Core attitudes of professionals in palliative care: A qualitative study

Steffen T Simon, Christina Ramsenthaler, Claudia Bausewein, Norbert Krischke, Gerlinde Geiss

Abstract

Introduction: Self-awareness of one's own reactions towards patients and their relatives is of paramount importance for all professionals in palliative care. 'Core attitude' describes the way in which a person perceives himself and the world, and forms the basis for his actions and thoughts. ***Objective***: The aim of this study is to explore what core attitude means for palliative care professionals and whether there is a specific core attitude in palliative care. ***Methods***: Qualitative study with 10 face-to-face in-depth interviews with experts in palliative care (nurses, physicians, social workers, psychologists, chaplain) in Germany. ***Results***: Core attitude in palliative care can be best described with the following three domains: 1) personal characteristics; 2) experience of care; and 3) competence in care. Authenticity is the most important characteristic of professionals, along with honesty and mindfulness. Core attitude primarily becomes apparent in the relationship with the patient. Perception and listening are key competences. The experts emphasized the universality of the core attitude in the care of ill people. They stressed the importance and relevance of teaching core attitudes in palliative care education. ***Conclusion***: In the field of palliative care, core attitude consists predominately of authenticity, manifests itself in relationships, and requires a high degree of perceptiveness.

Key words: Attitude ● Authenticity ● Palliative care ● Professionals ● Qualitative

The character of the professional carer, his values, attitudes, and ways of interacting with patients have often been discussed as important technical and vocational skills in the professional care of people with psychological or physical problems or illnesses (Hurwitz and Vass, 2002; General Medical Council, 2006). In medical ethics, different authors define components of professional core attitude or values, including respect, thruthfulness and dignity (Boyd et al, 1997; Beauchamp and Childress, 2001). Some authors stress the importance of the physician-patient relationship, and medicine is seen as a relational science in this context (Balint, 1955; Rogers, 2003). In palliative care, empathy, honesty, acceptance, and authenticity are important qualities in the care of patients with life-threatening diseases and they are strongly related to the professionals' attitude (Doyle et al, 2004; Speck et al, 2004). As Cicely Saunders stated, 'there has always been a human as well as a professional basis that is fundamental to the work that we do' (Saunders, 1996).

We define 'core attitude' as the way in which a person is aware of himself and the world around, and in which he forms the basis of his thoughts and actions. This preliminary definition is based on Dörner's description of core attitude in the context of a medical ethos of physicians (Dörner, 2001). The meaning of core attitude here differs to the psychosocial concept of attitude in terms of opinion and position, although broader definitions of attitude exist (Gawronski, 2007).

The motivation for this study was the suggestion that the core attitude has a profound relevance in palliative care in addition to professional knowledge and skills, and to a caring environment. The aim of this study was to explore the meaning and relevance of 'core attitude' in professionals working in palliative care. The study is part of a wider research program about core attitudes in palliative care from the viewpoint of professionals in this field and will inform the development of a questionnaire.

Methods

Individual face-to-face in-depth interviews were conducted with 10 palliative care specialists from diverse settings and sites in Germany. Participants were experts in the field with long-time practical experience in palliative care and hospice work (inpatient and home care) and were selected by two researchers (STS and GG) based on the following criteria: the participants should have dealt with attitudes and the philosophy of palliative care in the past and had the competence to reflect on it. Other criteria were maximum diversity regarding age, gender, and professional group, as well as a diversity of disciplines and settings in palliative care to ensure that relevant views were represented.

Before the interviews, the 10 participants

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Table 1. Topic guide for the interviews

• General and specific meaning of core attitude
• First cognition of core attitudes in their field of work
• Development of core attitudes
• Impact of core attitudes on themselves and their work
• Role of core attitudes in the palliative care setting
• Existence of a specific or more general 'palliative care core attitude'
• Description of a 'good physician/nurse/ chaplain/psychologist' and their characteristics
• Understanding of their personal role as physician/nurse/chaplain/ psychologist in the care of the dying
• Most important issues in palliative care on the background of their long-time experience
• Description of their inner attitude in day-to-day care of the dying
• Role of teaching and training regarding core attitudes
• Other concerns, suggestions and thoughts not covered yet

received written information in form of a leaflet, which detailed the project description and aims of the study. An in-depth interview was conducted face-to-face with each participant; duration ranging from 35 to 90 minutes. All interviews were conducted by the first author (STS), a palliative care physician experienced in qualitative research. During individual interviews, the participants were asked to describe, discuss and critically reflect on the different areas of core attitudes (*see Table 1*). The topic guide was developed by group discussion and expert advice (scientific advisory board). The following sociodemographic data were collected at the end of the interview: age, gender, profession, position (head, team member), work setting (home care/ inpatient), overall work experience (in years), work experience in palliative care (in years), occupation in an educational setting. Data were collected between September and December 2006. The individual interviews were audiotaped and fully transcribed verbatim.

Data were analysed using content analysis as the qualitative methodology approach (Mays and Pope, 2000; Ritchie and Lewis, 2004). Two researchers (STS, GG) coded the data independently and developed the presented category system in a multi-staged approach. Firstly, the transcribed narratives were analysed in order to identify individual topics. Secondly, the text was divided into meaning units. Coding involved line-by-line examination of the transcripts and paraphrasing them using the participants' own language where possible. After that, paraphrases with similar meaning were summarized and transformed into mutually exclusive categories and then organized into themes. Data reduction involved organization and refinement of categories through condensation and revision. Both researchers met regularly to review the data and discuss the evolving themes to ensure consistency of interpretations. The individual analysis of every interview was given to the relevant interviewee, and his or her commentaries were incorporated. Subsequently, data with additional comments were re-categorized including second consensus building between authors. Finally, the resulting category system was reviewed by the third author (NK), and any discrepancies were resolved.

Ethical approval was sought from the ethics committee at the University of Oldenburg but judged to be unnecessary as the study did not involve patients.

Results

Demographics

The interviewees comprised seven women and three men with a mean age of 47.6 years (range 40–60). Four participants were nurses, three doctors, two psychologists and one a chaplain. Their mean working experience was 22.7 years (range 14–30), with a mean of 10.5 years in a palliative care setting (range 2–20). Nine participants were also responsible for training and teaching. Detailed information is shown in *Table 2*.

The concept of core attitude

On a meta level, the interviewees describe their understanding of core attitude as 'foundation', 'core value', 'base', 'essential philosophy of life', 'identity', and 'view of the world'. 'Faith' and 'spirituality' were also mentioned (experts 1–10):

> **'Core values determine the thinking of a person and are superior to concrete guidance of action' (Expert 5).**

The participants define the concept of core attitude as being fundamental and all-encompassing. It can include physical, emotional, cognitive, and spiritual aspects. The majority of participants agree that there is no simple definition or description of core attitude:

> **'It is similar to humour: always when you try to describe it, it is fluid, then disappearing and then you try to find the essence. It is something that I try to describe through examples but it is transient if you try to keep it' (Expert 7).**

Table 2. Sociodemographic characteristics of interviewed experts in palliative care

Experts	1	2	3	4	5	6	7	8	9	10
Age	54	43	43	40	49	41	43	58	60	45
Gender	female	female	female	male	male	female	female	male	female	female
Occupational group	chaplain	nurse	nurse	nurse	doctor	doctor	nurse	doctor	psychologist	psychologist
Working field	in	hc	hc	in	in/hc	in	hc	in	in	hc
Work experience (in years)	25	26	18	19	15	14	25	30	30	25
Work experience in palliative care (in years)	5	5	15	1,5	5	10	16	20	12	15

Abbreviations: in = inpatient, hc = home care

Development of the core attitude

Addressing the question of how a core attitude can develop, the participants consistently think that the social environment (e.g. family) plays an important role in early childhood. The core attitude in this early stage of development is 'unknowingly', 'premature in terms of not developed' and can thus be described as 'implicit knowledge of experience' (experts 2, 8–10). In the course of life, the core attitude is subject to constant change and development based on insight. It is not a continuous and linear process but described as cyclic and driven by life events, especially in life crises (see *Figure 1*). Sources of this growth process are 'experience of own limitations', 'conflicts', 'crises', 'reflection', 'observing and witnessing examples', 'the experience to be accepted with love', 'conscious experiences and learning processes' (experts 3–10).

> **'The core attitude also changes because of the constant change of the relation of vulnerability and transitoriness of the own life' (Expert 8).**

Another attribute in the development of a core attitude is its dialogical nature. The core attitude develops through a relational process with oneself and with one's own identity, which takes place especially in contact with another person, with society, or with an idea or phantasy:

> **'I experienced this as an inner dialogue ... I realised that I have been confronted with my own attitude and have developed it further' (Expert 1).**

Figure 1 summarizes the interviewees' comments on the development of core attitudes over the life span. The core attitudes are changing through the personal history from a subconscious stage of experimental knowledge to a conscious and reflective level, which can be discussed and verbalized. The contact with death and dying is described as the focal point for the development of core attitudes.

Core attitude in palliative care

Nine out of ten participants state that the core attitude is not specific for the palliative setting, but rather universal. It is neither different from other medical fields (e.g. surgery), nor specific for any profession:

> **'I am even not sure whether it is a common attitude of doctors or whether a common human attitude is uniting us. I think it is the latter as nurses and psychologists have the**

Figure 1. The developmental process of core attitudes over the life span and the contact with death and dying as a focal point for the development of core attitudes

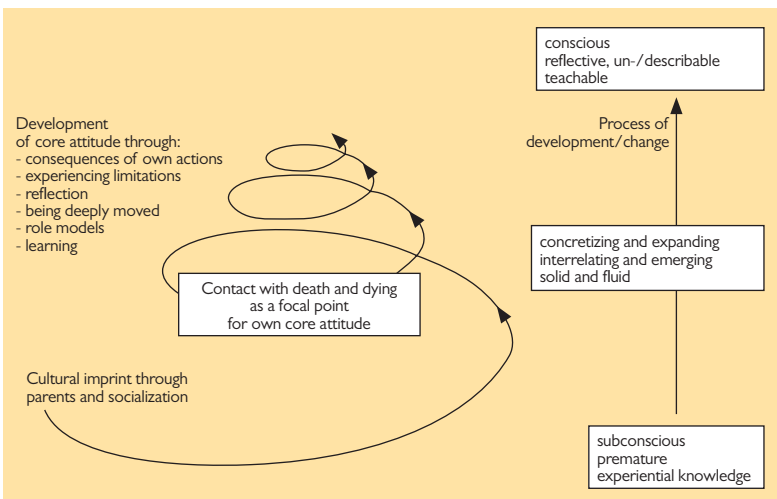

Table 3. Concept of core attitude in palliative care

Personal characteristics	Experience of core attitude	Competence in care
Authenticity	In relationship	Perception
Honesty	Dialogue	Active listening
Mindfulness	Companionship	Getting involved
Esteem / appreciation	Systemic approach	Creating space
Openness	Letting go	
Personal presence	Closeness / distance	
Responsibility		

same attitude. This is independent of the profession' (Expert 6).

The palliative care context, though, encompasses the topic of death and dying as 'a focal point' (expert 1) like a magnifying glass (under which objects magnify and become more obvious). A continuous confrontation with the finiteness of life fosters a deepened reflection of the own grain in the sense of a developmental stimulus (see *Figure 1*).

Moreover, some participants suppose that certain aspects of professional interaction with critically ill people (patients) are closely related to the professional's core attitude, such as 'holistic approach to the patient' or 'being able to bear or tolerate something and not knowing' in dealing with dying people (experts 9 and 10).

Concept of core attitudes in palliative care

The core attitude in palliative care is described in more detail by the interviewed participants. It can be classified in three groups (see *Table 3*).

Personal characteristics

The following characteristics are named as essential by the interviewed participants.

Authenticity: Nearly all interviewees highlight authentic behaviour as one of the fundamental characteristics of core attitude in palliative care. Authenticity is described as being present and accessible as a person rather than behaving only in a specific role (e.g. physician, pastor):

'It would be most important to be present as a person not only as Y (profession; authors), but primarily as Mr or Mrs N (name of interviewee; authors)' (Expert 10).

In order to be authentic in new situations with another person (e.g. patient), a certain degree of self-awareness as well as the knowledge of own strengths and limitations is needed. Modesty and an honest interest are described as essential parts of authenticity.

Personal presence: Being present is described several times as a feeling of 'completely being in the here and now' (Expert 7). This gives the other person the reassurance that he is the focus of the current moment and all other things are secondary (e.g. appointments). Although presence and authenticity are similar concepts, they differ in focus: presence refers to a non-restrictive attendance in the relationship to the other person, and authenticity is a capacity of the own person, as mentioned by the interviewees. Their common ground is a certain amount of personal drive, which means that the professional really wants to do his work or an actual task:

'I need to want it. I can't go to see a patient when I am completely distracted in my mind. I have to want it and that is an active decision especially in our area' (Expert 4).

Honesty and truthfulness: Providing accurate, truthful information regarding diagnosis, test results, and prognosis is regarded as one of the essential preconditions for a good relationship between carer and patient. In communication, honesty can be achieved by finding a common language; creating a link between patient and caregiver:

'I can't promise the patient that the therapy is working but I can promise to talk to him in an understandable and truthful way' (Expert 5).

It is stated that truthfulness has a relational dimension (in the contact with others) as well as a personal one (regarding one's own limitations, fears, and resources).

Openness: Openness is closely linked to honesty. On the one hand, it means being open to the individual with its concerns and wishes, even if these might by unusual. On the other hand, it represents a more basic principle:

'It is not part of the core attitude how I have to behave in a specific situation, that this is the defined norm. The core attitude is this fundamental openness for the personhood of the other human being' (Expert 1).

Unconditional positive regard: Several times Rogers' term 'unconditional positive regard' is mentioned by the participants and seems to be strongly related to the concept of 'core attitude':

'Yes, attributes of core attitude are something like the 'unconditional positive regard' (Carl Rogers) to others as well as as a deep respect for life and for the life of the other person' (Expert 7).

Mindfulness: Mindfulness is often paraphrased with cautiousness, attentiveness, humility, and acceptance. It means non-acting, appreciating the other in his being:

'You know deep inside what is right and I am allowed to be the person that reminds and supports you ... again this inner awareness and concentration on the uniqueness of this person, looking what is happening' (Expert 7).

Experience of core attitude

All participants emphasize that the core attitude is experienced in the relationship with the other person, which means in dialogue or in the interpersonal space. All participants state that it is an important skill to establish a relationship with a critically ill patient:

'Core attitude becomes most obvious when you are together with others' (Expert 6).

The participants define their role as being companions and mediators for the patients and their relatives: 'facilitator', 'companion', 'catalyst' (experts 2, 6, 10).

It expresses itself in the professional's body language:

'This special way to shake hands, to answer a question, to be quiet at times' (Expert 4).

Because the core attitude can be observed in the relationship to the patient, it can be learned through role models and practical examples:

'You can notice it at the reaction of others and therefore I think that you can exemplify it through your own life rather than describe it because the description of attitude can then easily be seen as a skill only' (Expert 7).

The core attitude as a competence in care

Besides expressing itself in the relation to others, the core attitude guides overt behaviour and action.

Perception: Perceiving another person in his individuality and uniqueness requires an inner, active process of being attentive, observing and perceiving all that is there in an open and patient manner:

'My motto is: let it happen actively' (Expert 9).

Perception includes all senses and the wishes, fears, questions, and intentions of the other person as well. The process should be guided by the questions: What does the person want? And what are my tasks here and my task regarding the other person and his development? Openness is needed as a precondition, ensuring a non-judgmental, non-evaluative point of view.

Getting involved: The process of working with terminally ill patients starts with getting involved in a relationship with this person. Therefore, it is the precondition for the above mentioned open and free perception of the other person:

'I have the picture in mind that when I see a patient I fully concentrate on the patient and be completely present in the moment and when I leave the room I come back into my own world and leave behind what happened in the room' (Expert 6).

Creating space: Enabling the patient to find and go his individual way is, in several participants' opinion, an essential competence in care of palliative patients. What each patient needs in order to be able to choose his own way is unique. This can only be determined by the patient himself, e.g. pain relief, reduction of unpleasant smells of open wounds, a conversation about own anxieties etc. It is essential that the patient should initiate these processes. Often, it is only the professional's task to provide the preconditions, i.e. a quiet room for a chat:

'Space is created through the way of contact or the atmosphere in the room where a process can take place and that is my role to create the space whatever that means for the individual patient' (Expert 6).

Intuition, creativity, and courageousness: These three qualities are often named as being needed to find out what a patient wants and needs to find his own way. All three competences can be developed with certain intensity in the work with dying people:

'This can be intuitive knowledge that you rely on but also a high degree of expertise ... you develop a creativity from your attitude, look what the other person needs and the skills you

'All participants state that it is an important skill to establish a relationship with a critically ill patient'

'Core attitudes develop through personal and professional experience as well as inner contemplation with oneself'

need will evolve' (Expert 7).

Discussion

This is the first study describing the core attitude in palliative care by professionals. It demonstrates that professionals conceptualized core attitude as the inner attitude toward their life, the world, and the other person. Working in the field of palliative care is characterized by a high degree of authenticity, mindfulness, and openness manifesting itself in the relationship with the other person and made possible by certain professional competences.

As described by participants, authenticity and personal presence mean that the carer presents himself whole-heartedly in the relationship with the patient with his own personality in a professional role. The importance of authenticity in the doctor-patient relationship is emphasized by patients and their families missing it painfully in day-to-day medicine (Kirk et al, 2004). Authenticity does not depend on time available for the encounter. Mindfulness seems to be the more practical correspondent of authenticity. As it is stated in care ethics, the patient is in special need of mindfulness and care as an interrelated person, particularly when he is ill or dying (Conradi, 2001). The professional should be aware of the feelings, needs, and concerns of the patient. Moreover, mindfulness implies a non-judgemental stance of being open to the actual moment without evaluating it and being based on passionate interest in the other person (Lavoie et al, 2006).

Several participants named, explicitly or indirectly, elements of Carl Rogers' person-centred approach as central for their own core attitude. Respect, authenticity and honesty are closely related to Rogers' conditions congruence, acceptance, empathic understanding, and unconditional positive regard (Rogers, 1992). These conditions assure caring for the client 'as a separate person, with permission to have his own feelings, his own experiences' (Rogers, 1992).

The core attitude becomes apparent primarily in the relationship with the other person. The before mentioned key elements authenticity, honesty, openness and mindfulness are relational concepts (Fredriksson and Eriksson, 2003; Naef, 2006). The importance of relationships along with solidarity and community is also emphasized by other therapeutic approaches, e. g. care ethics (Gilligan, 1990) or the family systems therapy, which conceptualize the human being as a 'being in relation' (Nichols and Schwarzt, 2006). The relation-centred approach seems to be one essential element of palliative care (Doyle, 2004). It is remarkable that all the participants underlined the importance of this approach being in the centre of their work. This is confirmed by the work of Murray and Sulmasy, who emphasize that a person is a being-in-relationship: towards other persons, but also regarding relational aspects within the person (biopsychosocial-spiritual model) (Sulmasy, 2002; Murray et al, 2004).

The participants listed different competences as core elements in palliative care, e.g. perception, getting involved and creating space. Perception as the first step in developing a relationship is getting a first impression of another person that is, in a real sense, an im-pression; formative for the further process. Getting involved enables the professional to understand the other person – to listen attentively and mindfully where and how the other wants to go (Clark, 1999). The competences were often described by the paradox of 'active passiveness', but require a high degree of inner activity by the caregiver (Greenwood, 2007).

As described by the interviewed participants, core attitudes develop through personal and professional experience as well as through inner contemplation with oneself, especially in existential crises. In such a situation, a person can be confronted with the dissolution of his identity, and have to accept his mortality and limitations (Speck et al, 2004). The interviews underlined that caring for the dying is like a magnifying glass under which the own core attitudes become more visible.

The accurate definition of 'core attitude' seems to be difficult, because of its broad and fundamental character. All participants pointed out that core attitude is a slippery concept that is not easy to capture or to define. Furthermore, some difficulties in definition regarding 'core attitude in palliative care' might be related to the challenge to define 'palliative care' as an approach, which is still in debate (Pastrana et al, 2008). Although it is possible that the term 'core attitude' cannot be rigorously defined, qualitative analysis of the interviews showed that its nature can be approached by examples of its practical, scientific, or literary manifestation.

Surprisingly, nine out of ten interviewees stated that there is no specific 'palliative care core attitude' but emphasized the general validity of the concept. This issue has to be addressed in further studies.

There are several limitations to this study. First, we interviewed only professionals with a long-time experience in palliative care and

excluded younger and unexperienced professionals. The aim of the study was to get a first insight in the meaning of core attitudes in palliative care; therefore, we focused on professionals with knowledge and experiences in the field as well as a philosophical understanding of palliative care. Second, sampling of participants was made subjectively; therefore, it might have caused selection bias and it is possible that core attitude was conceptualized in a similar way. Third, as some professionals, e.g. physiotherapists were not represented, results may not fully represent all perspectives of this topic. Because of the study design and limited funding, not all professions could be included.

The value of this study is that it presents the first exploration of the understanding of core attitudes in palliative care described by experienced professionals in the field. Because of its broad and fundamental character it refers to other terms and approaches, such as core value, identity and view of the world. Therefore, there is a need for further studies, including different designs and different disciplines (e.g. philosophy, psychology).

Conclusion

Core attitude is conceptualized as one's inner attitude toward the world and other people. This study suggests that the work in the field of palliative care is characterised by a high degree of authenticity, mindfulness, and openness manifesting itself in the relationship with the other person and made possible by certain competences of care. As the participants pointed out, the concept of core attitude can be useful in education and training and in team work. The results give a first insight into the field and have to be validated in further studies. IJPN

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