How can We Improve the Communication Skills between Doctors and the Relatives of Postarrest Patients Receiving Home Palliative Care Services?

Postarrest Evde Bakım Hizmeti Alan Hastaların Yakınları ile Doktorlar Arasındaki İletişim Becerilerini Nasıl Geliştirebiliriz?

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ABSTRACT

Objective: It is more complicated to include the relatives of the patients in this process of the patients who are discharged home after cardio pulmonary resuscitation (CPR), especially those who are dependent on household mechanical ventilator and with the lack of communication skills to describe and express their own conditions. The aim of this study is to evaluate the communication between the doctors and the relatives of the postarrest patients who are followed at home, to contribute to the improvement of communication skills identifying the barriers for communication and facilitating factors.
Methods: This descriptive study was carried out with 76 relatives of 44 palliative patients who survived after cardiopulmonary arrest and were discharged from hospital between June 2016-2018. Of the patients who survived at the end of the first year; A total of 76 relatives who were over 18 years of age and were able to read/write Turkish and consented to participate were included in the study. All patient relatives consisted of family members.
Results: A communication attitude scale with a 5-point Likert scale was applied to 76 patients' relatives of total 44 palliative patients who were included in the study. There was statistically significant difference in the confidence sub dimension between the genders of the patients' relatives. There were statistical differences in the information, empathy and confidence sub dimensions of the relatives of the patients. Statistically significant difference occurred between the frequency of visits by the relatives of the patients who received homecare and empathy and trust sub dimensions. There was statistical difference between the chats of the relatives of the patients with the physicians in the sub-dimension of empathy. In terms of the characteristics of the doctors that are important for the relatives of the patients, "giving good news" group was statistically different in the informative and empathy sub-dimensions and " giving correct information "group was statistically different in informative, empathy and confidence sub-dimensions and "having a sympathetic attitude"group was statistically different in the information and confidence sub dimensions.
Conclusions: Patient-doctor communication is basically a communication between two people and requires mutual information support, respect and trust. Doctors may not be born with good communication skills, but since a doctor is expected to be the professional side in this communication, a doctor should be one to direct the communication and to solve the problems.
We believe that communication between the patient's relatives and the doctor can be increased improving the existing communication skills of the doctors through various training programs and good samples of communication scenarios.

Key Words: Palliative care, physician-patient relations, communication

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ÖZET

Amaç: Kardiyo pulmoner resüsitasyon (KPR) sonrası hayatta kalarak eve taburcu olan özellikle ev tipi mekanik ventilatöre bağlı hastaların kendi durumlarını tanımlayacak ve ifade edecek iletişimden yoksun olması ile beraber, bu sürece hasta yakınlarının da dahil olması daha karmaşık bir yapı oluşturmaktadır. Bu çalışmanın amacı postarrest evde takip edilen hastaların yakınları ile doktorlar arasındaki iletişimi değerlendirerek, iletişim önündeki engelleri ve kolaylaştırıcı faktörleri belirleyip iletişim becerilerinin gelişmesine katkı sağlamaktır.
Yöntem: Bu tanımlayıcı çalışma, Haziran 2016-2018 tarihleri arasında kardiyo pulmoner arrest (KPA) sonrası hayatta kalarak hastaneden taburcu edilen 44 hastanın 76 hasta yakını ile yapıldı. Çalışmaya birinci yıl sonunda hayatta kalan hastaların; 18 yaş üzeri, Türkçe okuyabilen ve yazabilen, çalışmaya katılmayı kabul eden 76 hasta yakını dahil edildi. Tüm hasta yakınları aile üyelerinden oluşuyordu.
Bulgular: Çalışmaya katılan toplam 44 hastanın 76 hasta yakınına 5'li likert ölçeği ile bir iletişim tutum ölçeği uygulandı. Hastanın akrabalarının cinsiyetleri arasında güven alt boyutunda istatistiksel fark vardı. Hasta yakınlarının bilgilendirme, empati ve güven alt boyutlarında istatistiksel farklılıklar vardı. Evde bakım alan hastaların yakınlarının doktorların ziyaret sıklıkları ile empati ve güven alt boyutları arasında da istatistiksel olarak anlamlı fark oluşmuştur. Empati alt boyutunda hasta yakınlarının hekimlerle yaptıkları sohbetler arasında istatistiksel olarak fark vardı. Hasta yakınları için; hekim özellikleri açısından, bilgilendirici ve empati alt boyutlarında ''müjde verme'' grubu istatistiksel olarak anlamlı derecede farklı, ''doğru bilgi verme'' grubu ise bilgilendirici, empati ve güven alt boyutları ile ''sempatik tutuma sahip olma'' grubu bilgi ve güven alt boyutlarında istatistiksel olarak farklıdır.
Sonuç: Hasta yakını-doktor iletişimi temelde iki insan arasındaki bir iletişimdir ve karşılıklı bilgi desteği, saygı ve güven gerektirir. Doktorlar iyi iletişim becerileri ile doğmamış olabilirler ancak bu iletişimde profesyonel tarafın doktor olması beklendiğinden, iletişimi yönlendirecek ve sorunları çözecek bir doktor olmalıdır. Hasta yakını ve doktor arasındaki iletişimin, doktorların mevcut iletişim becerilerini çeşitli eğitimlerle ve iyi iletişim örneği senaryoları ile geliştirerek arttırabileceği kanaatindeyiz.

Anahtar Sözcükler: Palyatif bakım, hekim-hasta ilişkisi, iletişim

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INTRODUCTION

It is more complicated to include the relatives of the patients in this process of the patients who are discharged home after cardio pulmonary resuscitation (CPR), especially those who are dependent on household mechanical ventilator and with the lack of communication skills to describe and express their own conditions. It is important that the communication between the doctor and the relatives of the patients be as reliable as the communication between the doctor and the critical patients. A good communication is the most important step in patient-centered care in order to exchange information with the patient, to make decisions about treatment and to determine the needs and desires of the patient (1,2). In various publications, it is stated that the contribution of the doctor in the communication of doctor-patients' relativesis 60-70% (3,4). Therefore, the development of communication skills should have a placein medical education (5,6). Although there are many publications in the literature stating the communication between the patients and the physicians, the number of the papers studying the communication skills between the relatives of the patients and doctors is very limited (7,8).

The aim of this study is to evaluate the communication between the doctors and the relatives of the postarrest patients who are followed at home, to contribute to the improvement of communication skills identifying the barriers for communication and facilitating factors.

METHODS

Study design and patients

This descriptive study was carried out with 76 relatives of 44 palliative patients who survived after cardiopulmonary arrest (CPA) and were discharged from hospital between June 2016-2018. Of the patients who survived at the end of the first year; A total of 76 relatives who were over 18 years of age and were able to read and write Turkish and consented to participate were included in the study. The relatives under 18 years old, the relatives whose patients could not survive in the first year after discharge and the relatives who did not consent to participate were excluded from the study. All patient relatives consisted of family members. The scale used in this study based on the patient-physician communication scale used by McCroskey in 1970 for measures of communication (9). As a result of observations made in intensive care units, the questions were reviewed. The modified final scale; was obtained revising the original version made by McCroskey et al.

The attitudes of the patients' relatives towards communication were evaluated with 23 questions based on the 5-point Likert communication attitude scale (5 = always, 4 = usually, 3 = occasionally, 2 = rarely, 1 = never). In calculating the total score in the communication scale; answers according to whether the statement is positive/negative; it ranks from 1to 5 or from 5 to 1. Factor analysis is performed to select the most distinctive items. In item analysis, items that show high correlation with all scale scores are kept, others are discarded. Information, empathy and trust sub dimensions were evaluated with these questions. The score of each dimension was calculated by averaging the scores given to the questions of that dimension. However, before the scores of the language and communication size of the physician were calculated, the scores of 2nd, 18thand 22nd questions were reversed (inverse Likert) since the statements in the scores of these questions were configured negatively compared to the statements in the other questions. The questionnaire is available online (7).

Ethical approval

Ethics approval was obtained from the Ethics Committee of OOOOOO University of Medical Sciences (NMRR-2019/13).

Statistical analysis

Statistical Package for Social Science (SPSS, 21.0 SPSS FW, SPSS Inc., Chicago, IL., USA) were used for statistical analysis of the data. Frequency (n) and percentages (%) were obtained for descriptive data. One-way analysis of variance (One Way ANOVA F test) and significance test (Student's t test) of the difference between the two means were used for the normally distributed numerical data of patients' relatives. Kruskal-Wallis variance analysis and Mann Whitney U test were used for numerical data that did not conform to normal distribution. When the difference between the groups was found as a result of the variance analysis, Fisher's LSD (Least Significant Differences) test was used to determine which group or groups the difference was caused by. This LSD test was chosen because even smaller mean differences are likely to be significant. The significance level was taken as 0.05.

RESULTS

A communication attitude scale with a 5-point Likert scale was applied to 76 patients' relatives of total 44 palliative patients who were included in the study. The scores of the responses of the relatives of the patients about the informing, empathy and trust subscales in the 5-point Likert-type communication attitude scale is shown in Table 1.

Table 1: The scores of the responses of the relatives of the patients about the informing, empathy and trust subscales in the 5-point Likert-type communication attitude scale

Patient's Relative Scale	Always (%)	Often (%)	Occasionally (%)	Rarely (%)	Never (%)
Informing scale					
1- I think that I get enough information about my patient	61.0	14.6	17.1	7.3	0.0
2- After the interview, I still feel being informed insufficiently	31.7	14.6	19.6	0.0	34.1
3- I think that I have learned in every detail the medical conditions associated with my patient	63.4	24.4	9.8	0.0	2.4
4- I get all the information about my patient during the interviews with the doctor	68.2	22.0	4.9	4.9	0.0
5- Doctors tell me about the medical conditions in my language	75.6	17.1		2.4	0.0
6- I would like to receive the medical information about my patient while I am with my patient	43.9	22.2	4.9 7.3	14,6	12.0
7- I want to be informed about my patient away from the patient but at home	46.3	24.4		17.3	9.8
8- Doctors answer all my questions	70.7	19.5	2.4	4.9	0.0
			4.9		
Empathy scale					
9- I think my doctor cares about my patient	73.2	12.2	0.0	2.4	12.2
10- I think the doctor cares about me as a patient relative	70.7	12.2	4.9	2.4	9.8
11- I try to think calmly when I have problems with the doctor	48.8	31.7	12.2	2.4	4.9
12- The friendly approach of the doctor makes it easy for me to establish a close relationship	63.4	17.1	12.2	0.0	7.3
13- The doctor tells me what to do about my patient and it makes my job easier	87.8	12.2	0.0	0.0	0.0
14- I think my doctor is treating patients equally	73.2	7.2	9.8	9.8	0.0
15- Intensive care doctors are friendly	68.3	12.2	14.6	4.9	0.0
16- Intensive care doctors act sympathetically	73.2	12.2	9.8	2.4	2.4
17- I think I receive the necessary support from the doctors	68.3	17.1	12.2	2.4	0.0
Trust subscale					
18- I feel peaceful after the interview with the doctor	65.9	14.6	17.1	2.4	0.0
19- I feel nervous during the interview	31.7	14.6	17.1	19.5	17.1
20- I trust the doctor's words during the interview	73.2	17.0	4.9	4.9	0.0
21- I can reach my doctor when I need him/her form y patient	51.3	26.8	14.6	0.0	7.3
22- If a problem occurs in my patient, the doctor is responsible for it	26.9	14.6	14.6	14.6	29.3
23- Home care doctors give confidence	70.7	14.6	9.8	4.9	00

There was statistically significant difference in the confidence sub dimension between the genders of the patients' relatives. There were statistical differences in the information, empathy and confidence sub dimensions of the relatives of the patients (p=0.004, p=0.019 and p=0.001, respectively). According to the description of the physicians by the patients' relatives, there was statistical difference in information and empathy sub dimensions (p=0.041 and p=0.039, respectively), as well as information and empathy sub dimensions between the age groups of the patients' relatives (p<0.001). There was statistical difference in the confidence sub dimension (p=0.040) according to being close relatives of the patients. In addition, there was statistically significant difference between the frequency of seeing the relatives before the patients began to receive homecare service and empathy and trust sub dimensions (p=0.005, p=0.001 and p=0.008, respectively).

Statistically significant difference occurred (p<0.001) between the frequency of visits by the relatives of the patients who received homecare and empathy and trust sub dimensions. There was statistical difference between the chats of the relatives of the patients with the physicians in the sub-dimension of empathy (p<0.001). Regarding the conditions that relieved the stresses of the relatives of the patients, ''talking with the doctor " showed a statistically significant difference in the empathy and confidence sub dimensions (p=0.001 and p<0.001); "Being with the patient " was a statistically significantly different in the informative and empathy sub-dimension (p=<0.001 and p<0.001) and "praying" in the informative sub-dimension (p = 0.001). In terms of the characteristics of the doctors that are important for the relatives of the patients, "giving good news" group was statistically different in the informative and empathy sub-dimensions (p=<0.001 and p= <0.001), and " giving correct information "group was statistically different in informative, empathy and confidence sub-dimensions (p=0.037, p=<0.001 and p=0.005 respectively), and "having a sympathetic attitude"group was statistically different in the information and confidence sub dimensions (p=0.018 and p=0.001) (Table 2).

Table 2/Part 1: Comparison of socio-demographic datas of the patient’s relative about the informing, empathy and trust subscales of the attitude scale

Characteristics	n	Informing Median(25th-75th Percentile)	p	Empathy Median(25th-75th Percentile)	p	Trust Median(25th-75th Percentile)	p
Patient’s relative gender							
Male	51	38 (22-42)	0.486	43 (26-43)	0.093	25 (16-30)	***0.011***
Female	25	37 (20-46)		42 (26-45)		24 (12-28)	
Education level							
Iliterate	2	41 (34-41)[a]		41 (40-45)		35 (33-46)	
Elementary school	23	36 (28-41)[b]	***0.004***	42 (31-45)[a]	***0.019***	28 (18-31)	***0.001***
Secondary school	13	37 (27-42)[ab]		41 (20-45)		23 (18-31)	
High school	22	36,5 (20-46)		40 (28-43)		28 (19-33)[a]	
University and ↑	16	36 (18-42)		37 (22-46)[a]		24 (18-33)[a]	
How would you describe the doctor?							
Legal technical advisor	6	35 (23-42)[a]		42 (22-46)[a]		26 (16-30)	
Recommended	12	35 (18-39)		41 (18-46)[b]		22 (11-30)	
Friendly	8	37 (29-41)	***0.041***	42 (34-46)	***0.039***	25 (20-30)	0.207
Protector	45	44 (32-45)[a]		46 (24-46)[a,b]		22 (16-29)	
Other	5	33 (29-40)		41 (31-46)		26 (23-28)	
Age (years)							
<35	22	30 (20-45)[a b]	***0.001***	35 (18-46)[a b]	***0.001***	25 (18-30)	0.167
35-50	30	35 (25-42)[a]		42 (30-46)[a]		26 (19-31)	
>50	24	40 (27-44)[b]		42 (33-46)[b]		26 (15-30)	
Proximity to the patient							
Partner	12	39 (31-42)[a]		41 (26-45)		28 (19-31)[a]	
Child	42	36 (22-44)[b]		40,5 (18-42)		23 (12-28)[b]	
Brother/Sister	10	37 (29-41)	***0.005***	42 (37-45)	0.438	26 (16-33)	***0.040***
Grandmother/Grandfather	5	38 (30-45)		39 (26-44)		21 (22-30)	
Mother-Father	2	38 (26-42)		44 (39-45)		22 (19-25)	
Cousin-Other Relatives	5	38 (34-43)[a,b]		41 (37-46)		22 (19-25)[a,b]	
The frequency of interviewing the patient with the patient’s relative before becoming a home care patient							
More than once a day	23	36 (22-44)		39 (30-45)		25 (11-29)	
Once a day	40	37 (28-42)	***0.005***	39 (18-43)	***0.001***	25 (16-30)	***0.008***
2-3 times a day	11	36 (22-43)		41 (40-45)		22.5 (16-28)	
Per week ≥1	2	43,5 (31-45)		35 (22-37)		28 (26-28)	
The frequency of interviewing the patient's relative with the patient at home							
Everyday	38	39(20-44)		40 (18-44)		25 (10-28)	
2-3 times a day	25	37,5 (22-42)	0.112	40 (22-45)	***<0.001***	22 (14-29)	***<0.001***
Once a week	10	38.5 (31-44)		36 (32-43)		21 (18-30)	
More than 1 per week	3	36 (31-40)		27 (25-43)		25 (12-27)	

Table 2/Part 2: Comparison of socio-demographic datas of the patient’s relative about the informing, empathy and trust subscales of the attitude scale

Characteristics	n	Informing	p	Empathy	p	Trust	p
Patient’s relative interview with the doctor							
1-2 minutes	19	35 (22-44)		38 (26-44)		22 (11-26)	
5 minute	39	35 (24-41)	0.397	41 (18-45)	***<0.001***	25 (17-31)	0.096
10 minute	12	36 (26-44)		41 (32-45)		22 (16-31)	
>10 minute	6	36,5 (31-43)		45 (41-45)		23 (21-36)	
Relieves the patient’s relative							
Interview with the doctor*							
Yes	50	36 (21-44)	0.336	40 (21-46)	***0.001***	24 (11-28)	***<0.001***
No	26	36,5 (24-44)		36 (18-46)		21 (14-27)	
Be with the patient							
Yes	39	37 (21-45)	***<0.001***	40 (18-45)	***<0.001***	24 (11-29)	0.537
No	37	37.5 (26-45)		42 (32-459		24.5 (17-30)	
Praying							
Yes	22	38 (20-46)	***0.001***	41 (20-44)	0.448	22 (13-28)	0.782
No	54	34 (18-45)		40 (28-44)		23 (15-29)	
Good news							
Yes	25	36 (20-45)	0.549	41 (18-45)	0.681	24,5 (12-20)	0.603
No	51	36 (21-43)		41 (24-45)		25 (15-32)	
Which feature of the home care doctor is important for the patient's relative?*							
Gives good news							
Yes	35	37 (29-44)	***<0.001***	42 (24-45)	***<0.001***	24 (16-29)	0.308
No	41	36 (20-45)		40 (18-45)		24 (11-30)	
Correct information							
Yes	48	36 (20-42)	***0.037***	39 (22-45)	***<0.001***	25 (11-33)	***0.005***
No	28	40 (30-44)		43 (18-45)		23 (16-28)	
Sympathetic attitude							
Yes	19	37,5 (22-44)	***0.018***	40 (24-45)	0.440	26 (11-29)	***0.001***
No	57	37 (23-42)		41 (18-45)		24 (16-30)	
Detailed medical description							
Yes	27	37 (18-42)	0.484	41 (18-45)	0.832	25 (19-29)	0.068
No	49	37 (20-45)		40 (24-45)		24 (18-30)	
Interest and relevance							
Yes	30	37 (20-43)	0.522	41 (24-45)	0.871	24 (11-30)	0.676
No	46	37 (21-45)		41 (18-45)		24.5 (16-29)	

*More than one answer
[a,b] The statistical difference between the groups is shown in the same letter
The data of the statistical difference in the group were shown in italics.

DISCUSSION

Communication skill is one of the most important factors in the relationship between the patient and the doctor. Patient's relative-doctor communication is not only the process of getting information about the epicrisis from the patient's relative, but also a relation / communication between two people. Credibility, context, content, clarity, continuity and consistency, channels and capability of audience are the basic elements that make up this communication (10). In this study, it is seen that male relatives of the patients trust the doctors more. This result was not surprising given that female relatives of the patients were more emotional in this process.

Nowadays because of the easy access to information by means of internet etc., the number of university graduates and relatives who read and understand the disease and treatment methods in detail, make many additional requests, dislike the treatments applied and criticizes increasing gradually (11). In our study, it was observed that the relatives of the patients thought that they were less informed as their education levels increased. Similarly, the empathy and trust relation between the doctor and relatives decreased as the level of education increased.

In the relationship model where the patient is passive and the doctor is active, there should be always a doctor figure like a 'father' acting on behalf of the patient. However, with the 20th century, changes in health and disease concepts, differences in physician identity, the concept of right to health and medicine being a discipline that increasingly uses intensive technology, the patient's autonomy in medical decisions and health have caused the conflict between the patient's values and the physician's values (12). However, the relatives of the patients still regard the doctors as a ''life-saver". In this study, it was found that the relatives of the patients who defined the doctors as a life-saver received more information from the doctors and had better empathy.

Literature mostly focuses on the communication of younger patients with doctors (13,14). It was determined in this study that the relatives of the young patients, the relatives of the patients below the age of 35, were less informed by the doctor and had less empathy.

There is no literature regarding the effects of the visiting frequency of the patients by the relatives of the patients on the communication with doctors. In this study, while there was a lack of being informed and confidence in the relatives who met more frequently with the patient before admitted to hospital, these relatives had more empathy with doctors.

Communication with the patient's relatives is often a short-term interview on a daily basis. To reach information about the patient's medical condition and to have a high quality relationship with health care practitioners is a priority for the relatives. Although the length of interview between the relatives of the patients and their doctor is generally quite short, it is regarded as the most important moments for them. In this short period, relatives often state that doctors do not give enough information about their patients, their interview is frequently interrupted and they can not ask several things they want to ask (8,15,16). In another study, ''good''ranged first with 42.1% among the opinions about the time health care professionals devoted to the patients. The reason for this was attributed to the fact that the service provided in the patient's place prevented unnecessary distraction and thus, good service was given in sufficient time (17). In this study, it was observed that the daily communication of the relatives of the patients with the physicians for 10 minutes and over improved the empathy ability.

Socio-economic conditions, level of education, religion, moral attitudes, ethnic and cultural background, previous experiences, doctor perception and expectations determine the results of the relationship between doctor-patient in the health system (18). In the study of Hunsucker et al. (19) the sense of trust and being informed were determined as the most important requirements of the families and these were followed by being close to the patient, comfort and support requirements. In this study, the relatives of the patients who relieved after the interview with the doctor had better empathy with the doctor and they trusted in the doctor more. In addition, the patient's relatives who cared about the good news by the doctor thought they were better informed and had better empathy with the doctor. However, the relatives, who were relieved when they were with their patients, thought they were not well informed and had a worse empathy with the doctor. The relatives of the patients, who were relieved praying in addition, thought that the doctors informed them worse.

The relatively low frequency of visits in the home palliative care services and the fact that they think that there is not enough time to talk with the relatives may cause many problems in the minds of the relatives.

Home palliative care services are mostly used by non-cooperating patients who receive household mechanical ventilator therapy. Therefore, the families of ICU patients experience high levels of emotional stress (5). It is frequently needed to use communication skills to obtain adequate/appropriate information about the disease of the patient and to inform the relatives of the patient about the treatment management. Earlier studies in the West reported that the most urgent need of relatives of the patients in the intensive care unit was to obtain clear, straightforward and honest information about the patient's condition, but only half of the relatives of the patients were able to obtain full information from the doctors about the diagnosis, treatment and prognosis of the patient. In other studies, while the relatives of the patients emphasized the importance of the purpose of communication, they reported that the information given about the patient was more than the emotional support exhibited (20,21). Yeşiltaş et al. (17) reported in a study conducted with the relatives of the patients that the relatives of the patients' expressed the courtesy levels to be very high at the point of applying for home care services and providing service to the patient and his relatives, and this demonstrated that the health staff who provided home care services were sufficient in communication. In this study, the relatives of the patients who care about being given the correct information, stated that they were better informed, they had better empathy and they felt more trust in doctors. The relatives of the patients who care about the sympathetic attitude of the doctors have more confidence in doctors. Chenoweth et al. (22) emphasized the importance of communication between nurse-patient and nurse-patients' relatives in a review. In order to determine the factors that affect nurses' recruitment and employment, many studies have been evaluated and the nurses' care about their patients and their relatives, and the presence of the relatives of the patients, who appreciate their nursing duties, ensure nurses to be kept in elderly care.

In Norway, an electronic messaging system, which is a standard communication network, is used in primary health care. This system is also adapted to home health care systems used in the offices of family physicians working in Norway. In this system, a dialogue messaging system is designed for all health information of the patients, their requests for special care needs, the drugs they use, the types of health services provided to the patients (23). The establishment of such a system network in our country can solve the existing problems between the health staff working for home health services and the patients and their relatives by improving communication.

There have been some limitations in this study. First, the number of doctors providing home palliative care services being few and fixed has limited our ability to apply this survey to doctors, the other side of the communication. Secondly, this study was performed in the first year of the patients who were discharged home after postarrest. In the following years, information, empathy and trust attitudes could be re-evaluated through re-applying the sub-dimension of the communication to the relatives of the ex-patients followed-up.

CONCLUSIONS

Patient-doctor communication is basically a communication between two people and requires mutual information support, respect and trust. Doctors may not be born with good communication skills, but since a doctor is expected to be the professional side in this communication, a doctor should be one to direct the communication and to solve the problems. We believe that communication between the patient's relatives and the doctor can be increased improving the existing communication skills of the doctors through various training programs and good samples of communication scenarios.

Suggestions developed by the authors according to the findings obtained from the study

1. Patients' relatives have better empathy with female doctors, but rely more on male doctors. Therefore, interviews with female and male physicians with the relatives of the patients can compensate the communication deficiencies.
2. Satisfactory level of information can be provided according to the education level of the people in order to eliminate the lack of empathy and confidence in doctors caused by the increase according to the level of education of patients relatives.

3. It is an advantage that the relatives of the patients still regard doctors as life-savers, and this can be used in a positive way without impairing the social and emotional status of their relatives.
4. As the relatives of patients under thirty-five are less empathetic, cooperation with young colleagues can be established and communication scenarios can be determined to develop a communication language for this age group.
5. Further information may be provided to maintain information and confidence between the relatives,who visited the patient more often when the patient was alive, and doctors.
6.Mutual empathy can be improved if doctors and the relatives of a patient have a minimum of 10- minute interview.
7. A good communication dimension can be provided if home palliative care doctors give accurate information and good news, adopt sympathetic behaviors and mind providing their relatives with medical information support.
8. Developing professional guidance application protocols for home palliative care services and monitoring and controlling home palliative
care services by health authorities can eliminate the existing problems. In addition, it can provide a good communication skill between doctor and patient, doctor and patients' relatives, other staff employed in home palliative care services and patients and the relatives of patients.
9. Implementation of continuous training programs with certain periods in order to improve the communication skills of home palliative care personnel can be effective in solving the existing problems.
10. Developing a common communication network between all institutions providing home health care services, developing guidelines in a certain standard and establishing follow-up mechanisms and introducing certain standards for home palliative care services can be a very effective method for solving the existing problems.

This study, which was conducted to evaluate the communication between the doctors working in home palliative care and the relatives of postarrest patients, is thought to be the first study according to the English literature. It is thought that studies to be conducted in larger sample groups in order to get healthier information in this field will contribute more to the literature and will be useful to develop home palliative care services.

Conflict of interest

No conflict of interest was declared by the authors.

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