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Conveying hope in consultations with patients with life-threatening diseases: the balance between supporting and challenging the patient

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ABSTRACT

Objective: There is limited knowledge about the communication of hope and denial in consultations with patients with life-threatening diseases on a practical level. In this study, we explored a real-life medical consultation between a doctor and a patient with incurable cancer, focusing on conveying hope.

Design and methods: We found one consultation especially suited for illustrating how a physician can convey and reinforce hope without attaching it to curative treatment. The consultation was analysed using a method for discourse analysis, where we took as a point of departure that discourse means language in use.

Results: The doctor communicated in a recognising manner, expressing respect for the patient as a subject and an authority of his own experiences. The doctor and patient succeeded in creating a good working alliance characterised by warmth and trust. Within this context, there was room for the doctor to challenge the patient's views and communicate disagreement.

Conclusions: The doctor succeeds in conveying and maintaining hope. Within a good working alliance with the patient the doctor can convey hope by balancing between supporting and challenging him. Exploring and grasping the patient's real concerns is essential for being able to relieve and comfort him and convey hope.

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Doctor–patient communication; life-threatening disease; hope; recognition; qualitative method; Norway



Introduction

Background

Communication is an essential part of medical work and a good doctor–patient relationship is crucial for the patient's experiences with being helped. Communication is an interaction between at least two subjects who simultaneously understand and interpret. The actions of one part influence the other's actions and vice versa. Patients tell a lot about what is necessary for a good relationship with the doctor, and expressions such as recognition, enablement, empathy, understanding, reassurance and confirmation are used [1–5]. In psychology, one talks about a therapeutic alliance, or a working alliance, in patient–provider relationships [4,5]. Psychotherapy is not dealing with special techniques, but about an interpersonal relationship created by the therapist and the client. The therapist's clinical attitude is nothing inside the therapist, but only what is expressed in interactions with

the patient. As Schibbye has stressed, interpersonal recognition is a relational concept based on mutuality, equality, and a basic respect for another person as a subject and authority of his or her experiences [4,5]. At a practical level, recognising behaviour involves listening, understanding, acceptance, tolerance and confirmation.

Good communication is especially demanding in consultations with patients with life-threatening diseases and research on the topic has addressed patients suffering from cancer in particular; often in terms of discussing prognosis. In such research, a recurring result is that patients with cancer want honest and complete information [6–10]. Both the majority of patients with early stage cancer [8] and patients with metastatic cancer [9] considered individualised and realistic disclosure from a confident, collaborative, supportive cancer specialist to be more hopeful than avoidance. Moreover, most patients, carers and professionals have expressed that concealing or distorting

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the truth does not engender hope [8]. Whereas oncologists often underscore the importance of being open and honest when discussing the end of life with patients [7], a minority of patients and carers expressed preferring nondisclosure and found hope in avoiding the truth [11,12]. The researchers emphasised the importance of respecting individual preferences. Patients have the right to refuse information. In particular, giving patients information that they do not want or at a time when they do not want it is not regarded as respecting individual autonomy [11,12]. The aspects of communication that patients have most valued are those that help them and their families to feel guided, that build trust, and that support hope [13]. Patients report being supported by clinicians who empathically respond to their emotions [6]: ‘Silence can “speak” loudly to tell the patients that the doctor is comfortable with them taking their time’ [6].

Hope and denial

When asked about what they perceive as most important in consultation, especially when discussing a poor prognosis, both doctors and patients have emphasised conveying hope as essential [6,7,11]. At times, hope is attached with an offer of treatment [14,15]; however, both doctors and patients have emphasised the importance of hope independent of prognosis and treatment possibilities [6,7,11]. In fact, patients seem able to maintain a strong sense of hope despite having accepted that their life expectancy is limited [11,16]. In such situations, patients have identified diverse sources of hope, which indicates the importance of professionals’ being able to explore and foster realistic forms of hope that are meaningful for individual patient [11]. Hope cannot be ‘given’, but patients can be directed toward new foci of hope and allowed to make individual decisions. The balance between hope and realism is vital. Some professionals have expressed that allowing patients to imagine a highly unlikely outcome can help them to come to terms with the reality of their situations at their own pace [17]. Meanwhile, other professionals have felt a responsibility to help patients refocus on realistic, achievable hopes in order to avoid wasting their time and energy with futile treatments. In particular, they related that withholding information could prevent patients from forming realistic hopes.

In literature about communicating with patients with incurable illnesses, death denial is a recurring theme. Zimmermann [18–20] performed a discourse analysis of the concept of ‘death denying’ in 30 articles from clinical and palliative care literature to

find that terminally ill patients and their families are often referred to as being ‘in denial’ of impending death. Meanwhile, Rayson [21] has described how we all live with a component of denial. He argues that mortality denial on a daily basis is a highly adaptive coping mechanism used to help all of us live as well as we can for as long as possible; goals that we all seek in the care of those with metastatic disease. Recognising the importance of denial as an adaptive coping mechanism should make all individuals more sensitive to the timing and context of difficult conversations about death and dying. Penson et al. [22] has argued that hope does not require any action at all; it is very passive but it requires very active listeners.

There are guidelines and advice for conducting conversations with patients with life-limited illness prognoses, and a great deal of literature has addressed how healthcare professionals should communicate with and bring hope to patients with incurable disease. Such studies are typically based on interviews with patients, family caregivers and healthcare professionals or on clinicians’ experiences. To our knowledge, however, research exploring communication about hope and denial on the practical level remains limited.

Aim

In this study, we explore a real-life medical consultation between a doctor and a patient with incurable cancer, by paying particular attention to conveying hope.

Design and methods

Materials

We accessed 380 videos from doctor–patient encounters at a university hospital in Norway previously collected as part of a randomised controlled trial evaluating the effect of communication skills training [23]. The Regional Ethics Committee for Medical Research in South East Norway approved our study. Fifty-nine hospital physicians, all less than 60 years old, and 380 patients had previously given broad consent for future communication studies based on the video material. From the 380 videos, we formed a randomised sample of 80 videos with physicians of both genders from different medical specialties, excluding paediatrics. We systematically watched the videos in search of consultations with patients with life-threatening diseases in which the doctors and patients discussed hope. Of the 80 videos, we identified four consultations in which we interpreted hope

to be an explicit topic of conversation. We selected one of those consultations, 22 minutes in length, which we found suitable to illustrate how a physician can convey hope without attaching it to any curative treatment. In order to present longer sequences of the doctor–patient interaction in detail, we chose to analyse only the one consultation, which involved neither clinical examinations nor tests. In that sense, the only medical outcome was the dialogue between the doctor and patient.

Discourse analysis

We analysed the consultation by using a method of discourse analysis [24–26]. The term ‘discourse’ has been used in many varying ways [27]. Here, we take as the point of departure that discourse means spoken language in use [24]. Discourse analysis assumes that language, action, knowledge and situation are inseparable and that context is vital. Nessa [24] conceives talk as an essential part of medical action and emphasises that talk is medical work. Since words affect the shaping of the world, both the structure of the communication (the medical consultation as the context) and the themes discussed (the patient’s illness) constitute the meaning of the dialogue as a medical conversation [25].

Discourse analysis can be divided into four steps: registration, transcription, coding and interpretation [26]. Following registration of the consultation on video, the first author transcribed the dialogue word by word into data – written text. We also watched the video several times to identify and take notes about the nonverbal communication related to each statement throughout the dialogue. Consequently, we summarised a few sections in which the doctor and patient discussed issues of less interest regarding hope. We read the transcript to gain an overall impression of the interaction and grasp the meaning as a whole. As a third step, we performed coding. That is a methodological procedure to classify what happens in a conversation and to produce text-based units suitable for further analysis, by dividing the consultation into episodes according to themes discussed in [Box 1](#). An episode is a section of discourse with a continuous topic and linguistic markers from its start and finish. The fourth step, interpretation, is a reflexive process between data material and theory. Our interpretation was carried out within perspectives on conveying hope. We situated our knowledge about doctor–patient communication as a starting point, i.e. a medical conversations in the context of consultation.

Results

A case story: I am doing fine

A man in his mid-50s has visited an outpatient clinic for a follow-up meeting with a specialist in internal medicine. The patient is HIV-positive and has incurable lung cancer. The doctor begins the consultation with a question that signals that he knows the patient well from earlier consultations (See [Box 1](#)).

Interpretation and discussion

The aim of our study was to explore a real medical consultation in which a doctor talks with his patient with incurable cancer from the perspective of conveying hope. Our analysis showed how the doctor contributes to conveying hope by balancing between challenging and supporting the patient, who himself introduces themes of hope to the conversation. Trying to grasp the patient’s concerns, the doctor listens to the patient and explores his perception of the situation. Without understanding what actually worries the patient, the doctor cannot comfort him or contribute to conveying and reinforcing hope. At the same time, the patient’s potential denial of his life-threatening illness is explored. In this case, the doctor does not reveal any denial in the patient. Below, we elaborate on those findings by giving an account of the interpretation process and describing how collaboration between the doctor and patient creates and strengthens hope.

Conveying hope – balancing between supporting and challenging the patient

The consultation begins with the patient’s recounting his journey and the doctor’s listening to him. In their engaged discussion about ice hockey, the doctor communicates that he and the patient have that interest in common. The patient seems comfortable in the situation. This introduction can be characterised as small talk without medical interest. The doctor–patient relationship is, however, essential in medical work. There is argued that it is important that the doctor and patient function as a team without hierarchy in a mutual, equal therapeutic alliance [5,22]. We understand their small talk as the doctor’s way of building and reinforcing his relationship with the patient, recognising him when he communicates equality and respect to him by valuing his activities. The doctor’s questions are also highly medically relevant. The patient’s story informs the doctor about the patient’s health condition, how he manages his illness, and how

Box 1. A case study: I am doing fine.

Episodes	Coding
<p>1 The doctor has fetched the patient, and they take a seat: the doctor behind the desk and the patient in the chair beside him. The doctor asks about the patient's recent journey, and the patient tells him enthusiastically about a successful ferry trip to Copenhagen. Later on, they talk engagingly about ice hockey and their shared favourite team's chances of winning, before the patient wraps up their talk on the topic, followed by a brief period of silence.</p>	<p>This opening episode addresses the patient's journey and ice hockey. We interpret the pause at the end as the patient's signal to the doctor that it is his turn to lead their talk.</p>
<p>2 D: How are you? P: Very good! [Eager, engaged, almost cheerful.] But a lot of hassle. I'm meeting the priest afterward. D: Yes. [Kindly, with a slightly curious tone of voice, he looks interested in the patient.] P: I could've set it aside for others [the planning for the funeral], but I like to have things arranged in advance, you see. But, I haven't had a bad day since I last spoke with you. [Content tone of voice emphasises what he's saying. He shakes his head.] [A short pause occurs.] D: You know what: It makes me happy to hear you say that. [Kindly, with a warm tone of voice.] P: Yeah, seriously. Not a single day. [Shakes his head again and smiles.] D: None at all? P: No. [Shakes his head and smiles again.] [A short pause.]</p>	<p>The doctor initiates this episode, in which he discusses the patient's condition with him. The episode ends with a pause.</p>
<p>3 D: Have you been at the [cancer] hospital? P: No, I'm heading there on Monday. I actually don't have time to go to the hospital. I'm going to travel to a lot of cities in Europe during most of April and all of May, by train. [Shares some details about the journey.] D: Mm. Are you travelling alone or with any of your friends? P: No, just alone. [A short pause occurs.]</p>	<p>The doctor introduces a new theme, but the patient again brings up the plans for his upcoming travels.</p>
<p>4 D: How are your friends dealing with your situation as time passes? You said they— cried a lot. P: Yeah. They're not entirely sure what to say. That's the case, you know. You kind of don't know. How am I supposed to talk? What am I supposed to say? Am I supposed to ask him about something or not? [Chuckles.] D: No. [Kindly, affirmative tone of voice.] P: But a lot of them are all right. They talk about it when I start [to talk about it]. [Chuckles heartily.] D: Yes. [Chuckles lightly.] P: 'How are you?' some of my friends ask me on SMS. 'I haven't left yet', I answer. [Chuckles warmly and adjusts his sitting position.] I think that's okay. [A pause occurs.]</p>	<p>The doctor initiates this episode by asking about the patient's relationships with his friends, and the patient ends the episode.</p>
<p>5 D: You have a black sense of humour, don't you? [Kindly, affirmative.] P: Yes, but I must have it. If you don't, you don't live, you know. D: Yeah, that's true. [Affirmative.] P: Honestly, you have to stay alive, because in dying, there's just a lot of paper work to do. It's a bloody hassle. [A slightly flip tone of voice. Looks at the doctor and shakes his head.] D: Mm. [Chuckles.] P: I mean, how am I going to be buried, am I going to be cremated, is it going to be like this or like that— D: Do you think about that? P: Yes, I think it's important that I arrange it myself [nods, looks at the doctor]—that everything is decided, like on a menu and that I just tell my landlady, 'Can you make sure that it is done this way?' I'll give her responsibility for my funeral. Otherwise, it will be left for my children, whom I haven't seen in years, so I see no reason why they should be involved now. D: Do they know how you're doing? P: No, no, no. [Shakes his head.] I have no intention to tell them that. [Determined.] I don't want them to know anything. [Calmly.] I don't see why they [the children] should come to the funeral and act really sad. It's more or less the same as stopping in the street when you see a coffin and being like, 'Oh my God—now I'm really sad', right?</p>	<p>The episode is initiated by the doctor, who meta-communicates about the patient's using black humour as a coping strategy. In the discussion, the patient admits not informing his children, which the doctor challenges. However, the episode ends with the doctor's acceptance of the patient's choice.</p>

(continued)

Box 1. Continued

Episodes	Coding
<p>[Rubs his eyes.] D: No, that's not exactly the same. P: No, but it's approximately the same. [Underscores what he is saying.] D: I understand what you're saying. P: They have absolutely no relationship with me. [Shakes his head.] D: No. [A short pause occurs.]</p>	
<p>6 D: You're seeing the priest today. Are you the one who wanted to meet him? P: Yes. [Nods.] I met with the social worker, and I told her that I had a couple of things I wanted to ask [the priest] about, so she looked into it. It's the first time I've ever done it, so I'm not entirely sure where I should enquire or whom I should talk to about anything. [Neutrally.] It's unknown territory for me. D: I get that. But I'm happy to hear that you're doing well, and I actually believe that you mean it, because I know you pretty well. [Kindly, addresses patient.] P: Yes, I am. I'm as snug as a bug. I really don't have time to lie down, because there is so much going on all of the time. So I don't intend to just lie down in May and say that I hope for everything to end soon. D: No. P: If I'm in good shape, I'm going to celebrate my birthday in Rome in August. [Pause.]</p>	<p>The doctor initiates this episode by asking about the priest and expresses satisfaction and pleasure with the patient's well-being. The patient ends the episode.</p>
<p>7 D: You have of course read on the Internet, so there is no point in hiding anything from you. [Patient nods.] But that is, after all, only statistics. P: [Leans forward, shoots out his arms, and speaks engaged:] Yes, I know, but I've found out something, you see. [Leans back again, speaks eagerly and gesticulates with his hands.] There are, after all, close to 40 per cent who live longer than a year. If I had been given those odds, I would have given everything, right. But now I've found out that among those, the 60 per cent who die within a year, a lot of them just lie down and give up, I think. That's what I think. [Determinately.] D: You might be right about that. [Affirmative.] P: Yes, I actually believe that, because the statistics, you know, say nothing about how to handle it. The mental part is also preventive in every disease, right? D: That's true. We know that from research. [With confidence.] P: Being depressed and feeling discouraged all of the time will never make you healthy, right? D: There's no doubt about that. It's shown in a lot of research that those who look brightly at it, even though it all might look pretty dark, live longer. That's no joke. P: Yes, I'm certain about that. And it suddenly hits me that that's not peculiar. If there's a truth in that, then I'll be around for more than one or two years, right? D: Yes. [A short pause occurs.] P: Yes, that's what I think. [Determinately.] D: Yes, it's true.</p>	<p>The doctor introduces the episode and the themes of prognosis and managing the situation. The episode ends when the patient and doctor agree on the importance of having a positive attitude.</p>
<p>8 D: Is there anything I can do for you? P: No, what could that be? Nothing. [Shakes his head.] D: You have to continue to come to us at least, to continue to take your pills. P: Okay. I've forgotten, or neglected, to take them twice [shows two fingers], and that's the two times when I've been hospitalised here. D: Yes, I wouldn't preach, but it's important not only if you're going to have radiation therapy and maybe some chemotherapy, but also to keep the [HIV] virus at bay. [Talks with authority.] But, it's also important, as you said, to hold on to the everyday activities and your life. [Kindly, with warmth.] P: Yes, that's clear. D: Because it's a way to give up if you don't do it. P: And if I don't do it, then I have lost— [A pause occurs.]</p>	<p>The doctor initiates this episode by offering further help and emphasises the importance of taking the HIV medication. The episode ends when the patient's talking fades out.</p>

(continued)

Box 1. Continued

	Episodes	Coding
9	<p>The doctor brings up the trip to Europe again, and the patient elaborates details about the trip with joy and that he has been granted disability pension, as well as an endowment.</p> <p>P: I told the social worker that I would like to see Rome one more time. She arranged the paperwork, and now I've been given 780 euro in gift for the travel and recreation.</p> <p>D: That's great! [With empathy and joy in his voice.]</p> <p>P: I almost fainted! It made me tear up.</p> <p>D: Yes, it was very sympathetic that she arranged that for you. [Sincerely interested, empathy in his voice.]</p> <p>The patient continues to talk about his travel plans. The doctor answers with 'Mm' and 'Yes, right' from time to time, and the patient finishes talking.</p>	<p>The doctor initiates this episode by again referring to the patient's journey, and the episode seems to end when the doctor gives less attention to the patient's account.</p>
10	<p>D: I would like to ask you something: Has your lung doctor talked with you about chemotherapy?</p> <p>P: No. [Shakes his head.]</p> <p>D: You know nothing about the follow-up treatment from the [cancer] hospital?</p> <p>P: No, nothing. I haven't heard anything from—</p> <p>D: I will contact your lung doctor and hear what he has to say, and then I'll give you feedback.</p> <p>P: But there's no rush for me. I've gotten a clear message about the disease, and I'll stick to that—that there's nothing to do about it. There is talk about radiation to relieve the pain? [Acts slightly sceptical.] It is a relieving effect I'll get? If you don't experience any pain, then you can't relieve anything. Then it is preventive, is what it's supposed to be called. [The patient sits bent forward, toward the doctor, and partly states, partly asks.]</p> <p>D: Yes, well, there is a disagreement regarding the use of the word. I understand what you're saying. But this radiation is to prevent the tumour from pressing against something, even though it doesn't hurt. It is to reduce the tumour. It is hard to control when it first starts hurting.</p> <p>P: <i>Relieving</i> is bad choice of word, then— [Cheerful voice, underlines what he is saying.] [The doctor chuckles.]</p> <p>[A short pause occurs.]</p> <p>P: Oh well, I am doing fine. But I have given a clear message to the doctors that I'm going on the trip, even if I would have to run off from the hospital. They almost bursted into laughter. [The doctor laughs a little.] Though, I won't do that, but—</p> <p>[A pause occurs.]</p>	<p>When initiating the episode, the doctor seems to prepare for an introduction into the theme of palliative treatment.</p>
11	<p>They talk for a while about different medical examinations, and the doctor writes a referral that he gives to the patient.</p>	<p>This episode addresses practical matters.</p>
12	<p>Before the doctor finishes by saying 'Good bye', he asks the patient to contact him if there is anything else that needs to be discussed.</p>	<p>The doctor initiates this episode, which wraps up the consultation.</p>

D: Doctor; P: Patient. Nonverbal communication is shown in brackets. Episodes are numbered for reference in the coding and discussion.

he enjoys life. In reply to the doctor's question, the patient several times convincingly tells him that he is fine (Episode 2). The doctor listens attentively to his account; he seems to tune in to the patient's feelings, share his feelings, and after a short pause, responds that he is delighted to hear that the patient is doing fine. We believe in the authenticity of the doctor's response and interpret the doctor as being supportive and respectful. We think that he shares the patient's feelings and, at the same time, does not discount his own, given his awareness that the patient's feelings are the patient's. In Episode 3, the doctor asks about treatment at the hospital; the patient, however, introduces his plans for a trip to Europe, and the doctor

continues talking about that theme with interest. In Episode 4, the doctor relates to what the patient said earlier when he asks about the patient's friends. The doctor listens and gives the patient time and space to express his thoughts, and they share the patient's experiences with his friends' feelings of sorrow. In Episode 5, when the doctor meta-communicates that the patient has black humour, we interpret the doctor's observation as recognition of the patient's way of managing his situation. In accordance with Cassell's emphasis on an ill person's functioning [28], the doctor seems to appreciate the patient's functioning well and communicates his observation to the patient as a way to support him. The patient's

response to the characterisation indicates that he feels understood and appreciates the doctor's sympathy. Thereafter, a longer conversation about the patient's funeral and visit to the priest follows, in which the doctor displays a sympathetic, supportive attitude characterised by interest in the patient's thoughts and plans. When the patient tells the doctor that his children do not know that he is mortally ill, the doctor, however, challenges the patient's view and explores the patient's reason for not wanting to inform his children. The doctor disagrees with the patient and attempts to convince him. When the patient, upholds his decision not to inform the children, the doctor communicates that he disagrees with the patient and that he, at the same time, understands and respects the patient's choice. According to Schibbye, recognition embodies a fundamental respect for the other person's right to his or her own perspective, and that a relationship of recognition can bear disagreement [5]. In Episode 6, we again interpret the doctor as being empathic and supportive when he emphasises his delight in hearing that the patient is doing well, perhaps in an effort to restore harmony following their discussion about possibly involving the patient's children in his end-of-life affairs. In Episode 7, the doctor introduces the prognosis, and it becomes clear that the patient realises his serious medical condition and poor prognosis. The doctor seems to want to comfort the patient by saying 'but that is, after all, only statistics', and remarkably, the patient succeeds in arguing that his illness management will improve his prognosis. Salander et al. [16] have also found that patients with fatal forms of cancer have been able to use various cognitive manoeuvres to create a sense of protection and unite reality and hope. The doctor confirms the patient's estimations of the situation by referring to scientific arguments, yet perhaps drawing upon them slightly more than what is scientifically based. In our opinion, that communication captures the essence of hope described by Penson et al. [22]: 'Hope is ... at one and the same time both an anticipation of something positive and a positive acceptance of the inevitable'. Penson et al. [22] have argued that if one assumes what hope means for the patient, then a serious rupture in trust and communication has occurred. By contrast, this doctor awaits the patient's reasoning and refrains from assuming what the patient's hope involves. The episode ends with an agreement between the doctor and patient that a person's attitude toward illness bears consequences for his prognosis. However, we estimate that such a stance does not derive from denial. It would perhaps be both improper and mistaken to challenge the

patient's understanding that 'being depressed and feeling discouraged all of the time will never make you healthy'. In Episode 8, the doctor requests the patient to continue coming to control and argues for the importance of taking his medicines. We interpret this as the doctor's seizing the opportunity to both challenge and support the patient to reach his goal in life and to proceed with his travels. They seem to cooperate about maintaining hope. In Episode 10, they disagree on the meaning of palliative treatment. The patient argues that since he has no pain to ease, then the treatment should be called preventive, not palliative. The word 'palliative' can be associated with end-of-life treatment and thus threaten the patient's hope [29]. The doctor does his best to convince the patient that the disagreement is only linguistic. Then the patient again affirms that he feels well, perhaps to comfort both himself and the doctor, re-establish harmony in the conversation, and ultimately, maintain hope.

A therapeutic alliance

The importance of building an equal doctor-patient relationship – a therapeutic alliance – by attentive listening, recognition, responsiveness and guidance in communicating with patients, particularly those with incurable illness, is emphasised in the literature [2,4,13,22]. In the video, we could observe attentive listening; the doctor tunes in and seems to share the patient's emotions. He remembers what the patient told him, shows interest, and further explores different topics by asking about the patient's travel plans, ice hockey and funeral preparations, all of which gives the patient space to tell. The doctor acknowledges the patient's choices, wishes and goals, as well as the resources with which he has dealt with his situation: black humour, a creative use of statistics, and an appetite for living. Hagerty et al. [9] have found that patients discuss quality of life and the fulfilment of goals in order 'to get on with life, make sure you make the most of it for as long as you can; set a distant goal and work like hell to go there'. That appraisal aligns well how the patient in our case apparently manages his situation. We do not know whether it is realistic for the patient to pursue his travels, but indicating doubt might not help the patient. Penson et al. [22] have written, 'There is no thing as false hope, there is just hope. Interfering with that hope is risky. We have to do all the right stuff we want to do medically but also be hopeful in a way that resonates with patients and families'. Studies have found that

patients' sense of hope is strong despite their acceptance a having limited time left in their lives [11,16].

We interpret the doctor's actions – his statements and gestures – as conveying hope by balancing between supporting and challenging the patient in the consultation. The doctor seems to emphasise and succeed in creating an equal and mutual relationship with the patient: a therapeutic alliance in which they work well together. A warm atmosphere of mutual recognition characterises their interaction. During the consultation, the doctor tries to grasp the patient's understanding of his situation by exploring and challenging what that situation means. He avoids seeming to know what is best for the patient. The patient seems to trust the doctor, dares to communicate his opinions, and even raise objections.

Overall, our interpretation is that the patient feels well during the consultation. Campbell et al. [6] have argued that though the doctors cannot soften or eliminate the facts related to a lethal cancer diagnosis, patients have reported being supported by clinicians who empathically respond to their emotions. The doctor in our case does just that, and we think that the patient feels that he has been helped in the consultation.

Ensuring the medical agenda

Initially, it seems that the patient dominates the consultation. However, the doctor in fact initiates nearly every episode, introduces most of the themes, and seems to have good control over the consultation. The structure of the medical consultation is easy to recognise. The doctor allows the patient to discuss different topics and listens with interest to his accounts, yet repeatedly poses questions in suitable situations without interrupting the patient. He asks about the patient's condition, his friends, and his children and mentions the prognosis, medication and treatment plan. The patient receives time and space to share his stories but seems to finish his speech in a way that affords room for the doctor's agenda as well. Their interaction function well and seems harmonious without competition for an understanding of reality, and both parties appear to be pliable and to facilitate turn-taking. At the same time, the doctor displays respect for the relationship with the patient and for the medical agenda.

Methodological considerations

Registration with video is the most commonly used method for collecting qualitative data from doctor–patient consultations, for such interactions are precisely

recorded without overly interfering with the communication [26]. We found that coding the dialogue in episodes was an appropriate way of classifying what happened in the consultation and of producing text-based units suitable for further analysis.

We found the method of discourse analysis to be suitable for analysing the consultation. Drawing upon literature about hope and denial, we based our analysis on our interpretation of the patient and doctor's conversation and interactions. By presenting most of the consultation, we have provided readers with clues to understanding our interpretation. We have sought to describe the method in detail so that readers can follow the process. We argue that the chosen consultation was suitable for illustrating how to convey hope by balancing between supporting and challenging patients. Within the doctor's calm, recumbent attitude and style, his communication is clear, and it is easy to grasp his respectful, recognising way of approaching the patient. The patient has no symptoms, has an extraordinarily positive attitude, and brings with him many elements understood as aspects associated with hope; as a result, the consultation seems very easy for the doctor. Although we cannot know how the doctor in our case would have managed meeting a patient in pain, a hopeless state, or an existential crisis, we think that physicians can learn communication skills from his example. Since it is an easy consultation for the doctor, he can clearly demonstrate ways to create a therapeutic alliance and exhibit a recognising attitude in practice.

Conclusions and practical implications

In this article, we have described how a doctor conveyed hope to his patient with incurable lung cancer, balancing between supporting and challenging him. The doctor communicated in a recognising and respectful manner, and he and the patient succeeded in creating a good working alliance characterised by warmth and trust. The context afforded room for the doctor to challenge the patient and communicate disagreement. Patients and doctors are different, and there are many ways of communicating hope. Characteristic of this doctor was his calm attitude and affirmative, recognising communication using few words and small gestures. We argue that our results can be relevant even for patients in pain, in grief, or who struggle with regret and loss of meaning. A prerequisite for bringing hope to patients, especially seriously ill ones, is creating a warm working alliance guided by mutual recognition as a relational concept involving mutuality, equality, and a basic respect for the other person as a subject and authority of his or

her experiences. The doctor and patient in our case knew each other in advance and seemed to have a good relationship. During the consultation, the doctor seized opportunities that arose to build and reinforce unity and trust. Exploring the patients' view and challenging his meanings became essential to grasping his real concerns. We think that our results also can be applicable to other medical consultations in corresponding settings, specifically in primary healthcare. Cancer patients represent a significant patient group for general practitioners and they see themselves as key workers in end-of-life care [30]. By and large they feel confident, but they feel less competence about taking care of social issues [30]. General practitioners usually have long-lasting, trusting relationships with their patients and would perhaps feel more confident by focusing more on exploring patients' concerns by challenging them and recognising their right to their personal experiences and perspectives.

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