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Collusions between patients and clinicians in end-of-life care: why clarity matters

Running title: Collusions in End-of-Life Care

Friedrich Stiefel^{1*,2}, Kenji Nakamura¹, Takeshi Terui¹ and Kunihiko Ishitani¹

¹ Higashi Sapporo Hospital, Sapporo, Japan
* from 2016-02 to 2016-07

² University Hospital Lausanne, Lausanne, Switzerland

Correspondence:

Prof. Friedrich Stiefel, M.D.
Psychiatric Liaison Service
University Hospital Lausanne
Les Allières
Av. de Beaumont 23
1011 Lausanne
Switzerland
Phone : +41 21 314 10 90
Fax : +41 21 314 10 86
Email : Frederic.Stiefel@chuv.ch

Kenji Nakamura, M.D.
Chief, General Practitioner,
Chief, Palliative Care,
Higashi Sapporo Hospital
3-3-7-35, Higashi Sapporo, Shiroishi-ku,
Sapporo, Hokkaido, 003-8585,
Japan
Phone: +81-11-812-2311
Fax: +81-11-823-9552
E-mail: kenjin@hsh.or.jp

Takeshi Terui, M.D., Ph.D.
Director, Higashi Sapporo Hospital
Clinical Professor, Sapporo Medical University School of Medicine
3-3-7-35, Higashi Sapporo, Shiroishi-ku,
Sapporo, Hokkaido, 003-8585,
Japan
Phone: +81-11-812-2311
Fax: +81-11-823-9552
E-mail: terui@hsh.or.jp

Kunihiko Ishitani, M.D.
President, Higashi Sapporo Hospital
3-3-7-35, Higashi Sapporo, Shiroishi-ku,
Sapporo, Hokkaido, 003-8585,
Japan
Phone: +81-11-812-2311
Fax: +81-11-823-9552
E-mail: ishitani@hsh.or.jp

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Abstract

Collusion, an unconscious dynamic between patients and clinicians, may provoke strong emotions, un-reflected behaviours and a negative impact on care. Collusions, prevalent in the health care setting, are triggered by situations which signify an unresolved psychological issue relevant for both, patient and clinician. After an introductory definition of collusion, two archetypal situations of collusion - based on material from a regular supervision of a palliative care specialist by a liaison psychiatrist - and means of working through collusion are presented. The theoretical framework of collusion is then described and the conceptual shortcomings of the palliative care literature in this respect discussed, justifying the call for more clarity. Finally, cultural aspects and societal injunctions on the dying, contributing to the development of collusion in end-of-life care, are discussed.

Keywords: collusion, transference, counter-transference, palliative care, communication

In conversational English, collusion denominates a secret agreement and cooperation for an illegal or deceitful purpose between two or more persons who share an unvoiced and complicit intention; in psychology, collusion is defined as an unconscious bond: the associated persons take part in a plot without knowing the script of the play (the Latin root of collusion, “colludere”, signifies “to play together”) (1).

Collusion occurs in situations which reflect an unresolved psychological issue shared by the involved persons. Once these situations have produced an echo in the participants, strong emotional reactions and un-reflected behaviours are triggered. To illustrate collusion with a clinical example: a patient with severe difficulties to cope with separation, due to prior life events, faces death (and separation from loved ones) and requests assisted suicide. This request can be understood as an attempt to reduce the psychological tensions associated with the process of dying by means of a counter-phobic reaction: the patient desires to hasten a process he fears most in order to “get it over with”. If this patient meets a clinician who has the same difficulties (separation anxiety), the clinician might be stressed by this request to an extent, that he harshly rejects it and thus neglects to empathically explore the underlying reasons of the request. The harsh rejection by the clinician can be understood as a way to distance himself from an issue he fears. Collusion - in this example a “negative” collusion, since the shared unresolved issue is handled in an opposite way - can also be observed as “positive” collusion when the involved persons handle the issue at stake in a similar way: the clinician would, for example, blindly endorse the patient’s desire for assisted suicide or even take action without gaining a more precise idea of the dynamics underlying the patient’s request.

In order to deepen the discussion and to demonstrate the role of supervision in the prevention of collusion or its negative impact on care, we will now present two case vignettes

Two cases of collusions (vignettes)

During a six-month sabbatical at Higashi Sapporo Hospital (HSH) in Japan the first author (FS), a liaison psychiatrist, supervised the second author (KN), a palliative care physician, on a weekly basis. The two cases of collusion presented below, considered as archetypes of collusion in palliative care, have been identified during this supervision and discussed during a formal presentation at HSH and among the authors.

An impeccable gentleman

The 62-year old divorced man without children, working as an airport traffic controller, was admitted to HSH for dyspnea due to stage IV adenocarcinoma of the lung. This very polite and always smiling patient suddenly changed after having been informed by the treating physician (KN) that his pleural effusion was rapidly increasing; he made some uninhibited comments to a night-shift nurse about sexual matters. Asked the day after by KN how he feels, he responded that he had a dream in which he had lost his mind. In supervision, KN conveyed that it was very difficult for him to confront this patient with regard to the comments made to the nurse and to investigate his mental state, since he does not express his emotions and always presents himself in a polite and somehow distancing manner. The supervisor remarked that “control in times of threat” might be the key to understand the situation, and added: “control is an important issue, be it for patients or physicians”... This remark accompanied KN

over the following days and he reported in the next supervision that he had the impression that he also was a “very polite and always smiling” medical doctor for whom everything seemed to be “under control”. And he went on: “especially in a time, when I face a serious health threat which I completely denied over the last weeks” (health threat which meanwhile has turned out to be of a benign nature).

To summarize: supervision allowed to apprehend that this patient had severe death (separation) anxiety which he tried to control as best as he could. However, the information about the aggravation of his disease and the confrontation with increasing threat surpassed his capacity of control and his stance began to stumble, as manifested by two frontrunners of an impending loss of control (desinhibition with the nurse and the dream of losing his mind). On the same time the treating physician realized that he also had a controlling side, as manifested in the way he related to patients, and that he shared with his patient a way to handle death anxiety (denial). As he remarked in supervision: “I had my way to distance myself: here the healthy physician, and there the sick and dying patients”. As a result, the patient’s severe anxiety behind his polite attitude and his impending loss of control and disintegration were not addressed; these unpleasant and anxiety-provoking topics were carefully avoided by both, patient and physician. During the process of supervision KN considered that he became to feel closer to his patients, an experience associated with a certain degree of anxiety but also more satisfaction.

A tireless fighter

The 76-year old man, married and father of two adult children, former foreman in the construction industry, diagnosed with prostate cancer with multiple bone metastases

was admitted to HSH for invalidating gait disturbances, which turned out to be due to syringomyelia. A particular feature of this patient was his restless search for treatments - be it in the form of biomedical therapies, nutritional supplements or alternative remedies – which he hoped would enable him to walk again. Informed by the treating physician (KN) that his PSA is rapidly increasing he consented to be admitted to the palliative care ward of HSH. However, despite this decision, which might be interpreted as a wish to submit to the inevitable and somehow abandon his will to life, he continued to struggle with his destiny and asked KN about means to recover. A fact which moved but also puzzled KN.

Supervision allowed to clarify that KN was not only moved and puzzled by this patient but also frustrated and angered, mainly because he feared that this patient might – the way he behaved – only very late (or too late) apprehend the severity of his situation and then react with sudden despair. After having been asked by the supervisor why the patient's desire to live provokes so much frustration, KN was unable to answer. However, he realized in the following discussion, that he expected from this and other patients that they give up their struggle for life and adopt a serene attitude facing death.

To summarize: The collusion in this situation did not refer to the issue of death but of life. The patient consciously decided to be admitted to a palliative care unit, by denying his desire to live, a desire which continued, however, to manifest itself on a behavioural level (his continuing struggle to recover). On the other side the physician expecting his patient to silently accept death also denied him a right to live and fight for life to the very end. As a result, this attitude hampered the relationship with the

patient; during supervision NK realized that he was avoiding this patient, for example by not answering his questions concerning the recovery of (muscular) strengths or by failing to investigate the significance the search for supplements had for the patient. Following these insights, the relational tensions between the two ceased, KN opened up to this patient and told him that he considers his struggle not as a sign of a weakness but of strength. And the patient conveyed that he was conscious about his impending death, but that he sadly desires to live. This collusion can also be conceived as less determined by individual factors and more by social representations of expectations of patients and physicians (which will be discussed below).

In medicine, and especially palliative care, issues with the potential to trigger collusions between patients and clinicians are prevalent; to name a few: issue concerning dependency and independency, domination and submission, separation and loss, control and let go, intimacy and ego boundaries, etc.

The conceptual framework of collusion

Since collusion occurs in everyday life – it can be the origin of very long lasting relationships of attraction or hate (2) – it also is part of the health care setting. Not surprisingly collusion has been frequently described in the psychiatric setting where interpersonal relationships play a major role, occurring for example in the treatment of suicidal patients (3), victims (4) or patients with perversions (5). However, as mentioned in the introduction, the field of medicine, and especially palliative care, also harbours many situations which symbolize psychological issues, which have the potential to trigger collusion.

If collusion occurs, the clinician may well be aware of his strong emotional reaction - be it anger or overwhelming sympathy for a patient - but he is not aware that his reaction is related to an unresolved issue he shares with the patient. A clinician in collusion might explain and justify his reaction and thus rationalize his stance, but he remains unaware of the underlying dynamics which tie him so strongly to his patient. Indeed, collusion is viewed as a defensive, unconscious manoeuvre (a concordance of the patient's and the clinician's defences) with the aim to suppress a threatening or otherwise uncomfortable confrontation (3-5) with the issue at stake: for example how to deal with loss, dependency or intimacy.

Collusion as a shared defensive manoeuvre is part of the theoretical concept of transference and counter-transference. Transference, a key element of psychoanalytic theory, is understood as an unconscious redirection of feelings from one person to another (6) – a classical example would be the feelings one has towards a parent which are directed towards a therapist (e.g. manifested as search for intimacy, rebellion, submission). In other words: the person under transference is not perceived as he really is but coloured by transference feelings such as attraction, hate or ambivalence. Counter-transference on the other hand is the feelings directed from the therapist towards the patient: a patient might, for example, trigger in the therapist a counter-transference reaction since he reactivates in the therapist feelings he has or has had for his sibling (e.g.: rivalry, sympathy, fear). Both transference and counter-transference are unconscious but accessible through introspection. In psychotherapy, the patient becomes increasingly aware of the transference elements which distort the relationship to the therapist (and others) by

reflecting on the interpretations the therapist provides him in the therapeutic process. On the other hand, the therapist – having been himself in psychotherapy and aware of the issues he struggles with – who is submitted to counter-transference should be able to identify own feelings and reflect on them; in difficult situations the therapist can also consult a supervisor to discuss these aspects. First described by Ferenczi in 1933 (6), collusion links transference reactions of the patient with counter-transference reactions of clinicians (7) and thus explains the resulting specific and often explosive dynamics of colluding relationships. It is not surprising that such relationships destroy the holding environment (8) and therapeutic alliance (9) patients are in need of, be it in the psychotherapeutic or general health care setting (10).

Supervision and working through collusion

Supervision is an effective mean to identify and work through collusion (1, 4-7). For example strong emotions such as anger or anxiety reported in supervision, or a feeling of malaise or guilt when a reaction towards a patient is recognized as inappropriate, provide a clue that collusion might be at work. Supervision allows to access “the script” of the plot at play: by telling one’s story to an attentive third party, awareness of own contributions to the situation raises. Narration itself not only constructs new meanings and insights, the clinician in supervision can also be questioned about the origins of his reactions and introspection develops. Introspection, however, is not an easy task, since collusion has advantages: it helps to avoid the unresolved issue at stake and its associated discomfort (4-7). Introspection requires to be able to tolerate unpleasant thoughts and feelings and this becomes only possible, as any constructive human development in general, in a holding environment. In other words, a supervisor is not a “cognitive machine” who

points out the individual's fragilities, he has to create - as in a psychotherapeutic setting - an atmosphere of understanding, trust and empathy which invites the clinician to access and share his suffering (8, 9). Supervision is not a personal psychotherapy, if insight is aimed to be raised, a supervisor cannot restrict the discussion to the patient's unresolved issues, but has to point to elements the clinician is struggling with (1, 4, 7); to sense if and when such remarks are possible requires a certain experience of the supervisor.

Collusions reported in the palliative care literature

In order to apprehend how collusion has been described in the palliative care literature and to complete the discussion, a literature search was performed using the keywords ["collusion" AND ("palliative care" OR "terminal care" OR "end of life care")] in the databases Ovid Medline, Embase, EBM and Psychinfo in August 2016, resulting in 28 articles.

All articles were then read by the first author who selected only those references that explicitly addressed collusion, resulting in 13 references (11-23). While most principles of the systematic search were respected for the search part, the evaluation of the results – given the fact that the goal was not to conduct a systematic review but to gain an idea of how this topic is discussed in the specialized literature - was performed more freely.

These reports rightly underline that (i) collusion is a trans-cultural phenomenon (11, 14), (ii) occurs frequently in the palliative care setting (11-13, 18, 23), (iii) has the function to avoid unpleasant or painful feelings (13, 15, 16, 19, 20) and (iv) is often triggered by prognostic communication (11, 14, 15, 18, 21, 23). However, this

literature also shows important conceptual shortcomings which are summarized in Table 1.

Insert Table 1 about here

First, and most important, collusion is defined (some articles do not even define collusion), by the overwhelming majority of authors as a conscious phenomenon (12, 14, 17-19, 22), suggesting a deliberate choice or “an act of love” (13) of the “colluders”. This view ignores the unconscious dynamics involved in collusion. However, two authors (16, 20) introduce an unconscious dimension: one of them (16) refers only to the patient, but the other (20) also includes the clinician and calls for supervision and other approaches to work through collusion. Second, collusion is reduced to the exchange of information (11-14, 16-21), obscuring that collusion concerns topics sensitive for both patients and clinicians; collusion can have, among other, an effect on information exchange, but the real problem represented by collusion concerns the patient-clinician relationship. Some authors refer in this respect to non-verbal manifestations of collusion (11) or hope (14, 15, 22), but, again, a key characteristic of collusion, a defensive interpersonal dynamic, is not addressed. Third, many reports do not provide information on how to avoid, identify or work through collusion (13, 14, 16, 17, 19, 21). Among the two authors who address this issue, one simply states that collusion has first to be acknowledged, but he omits how this is possible (11). And the other mentions that collusion is reinforced by physicians’ activism (17), but activism is better considered as a consequence of collusion. Three authors provide suggestions how to handle collusion in daily clinics. Two of them call for a protocol (12) or supervision to diminish collusion (20) and the

third for the involvement of a third party person who is trusted by patients and physicians and who would serve to introduce a more objective view on the benefits of further treatment (18). Since two of these propositions do not take into account that collusion occurs without the awareness of the involved persons, it remains unclear how and when a clinician would be able to refer to a protocol or a third party. The author who understands collusion as a defensive and shared manoeuvre between patients and clinicians calls for more reflection on the part of clinicians by means of supervision or de-escalating techniques (20), but he reduces collusion to a problem of information exchange. Fourth, as a consequence of the above mentioned shortcomings, the overwhelming majority of authors, except one (20) do not address the fact that a key element of collusion is the clinician and that one has to focus on him, if one wants to diminish the risks of collusion or its negative effects once collusion has developed.

While the literature on collusion in palliative care is rather scarce and lacks conceptual robustness and relevance for daily clinics, only two studies exist which focus on collusion in end-of-life care. One of them concludes that a “recovery plot” between patients with small cell lung cancer and their treating physicians was prevalent (18); collusion is here again restricted to information exchange. The other study found that nurses, confronted with repeated requests for assistance in dying and at risk for collusions, did not seek orientation by consulting ethical guidelines, protocols or colleagues (23); however, it remains unclear whether collusion is considered as an unconscious phenomenon, the authors refer to its involuntary character due to “routinization of secrecy”.

Why we should be clear about collusion

To blur the concept of collusion harbours many dangers, the most important of them is that collusion appears to be “easy to handle”, one just has to think about it. This view scotomizes, that collusion is an unconscious manoeuvre and thus often only retrospectively identified (5), when the patient has left treatment and the dynamics have diminished due to chronological and geographical distance. And it obscures that collusion can only be identified and worked through by introspection (3-5, 20). Introspection is not an easy endeavour, especially when one is captured in collusion and under strong emotional tensions. Introspection demands a certain disposition of mind (a capacity to take a distant and critical stance to our thoughts, emotions and behaviours) and a reassuring setting which enables the clinician to tolerate discomfort (6, 7). However, as some of the authors describing collusion in palliative care have mentioned (20, 23), a resort to a colleague or liaison psychologist/psychiatrist may be of great help to identify and elaborate on situations of collusion. Based on experiences from liaison psychiatry, collusion is frequent in medicine (24) and regular supervision should therefore be considered not as a luxury but as a necessity to maintain adequate relationships with patients (25).

Archetypes of collusion in palliative care

We have selected the two above discussed situations among the material from the supervision, since we considered them as archetypical, in the sense that they represent situations which repeat themselves over time and in different cultural contexts (26). While cultural elements certainly influence how collusions unfold (11, 16, 27, 28), collusion is an ubiquitous phenomenon, and exists in cultures with different conceptualizations of death (11, 14, 18, 23). We therefore consider that the

discussed archetypes, the “anxious denier” and the “rebellious fighter”, not only create uneasiness and collusions in the Japanese palliative care clinician. They are archetypes since they confront clinicians in their roles as health care professionals and persons with two fundamental themes: how to face death and the desire to live. These are themes clinicians of different historical and cultural backgrounds have struggled with and will continue to struggle with (29), since they put into play essential psychological challenges such as control and let go, submission to the inevitable and revolt, loss and dependency, separation and uncertainty, hope and despair.

Culture and the culture of medicine

The encounter between an eastern physician and a western supervisor also raises the issue of culture and collusion. We would like to briefly discuss this aspect from two perspectives: the general cultural fact and the culture of medicine.

Some of the above mentioned authors (11, 14, 21) have pointed to the fact that Eastern culture tends to exclude the patient by providing diagnostic information only to his family and thus argued that collusion is thus less prevalent in the West. However, if one considers that collusion surpasses the issue of information exchange, culture seems to influence not prevalence but only the expression of collusion. Every culture has its own sensitive issues which are handled in a specific way. For example Margaret Lock convincingly argued that one might be surprised that the definition of brain death had important difficulties to prevail in Japan, but that one might also be surprised that this new definition of death, closely related to the developing possibilities of organ transplantation, has been so easily, and without

public discussion, introduced in the West (30). Collusions are thus shaped by culture and can involve not only several persons but a whole population. The same holds true for defence mechanisms which can be observed on a individual level but also as collective defences, for example among clinicians (7), which brings us to the second perspective.

Medicine as a practice has its own culture, depending on elements such as its theoretical framework, the socialization of clinicians or the technical means utilized (31). And it might well be that certain types of medical practice have an important trans-cultural influence. In other words, the predominance of the biomedical model of disease and evidence-based practice may have a stronger influence on medicine than local culture, and may produce, for example, uniform ways of how the body is perceived by patients or clinicians (32). Death may be conceived differently in the East and the West (30); however, the associated fears and the impetus to fight against it may not be that different (33, 34).

The “anxious denier” and the “rebellious fighter” both challenge the somehow comforting and ideal representation, be it in Japan or in the West, of how patients but also we as persons-clinicians should face death: consciously and serene (35). Maybe this ideal representation of how to die is closely linked to our need to maintain a certain control over something that remains uncontrollable. As pointed out by Zimmermann (36): “the impetus in contemporary society for a “planned” death and the role of palliative care in supporting this idea of death planning, create a structuring of possibilities for acceptable patient behaviour “ and those who do not correspond to this behaviour risk to be labelled “deniers” at best and rejected at

worst. From a broader perspective, patients, physicians, the practice of medicine and of palliative care inhabit a historical and social space with changing demands towards the dying. While the conspiracy of silence described by Ariès (33) does not operate anymore, which is certainly a beneficial evolution, new forms of injunctions have emerged expecting from the dying to play an active part (advanced directives, shared-decision making, communication about death and dying). As has been described for breast cancer survivors (37) who face a specific and confining discourse, dying patients are also subjected to discourses within and outside palliative care (35, 36, 38, 39).

It is not an easy task for clinicians to be confronted on an almost daily basis with suffering and dying patients, and one is easily seized by a dynamic, which provokes conscious and unconscious reactions. Among these reactions, collusion is frequent and has a great potential for harm. It therefore deserves our attention. Only a thoughtful approach can limit its occurrence and impact. Therefore, what is needed is not only patient-centred but also clinician-centred care and research (40).

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Table 1: Main shortcomings of the palliative care literature with regard to collusion

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- A definition of collusion is often not provided
 - Collusion is mainly conceived as a conscious phenomenon
 - Collusion is considered to interfere with information exchange only
 - The impact of collusion on the patient-clinician interaction is neglected
 - No strategies or unrealistic strategies to identify collusion are mentioned
 - Propositions for ways to work through collusion are lacking
 - The role of the colluding clinician is not discussed
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