcomes happen when all of the team members are available… most of my best outcomes have happened when we've had multidisciplinary teams meet with family and actually have a family conference and discuss everything openly and, and you know, give them information and scenarios

> …and that [multidisciplinary approach] seems to empower everybody and help everybody through the whole process.

> I think maybe just that their wishes are respected and, and listened to by, by the health care professionals and family and kind of work together as a team because people can kind of somehow get on the same page.

Within the vision of independence and individuality, the participants also focused on health care professionals making an effort to assess and attend to the unique learning needs identified in each situation. In a sense, the key focus was on assessing the patient and family in terms of their specific learning needs, their readiness and comfort with taking in and using new knowledge, and their past experiences with death and dying. Further, this included assessing and attending to the unique wishes and needs identified by patients and their family members, and striving to meet individual requests where possible (e.g., choice of location of death). Examples of data include:

> that's a key there too is dealing with them as individuals and, and, you know, remembering that everybody is, is different with their own set of coping skills and personalities and life experiences and good things and baggage...

> ...you know it's so different for each person…how much they can absorb and what wording you use and, you know, just...so important to I guess assess the individuality.

The importance of assessing and responding to the emotional needs and quality of life of patients and family members were also key aspects of the theme of

independence and individuality that was focused on by the rural professional participants. It was evident that the participants' felt that there is a general lack of access to formal counseling and bereavement care in rural palliative care. As such, provision of emotional support (e.g., active listening, supportive statements, comforting, appropriate use of touch) was often a major aspect of their role, with the need to provide ongoing reassurance and validation as central to patient and family coping and their quality of life. Within the context of working with rural older adults, sometimes it was just the small things that were communicated and discussed that seemed to make the most difference. This included communicating the importance of validating their lives, making the most of the time they have left, ongoing reassurance and encouragement, reframing their hope, celebrating small successes that have contributed to their independence, telling their stories, and dispelling myths of what being palliative entails. A few examples from the data included:

> ...not talking so much about the fact that death is going to occur, but just helping them to live with what they've got and to make the most of the time they have.

> and that meaning of palliative care… 'could we help you address the issues that are preventing you from living with quality'… It doesn't matter what we call it, we are there to help people live as well as possible, even though they may have limited time.

> …it's becoming more and more apparent to me…is now how people say that you're living with cancer, you're not dying with it .I think that's important that we help people realize that.

> Telling their story, their loved ones and caregivers. That helps validate life and is something I like to encourage, especially my elderly patients.

Timing, Early Access/Rural Rapport

The final main theme that was focused on by the professional participants was the importance of the appropriate timing surrounding effective interpersonal communication, and the overall necessity of developing rapport as early as possible. This was critical in the rural settings. Although the participants were aware of the gaps in service that were often present in rural palliative care delivery, they agreed that health care professionals must attend to appropriate timing in their communication with older patients and family members, and try to incorporate a step by step approach. This included assessing readiness and the appropriate pace with which to move forward, while allowing time for the patient and family members to absorb the information and impact of the changes in their lives as they experienced transitions in rural palliative care. Some examples included:

> So part of my role is to try to encourage them to pace themselves… So what are the things that you think they need to get done today?

> Let's just deal with one thing at a time, step by step…and every little step might be really tiny, but we're right along there with you.

> It works good to let the patient work through it at his/her own speed.

> Sometimes just taking a step back and taking a breath, and allowing that person time to absorb what's happening…can be more of a help.

The development of rapport early in the disease trajectory was also a key aspect of appropriate timing, and was viewed by the participants as central to the development of trust in interactions with older patients and family members. Participants shared that in many cases early rapport and trust were difficult if they were not aware of who in their community were in need of palliative care services, and/or if patients and family members viewed the need for palliative care as a death sentence. However, the participants felt that if interpersonal communication surrounding palliative care was more sensitive and occurred earlier in the initial stages of terminal disease, patients and family members were less likely to feel overwhelmed with the term 'palliative,' were more comfortable with their interactions with palliative caregivers, and were more trusting of and open to discussions with formal care providers. Examples from the data included:

> I think a lot of it is how we are presenting ourselves at that initial meeting…if they introduce me as we're going to send you the palliative care nurse and they're not ready to hear 'palliative.' Sometimes I have to be a cancer nurse, sometimes I need to be a pain nurse, sometimes, I think we have to be creative at finding out where is this patient in their journey, what are they willing to see right now and what are they willing to hear.

> I'm never just 'hi, I'm the palliative care nurse'…it's 'I'm one of the nurses and I am here to see how you are doing.' Using that palliative a little bit and explaining what it means before it's just thrown at them.

> …the cases that I find where I've been able to go in very early and discuss things with the family, they seem to go much better 'cause then you just bring everything and it's not such an overwhelming thing.

4.0 Discussion

In the initial findings, the professional participants focused on the knowledge of, and provision of essential information for older adults surrounding the issues of defining what resources are available, how to access resources, how to provide basic physical and emotional care, and knowing what to expect. It was the timely combination of these pieces that the participants felt could help decrease feelings of information overload for patients and families, and contribute to an improved sense of preparedness to deal with the uncertainty of a terminal diagnosis. The information needs of rural palliative patients have also been described in previous research (Wilkes, White, & O'Riordan, 2000). Specifically, the importance of sharing information on practical resources, providing physical care, and managing medications in rural settings were needed. As well, a unique concern in rural settings was that families were not always aware of their specific information needs until they were faced with a crisis (Wilkes et al., 2000). In the present study, the perceptions surrounding effective interpersonal communication within the context of care for older adults in rural settings were a primary area of interest for the professional participants. The main themes reflecting effective interpersonal communication as perceived by the rural palliative care professionals may enhance their ability to help patients and families deal with present circumstances and avoid future crisis situations.

Although not highlighted in the findings section, the study participants were highly devoted to their roles as palliative care professionals, and also seemed strongly linked to the communities in which they practiced. Specifically, in terms of the processes and manner of their interpersonal communication, they identified the importance of being open to being part of the lives of their patients, as well as engaging in the care of their own community members. These findings seem to be in contrast to those of similar studies that have identified numerous emotional challenges for rural palliative health care professionals including having difficulty distinguishing between personal and professional lives, professional isolation, and difficulties of dual relationships with patients and family members (Dunham, Bolden, & Kvale, 2003; Haxton et al., 2010; Kenny et al., 2007; McConigley et al., 2000; Rosenberg et al., 2004; Wilkes & Beale, 2001). In the present analysis, findings specific to having a clear focus on the positive aspects of working in rural settings may have been due to the fact that many of the participants were spending a large portion of their work week in a palliative caregiving role. As a result, their identity as rural palliative care professionals, including aspects of their palliative expertise, may have had a positive impact on how they viewed their relationships with the patient and family member care recipients.

Ferrell and Whitlatch (2007) emphasized that not only is the healthcare provider immersed in the microculture of the family when providing palliative care, but he or she is also immersed in the macrocosm of the community. Perhaps there is a need to use a rural lens, and include the knowledge of key rural professionals when defining the potential resources and opportunities that can strengthen the provision of high quality palliative care services in these settings. Despite the general rural challenges identified by the participants, the community and personal connections surrounding effective interpersonal communication with rural older adults receiving palliative care were evident. A review of the literature surrounding rural health care ethics suggests that there is a need to look beyond the impoverished or primitive view of rurality, to the strengths of rural settings including community commitments, close-knit relationships, and social solidarity (Nelson, Lushkov, Pomerantz, & Weeks, 2006). As the majority of participants were living and working in the rural communities that they served, the participants may have been more likely to be personally connected to where they lived and were able to see beyond the stereotypical views of "being rural." Further research is necessary to explore these relationships in greater depth and determine the benefits of community engagement with respect to the process and success of communication and information sharing in the rural provision of palliative care for older adults.

An additional theme related to effective interpersonal communication indicated the need to attend to the independence of rural peoples and their individual preferences, with a multidisciplinary team approach to creating a therapeutic environment. Given the multiplicity of palliative care settings and the complexity of roles of multidisciplinary team members, the term 'palliative care team' is considered a diverse entity (Cox & James, 2004; Krammer, Martinez, Ring, Williams, & Jacobs, 2006). Due to the difficulty in defining this team approach and accessing members in isolated areas, utilization of this approach to care poses significant challenges in rural and remote settings. Regardless of the geographical setting, a team approach to communication has been identified as having vital importance in decreasing suffering and improving the quality of life for those receiving and providing palliative care (Lowey, 2008). Within a context of caring for older adults, it has also been suggested there is a need to focus on patients and

family members as full participants in shared decision-making, while negotiating a balance between palliative and curative treatment (Jerant, Azari, Nesbitt, & Meyers, 2004). From a rural standpoint, an individualized approach to palliative care includes building diverse teams with important community members and recognizing the importance of individual and community independence throughout the process (Kelley, 2007). Further research is necessary to explore the issues and barriers influencing the ability of multidisciplinary teams in rural settings to work in the provision of palliative care, as well as how to better include older patients and family members as key players in shared decision-making.

The need to focus on individuality/independence in rural settings and provide ongoing emotional support for older rural palliative patients and their family members were additional areas influencing the effectiveness of communication in these settings. The literature surrounding the provision of palliative care in rural settings have identified the psychosocial context of caregiving to be one of most challenging aspects of providing care for rural palliative care professionals (Kelley et al., 2003; Kenny et al., 2007, Robinson et al., 2009). However, the participants in the present study clearly maintained a positive approach to their provision of emotional support, with a commitment to supporting and maintaining the independence and the psychosocial well-being of the elderly patients and families under their care. The findings of the present study seem to be in line with a model of palliative care for elderly persons outlined by Jerant and colleagues (2004) in which the maintenance of social roles, optimization of independence, and the ability to relieve existential suffering is considered of primary importance in providing palliative care for older adults. The participants in the present study identified key aspects of emotionally supportive communication that was centered on reassurance, encouragement and validation, maintaining independence, making the most of their patients' lives and the time they have left, reframing their care recipients' hope, encouraging their patients to tell their stories, and dispelling myths of what being palliative entails. All of these specific approaches to communication were understood within the context of caring for rural older adults, and provide unique opportunities for further research exploration. It is evident that further research in this area has the opportunity to broaden the understanding of rural older persons' emotional and communication needs in the context of palliative care delivery.

Effective interpersonal communication related to timing and developing trust and rapport early in the illness trajectory were identified by participants as being particularly important within rural palliative care settings. The participants seemed to have a clear understanding of their identity as palliative health care professionals; however, the dilemma of being viewed as the care provider associated with death and dying from the perspective of their care recipients was often challenging. Similar results were found in a study involving rural palliative professionals (i.e., clinicians, nurses, medical assistants, chaplains, social workers, administrators, and ancillary staff) in which the greatest barriers to providing optimal care in rural settings was reported as the patient and family members' avoidance of issues surrounding dying (van Vorst et al., 2006). In the present study, it is possible that society's general denial and ambivalence toward death (Dubler, 2005), together with the effect of the curative focus of the health care system (Callahan, 2005) may have contributed to the perceived resistance that the care recipients and family members were experiencing surrounding being termed 'palliative.' The step by step approach that was exemplified by the participants included important elements of timing, ongoing assessment, and evaluation of the

care situation. These findings are similar to previous research that have identified that the element of time and timing play a key role in the success of establishing trustful relationships and effective rapport (Dalgaard & Delmar, 2008; Kirk, Kirk, & Kistjanson, 2004; Luker et al., 2000; Parker et al., 2007; Stajduhar et al., 2010). The assessment of readiness and evaluation of appropriate pacing seemed to allow the participants to offset some of the myths surrounding palliation, and contributed to the development of positive rapport and trust. Similar to the present findings, in a large scale study exploring the perceptions of palliative cancer patients and family members around information sharing and communication, Kirk et al. (2004) found that there is a need to focus on both the content and the process of information sharing, which includes appropriate pacing. In addition, they described the crucial element of trust, which, if compromised in the initial interactions, often remained an issue throughout the illness trajectory (Kirk et al., 2004).

The ability to incorporate a step by step approach to communication was also strengthened when the participants were able to establish earlier contact with those who would benefit from integrated palliative care services. Previous research has established that the elemental components of interpersonal communication such as trust, sensitivity, and relationships that are built early are crucial in developing successful communication patterns between health care professionals and patient/family members in palliative care (Dunn, Sullivan & Kerohan, 2005; Lowey, 2008; Luker et al., 2000; Mok & Chiu, 2004; Penz & Duggleby, 2011; Stolz et al., 2006). The ability to develop successful patterns of communication may be of even greater concern in rural areas when considering the physical and social isolation of rural older adults (Clark & Leipert, 2007) and the declining and family-dependent social networks that often occur when they are faced with serious or terminal illness (Duggleby et al., 2011; Wenger & Keating, 2008). Further research is necessary to explore ways in which rural palliative health care professionals can access those in need of palliative care earlier in their illness trajectory, as well as look at ways to dispel some of the myths surrounding palliation and contribute to a more open outlook surrounding available resources.

4.1 Factors Influencing the Study

There are a few factors that may have influenced the findings of this study. As this analysis was conducted on existing data that were part of a grounded theory study exploring transitions in palliative care for rural older adults, the information needs and themes reflecting effective interpersonal communication were understood within the context of these transitions. Due to the sample only reflecting the views of rural palliative care professionals, this analysis does not take into account any rural person and/or family member perspectives of effective interpersonal communication. Limitations related to the characteristics of the study participants are their gender, professional affiliation, and the geographical location of data collection. All the participants were female, so it is difficult to determine the influence of their gender and of gender expectations on the findings. As well, although the participants were working in separate health regions in a Western Canadian province, which included a broad range of rural areas and practice settings, there is question of whether the findings would differ if other Canadian rural and remote settings were included in this study. In addition, the education of the professional participants, save one, was registered nursing. The inclusion in subsequent studies of a variety of palliative care professionals, including general practitioners and physicians with a background in palliative medicine, may result in different findings.

5.0 Conclusions

The findings of this component of a grounded theory study provide a unique glimpse into elements related to effective interpersonal communication within the context of caring for older rural adults requiring palliative care services. It was evident that the palliative health care professionals who participated in this study were highly committed to improving the quality of care for rural patients with advanced cancer and their family members. Although the participants alluded to the ongoing challenges of working in rural settings such as feeling isolated from their team members, facing gaps in knowing who may require their services, and feeling like they are often viewed as only associated with death and dying, they were positively focused on the future opportunities and improvement of palliative care within rural settings. The importance of understanding the context of aging and dying in rural settings, with a focus on essential information and effective interpersonal communication within this context was evident. The findings suggest the importance of rural older adults and their family members attaining knowledge about what services are actually available to them in rural settings and providing clear explanations about the best ways in which they can access these services. There are opportunities to explore ways in which information regarding the 'how to' of basic caregiving and patient and family needs regarding what they can expect can be conveyed and resources accessed in rural settings.

While focusing on the independence of rural people and on an individualized approach to care, the participants felt that were able to communicate their respect for their patients, while assessing and responding to their emotional needs and emphasizing the need to improve their quality of life. This has implications for rural palliative care services which should also attend to the individual psychosocial needs of rural families. Elements of time and developing rapport in rural settings included assessing and determining appropriate pacing in relation to the term 'palliation," taking things step by step, and developing trust and rapport as early as possible in the disease trajectory. Although the challenges of providing integrated palliative care services in rural areas was apparent in this study, the participants were connected to their patients and often viewed their older care recipients as part of their own lives. Having a rural sense of closeness and community connection seemed to have a positive impact on the professional participants and was reflected to provide a sense of peace for their care recipients. Although the findings of this study may not be generalizable to all rural settings, they provide ideas for future research directions in the context of rural and remote palliative care delivery.

6.0 Acknowledgements

7.0 References

Anselm, A. H., Palda, V., Guest, C. B., McLean, R. F., Vachon, M., Kelner, M., & Lam-McCulloch, J. (2005). Barriers to communication regarding end-of-life care: Perspectives of care providers. *Journal of Critical Care, 20*, 214-223.

Antai-Otong, D. (2006). *Nurse-client communication: a life span approach.* Sudbury, Massachusetts: Jones and Bartlett Publishers

Brazil, K., Kassalainen, S., Ploeg, J., & Marshall, D. (2010). Moral distress experienced by health care professionals who provide home-based palliative care. *Social Science and Medicine, 71,* 1687-1691.

Burge, F., Lawson, B., & Johnston, G. (2005). Where a cancer patient dies: the effect of rural residency. *Journal of Rural Health, 21*(3), 233-238.

Callahan, D. (2005). Death: ''the distinguished thing.'' *Hastings Centre Report, 35*(6), S5-S8.

Charmaz, K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis*. London; Thousand Oaks: SAGE.

Clark, K., & Leipert, B. (2007). Strengthening and sustaining social supports for rural elders. *Online Journal of Rural Nursing and Health Care, 7*(1), 13-26.

Cox, K., & James, V. (2004). Professional boundaries in palliative care. In S. Payne, J. Seymour, & C. Ingleton (Eds.). *Palliative Care Nursing: Principles and Evidence for Practice* (pp. 554-572). New York, NY: Open University Press.

Dahlin, C. & Giansiracusa, D. (2006). Communication in Palliative Care. In B. Ferrel, & B. Coyle (Eds.). *Textbook of Palliative Nursing* (pp. 67-96). New York, NY: Oxford University Press.

Dalgaard, K. M., & Delmar, C. (2008). The relevance of time in palliative care nursing practice. *International Journal of Palliative Nursing, 14*(10), 472-476.

Dubler, N. N. (2005). Conflict and consensus at the end of life. *Hastings Centre Report, 35*(6), S19-S25.

Duggleby, W., Penz, K., Goodridge, D. M., Wilson, D. M., Leipert, B. D., Berry, P. H., Keall, S., & Justice, C. (2010). The transition experience of rural older persons with advanced cancer and their families: a grounded theory study. *BMC Palliative Care,* 9(5), 1-9. DOI: 10.1186/1472-684X-9-5.

Duggleby, W. D., Penz, K., Leipert, B. D., Wilson, D. M., Goodridge, D., & Williams, A. (2011). 'I am part of the community but…' The changing context of rural living for persons with advanced cancer and their families. *Rural and Remote Health, 11*(2), 1733), 1-12.

Dunham,W., Bolden, J., & Kvale, E. (2003). Obstacles to the delivery of acceptable standards of care in rural home hospices. American Journal of Hospice and Palliative Care, 20(4), 259-261.

Dunne, K., Sullivan, K., & Kernohan, G. (2005). Palliative care for patients with cancer: district nurses' experiences*. Journal of Advanced Nursing,* 50, 372-380.

Evan, R., Stone, D., & Elwyn, G. (2003). Organizing palliative care for rural populations: a systematic review of the evidence. *Family Practice, 20*(3), 304-310.

Ferrell, B. R., & Whitlatch, B. J. (2007). Home care and caregivers. In A. M. Berger, J. L. Shuster, & J. H. V. Roenn (Eds.). *Principles and Practice of Palliative Care and Supportive Oncology* (pp. 615-622). Philadelphia, PA: Lippincott Williams & Wilkins.

Goodridge, D., Lawson, B., Rennie, D., Marchiniuk, D. (2011). Rural/urban differences in health care utilization and place of death for persons with respiratory illness in the last year of life. *Rural and Remote Health, 10*: 1349. (Online) 2010. Retrieved September 18, 2011, from www.rrh.org.au

von Gunten, C. F., Ferris, F. D., & Emanuel, L. L. (2000). The patient-physician relationship: Ensuring competency in end of life care, communication, and relational skills. *Journal of the American Medical Association, 284*, 3051-3057.

de Haes, H., & Teunissen, S. (2005). Communication in palliative care: a review of the recent literature. *Current Opinions in Oncology, 17*, 345-350.

Haxton, J. E., & Boelk, A. Z. (2010). Serving families on the frontline: Challenges and creative solutions in rural hospice social work. *Social Work in Health Care, 49*, 526-550.

Jerant, A. F., Azari, R. S., Nesbitt, T. S., & Meyers, F. J. (2004). The TLC model of palliative care in the elderly: Preliminary application in the assisted living setting. *Annals of Family Medicine, 2*(1), 54-60.

Johnson, C., Girgis, A., Chris, P., Currow, D. C., Adams, J., & Aranda, S. (2011). Australian palliative care providers' perceptions and experiences of the barriers and facilitators to palliative care provision. *Supportive Care for Cancer, 19*, 343-351.

Kelley, M. L. (2007). Developing rural communities' capacity for palliative care: a conceptual model. *Journal of Palliative Care, 23*(3), 143-153

Kelley, M. L., Sellick, S., & Linkewich, B. (2003). Rural nonphysician providers' perspectives on palliative care services in northwestern Ontario, Canada. *Journal of Rural Health, 19*, 55-62.

Kenny, A., Endacott, R., Botti, M., & Watts, R. (2007). Emotional toil: Psychosocial care in rural settings for patients with cancer. *Journal of Advanced Nursing, 60*, 663-672.

Kirk, P., Kirk, I., & Kristjanson. L. J. (2004). What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *British Medical Journal, 328*(7452): 1343, 1-7. DOI:10.1136/bmj.38103.423576.55.

Krammer, L. M., Martinez, J., Ring, E. A., Williams, M. B., & Jacobs, M. J. (2006). The nurse's role as a member of the interdisciplinary palliative care team. In M. L. Matzo & D. W. Sherman (Eds.). *Palliative Care Nursing: Quality Care to the End of Life* (pp. 133-150). New York, NY: Springer Publishing Company.

LoBiondo-Wood, G., & Haber, J. (2002). *Nursing Research: Methods, Critical Appraisal, and Utilization*. St. Louis, MO: Mosby.

Lowey, S. E. (2008). Communication between the nurse and family caregiver in end-of-life care: A review of the literature. *Journal of Hospice and Palliative Nursing, 10*(1), 35-45.

Luker, K. A., Austin, L., Caress, A., & Hallett, C. E. (2000). The importance of ''knowing the patient'': community nurses' constructions of quality in providing palliative care. *Journal of Advanced Nursing, 31*(4), 775-782.

McConigley, R., Kristjanson, L., & Morgan, A. (2000). Palliative care nursing in rural Western Australia. *International Journal of Palliative Nursing, 6*(2), 80-90.

Mok, E. & Chiu, P. C. (2004). Nurse–patient relationships in palliative care. *Journal of Advanced Nursing, 48*, 475–483.

Musselwhite, K., Cuff, L., McGregor, L., & King, K. M. (2007). The telephone interview is an effective method of data collection in clinical nursing research: A discussion paper. *International Journal of Nursing Studies, 44*, 1064-1070.

Nelson, W., Lushkov, G., Pomerantz, A., & Weeks, W. B. (2006). Rural health care ethics: Is there a literature? *Journal of Bioethics, 6*(2), 44-50.

Parker, S. M., Clayton, J. M., Hancock, K., Walder, S., Butow, P. N., Carrick, S. et al. (2007). A systematic review of prognostic/end-of-life communication with adults in the advanced stages of life-limiting illness: Patient/caregiver preferences for content, style, and timing of information. *Journal of Pain and Symptom Management, 34*(1), 81-93.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Penz, K., & Duggleby, W. (2011). Harmonizing hope: A grounded theory study of the experience of hope of registered nurses who provide palliative care in community settings. *Palliative and Supportive Care, 9*, 281-294.

Robinson, C. A., Pesut, B., & Bottorff, J. L. (2010). Issues in rural palliative care: Views from the countryside. *Journal of Rural Health, 26*, 78-84.

Robinson, C. A., Pesut, B., Bottorff, J. L., Mowry, A., Broughton, S., & Fyles, G. (2009). Rural palliative care: A comprehensive review. *Journal of Palliative Medicine, 12*(3), 253-258.

Rose, J., & Glass, N. (2006). Nurses and palliation in the community: The current discourse. *International Journal of Palliative Nursing, 12*(12), 588-594.

Rosenberg, J. P., & Canning, D. F. (2004). Palliative care by nurses in rural and remote practice. *Australian Journal of Rural Health, 12*, 166–171.

Sparks, L., & Nussbaum, J. F. (2008) Health literacy and cancer communication with older adults. *Patient Education and Counseling*, *71*, 345–350.

Stajduhar, K., Thorne, S., McGuinness, L., & Kim-Sing, C. (2010). Patient perceptions of helpful communication in the context of advanced cancer. *Journal of Clinical Nursing, 19*, 2039-2047.

Street, R. L., & Epstein, R. M. (2008). Key interpersonal functions and health outcomes. In K. Glanz & B. K. Rimer (Eds.). *Health behavior and health education: Theory, research and practice* (pp. 237-282). Jossey-Bass.

van Vorst, R. F., Crane, L., Barton, P. L., Kutner, J. S., Kallail, K. J., & Westfall, M. (2006). Barriers to quality care for dying patients in rural communities. *Journal of Rural health, 22*(3), 248-253.

Vachon, M. L. S., & Sherwood, C. (2007). Staff stress and burnout In A. M. Berger, J. L. Shuster, & J. H. V. Roenn (Eds.). *Principles and practice of palliative care and supportive oncology* (pp. 667-683). Philadelphia, PA: Lippincott Williams & Wilkins.

Wenger, G. C., & Keating, N. (2008). The evolution of networks of rural older adults. In N. Keating (Ed). *Rural ageing: a good place to grow old?* (pp. 33-42). Bristol, UK: The Policy Press.

West, R. (2006). Introduction to interpersonal communication. In R. West & L. H. Turner (Eds.). *Understanding interpersonal communication: Making choices in changing Times* (pp. 1-31). Boston, MA: Wadsworth.

Wilkes, L. M., & Beale, B. (2001) Palliative care at home: stress for nurses in urban and rural New South Wales, Australia. *International Journal of Nursing Practice, 7,* 306-313.

Wilkes, L., White, K., & O'Riordan. L. (2000). Empowerment through information: Supporting rural families of oncology patients in palliative care. *Australian Journal of Rural Health, 8*(1), 41-46.

Wilson, K., Roe, B., & Wright, L. (1998). Telephone or face-to-face interviews? A decision made on the basis of a pilot study. *International Journal of Nursing Studies, 35*(6), 314-321.

Wilson, D. M., Justice, C., Sheps, S., Thomas, R., Reid, P., & Leibovici, K. (2006). Planning and providing end-of-life care in rural areas. *Journal of Rural Health, 22*(2), 174-181.