ORIGINAL ARTICLE

Cultural Adaptation and Acceptability of the Crisis Conversation Guide by Emergency Physicians for Serious Illness Patients: Mixed Methods Study

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Background: During a medical crisis, emergency physicians often discuss life-saving interventions with seriously ill patients and their families. Crisis conversations require strong communication skills and a patient-centered approach.

Objective: To culturally adapt and assess the acceptability of an existing English crisis conversation guide for use by emergency physicians in Thailand.

Materials and Methods: A three-stage mixed-method study was conducted. The initial stage included the translation and cultural adaptation of an English crisis conversation guide to Thai using a modified Delphi method with an expert panel's consensus. The expert panel included four emergency physicians and four palliative care clinicians. The second stage involved surveying Thai emergency physicians on the perceived necessity of each step of the conversation guide using a 5-point Likert scale. In the third stage, the expert panel reviewed the survey results and incorporated feedback to produce the final Thai crisis conversation guide.

Results: The Thai crisis conversation guide was initially adapted from the English original via Thai word adaptation and practical rearrangement. In the refinement stage, the expert panel modified several strategies for exploring patient values and added a new step to the conversation guide, which the authors term "gathering the decision makers". The acceptability survey was completed by 180 Thai emergency physicians, with a 36% response rate. These physicians reported that the step with the strongest perceived necessity in the conversation guide was "summarize goal of care" with 176 participants (98%) responding "agree" and "strongly agree".

Conclusion: The crisis conversation guide was culturally adapted for clinical practice in Thailand. More than 88% of Thai emergency physicians reported the conversation guide to be acceptable in their clinical practice.

Keywords: Communication; Emergency medicine; Serious illness conversation; Palliative care; Crisis conversation; Goal of care conversation

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Emergency physicians frequently encounter patients with serious, life-limiting illnesses and acute clinical deteriorations. These encounters often require physicians to make difficult decisions about medical care quickly[1,2]. In the emergency department, more than 60% of seriously ill patients do not possess advance directives[3,4] and are at risk of receiving medical care influenced by the time-pressured, stressful situations[1,3]. This risk is in part because emergency providers prioritize life preservation by default when patients without advance directives are unable to communicate[1]. Further, during these critical moments, physician-led crisis conversations regarding potential life-saving treatments can induce false hope for families and subject seriously ill patients to futile treatments[3]. An alternative

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approach to crisis conversations utilizes shared decision making, which encourages physicians and family members to recognize and honor the patient's values while considering options for their care[1,2,5,6]. Research literature demonstrated a growing focus on patient-centered approaches in crisis medical situations[1,2,6].

Emergency physicians can provide goal-concordant care during acute health decompensation by discussing the patient's prognosis and potential outcomes, exploring their personal values and preferences for care, and making patient-centered recommendations based on these values and preferences[1,5-7]. An existing conversation guide, developed by experienced clinicians in the United States, aims to standardize crisis conversations between physicians and family members to provide patient-centered care in health crises[1]. However, the existing conversation guide may not be culturally appropriate for patients with sociocultural and linguistic differences[8,9]. Previous studies report that Asian societal attitudes towards advance care planning are influenced by diverse cultural values, such as differing degrees of emphasis on the importance of autonomous versus joint decision-making in care[10-12]. The present study aimed to comprehensively adapt the United States crisis conversation guide for use by emergency physicians in Thailand and assessed the acceptability of the adapted guide among Thai emergency physicians.

Materials and Methods

Between February 2022 and 2023, the authors conducted a three-stage, sequential mixed-method study with Thai physicians using the embedding approach[13]. The study flow chart is represented in Figure 1. The study was approved by the Institutional Review Board (COA.MURA2002/121).

Stage I: Cultural adaptation

The cultural adaptation began with one Thai emergency physician (TP) and one American emergency physician (KO) reviewing the existing English crisis conversation guide for practical use within Thai healthcare[1]. Three bilingual physicians (TP, TT, NP) translated the original English guide into Thai, followed by an item-by-item comparison and forward and backward translation. To proceed with the modified Delphi method, the authors recruited an expert panel consisting of two male and two female Thai emergency physicians and palliative care clinicians, resulting in a panel of eight individuals. These emergency physicians and palliative care clinicians had more than five years of clinical experience, with a median clinical experience of 14.5 years and 13.5 years, respectively. Members of the panel were actively practicing in Bangkok, the Northeast, and the South of Thailand at the time of recruitment. The panel members independently reviewed the translated Thai crisis conversation guide and subsequently discussed the cultural adaptations necessary via three two-hour online meetings scheduled one week apart. Two researchers (TP, SK) incorporated the resulting adaptation suggestions. The authors applied cross-cultural validity through cultural adaptation and translation-back translation, followed by content validity via expert panel discussion and expert rating. Finally, the panel reached an anonymized consensus on the draft of the Thai crisis conversation guide via surveying through Research Electronic Data Capture (REDCap), a private electronic data capture tool[14].

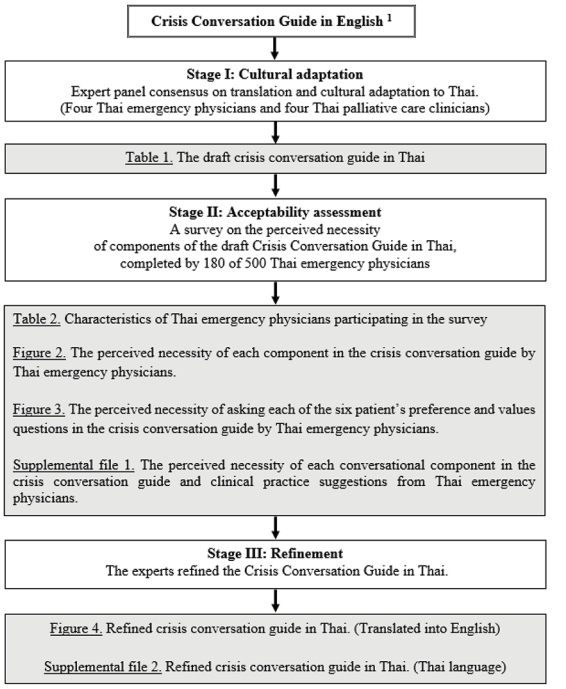

Figure 1. Study flow chart.

Stage II: Acceptability assessment

The authors conducted a survey on the perceived necessity of each conversational component of the initial Thai crisis conversation guide using a 5-point Likert scale, with strongly disagree, disagree, neutral, agree, strongly agree. The pre-specified threshold for acceptability for each component was defined as more

than 50% of emergency physicians reporting "agree" or "strongly agree". The survey also included space for free-text comments on the conversation guide. Prior to administration, each member of the expert panel piloted the survey to ensure content validity.

The authors provided the survey to 500 currently practicing Thai emergency physicians affiliated with the Thai College of Emergency Physicians (TCEP). TCEP is a national organization of board-certified emergency physicians with 1,400 members throughout Thailand at that time. The most feasible way to contact TCEP members is through their online messaging platform. The authors contacted their largest, most active private group of 500 emergency physicians, and the survey was shared in this group once a week for three weeks. Physicians were consented and surveyed anonymously using REDCap, and email addresses were recorded to ensure no duplicate responses[14]. Responses from emergency physicians were excluded if they opted not to participate or did not complete the survey in its entirety. To encourage completion, one-time reminder emails were sent to the recorded email address of each incomplete survey five days after the survey was initiated. Participants were not compensated for completing the survey. The authors used embedded validation using a large survey and open free text, then analyzed free-text feedback in stage II.

Stage III: Refinement

Finally, the expert panel reviewed the survey acceptability statistics and respondent comments in a two-hour online meeting. Free-text survey suggestions on the guide were discussed and accepted or rejected based on unanimous consensus of the expert panel. The suggestions accepted were incorporated into the revised guide. The panel further refined and reorganized the crisis conversation guide to produce the final version in Thai. A forward-backward translation into English was completed and presented for discussion by three bilingual physicians (TP, TT, SS). The authors applied construct validation using a thematic analysis of both quantitative and qualitative information from the previous stage, followed by content validation via the expert panel discussions and expert rating.

Data analysis

The authors qualitatively analyzed the thematic content from the free-text survey responses and the recorded expert panel discussions. This interpretive and descriptive information was integrated for the cultural adaptation and the refinement of the crisis conversation guide. The authors used descriptive statistics to characterize acceptability survey responses. The authors combined the responses "strongly agree" and "agree" into the category "necessary" and the responses "neutral", "disagree", and "strongly disagree" into the category "less necessary" for ease of interpretation. The descriptive statistical analyses were performed using Stata Statistical Software, version 16 (StataCorp LLC, College Station, TX, USA).

Results

During Stage I: Cultural Adaptation. The expert panel revised the introduction and rearranged steps of the conversation guide so that they were more appropriate for the Thai context. The meaning and aim of each conversational component were maintained. Some English words or phrases that were less pragmatic in Thai, particularly in emergency situations, were removed or replaced such as deletion of the phrase "I am afraid", and substitution of "most appropriate care" in place of "the best care". The panel agreed to add one crucial step to the beginning of the conversation guide, "gather the decision makers", as well as one alternate question for the step "explore values and preferences". In addition, to facilitate the patients' or families' understanding of questions regarding quality of life, the panel provided concrete examples of different conditions and healthcare. The draft of the initial revised Thai crisis conversation guide is shown in Table 1.

In Stage II: Acceptability. One hundred eighty of the 500 contacted Thai emergency physicians, which was a 36% response rate, completed a survey on the draft Thai crisis conversation guide. The majority of survey participants were female, with 102 participants (56.7%) and between 31 and 40 years old, with 133 participants (73.9%). Participants had a range of clinical experience: 72 (40.0%) were currently practicing in Bangkok, 117 (65.0%) had been practicing between 3 and 10 years, 102 (56.7%) conducted emergent code status conversations more than four times per month on average, 93 (51.7%) had prior communication training, and 119 (66.1%) had no prior palliative care training. This information is summarized in Table 2. Survey results indicated that at least 88.3% of participants either agreed or strongly agreed that each step of the conversation guide was necessary in a crisis conversation. The most necessary step was identified as "summarize the goal of care" (176 participants, 97.8%). The least necessary step

Table 1. The draft crisis conversation guide in Thai

Step	The initial version of Thai crisis conversation guide (translated into English)
Introduce and align	(Introduce yourself)
Ask permission	I would like to inform you of some important information about your father. Your father is very sick. We have to decide quickly about the care that is most appropriate for your father and his family.
Gather the decision makers	*Do you want someone to be here with you or to make decisions together?*
Elicit understanding	What do you know about your father's illness?
Break bad news	Your father is now having difficulty breathing due to a lung infection. Because of his previous health issues, I am worried that his response to treatment might not be good. There is a high chance of getting worse and dying.
Baseline function	Before we decide which care is proper for your father and family, I would like to ask about your father's health previously. What daily activities can he do by himself?
Values and Preferences questions as appropriate	Did your father ever tell you if his health worsens, what he would or would not want for his care?
	Since you know your father much more than I do, what care do you think he would want to receive for himself?
	How would your father feel if after today, our treatments are unable to help him return to doing his favorite things or his routine activities?
	What abilities do you think are valuable to your father *(give them an example which is appropriate, such as walking, speaking, appearance, eating, etc.)*, without which he may not want to live?
	Some treatments may make him uncomfortable. What kind of discomfort do you suppose he would be willing to have or accept as a trade-off for his extended life?
	Has your father ever mentioned that he would prefer to live or not to live in conditions that he wouldn't accept?
Summarize goal of care	From what we have discussed, I understand that AAA is what your father values the most. If after the full treatment, he won't be able to AAA, and this might not be acceptable for him. Did I understand correctly?
Recommend	I recommend that we should focus on reducing suffering and help comfort your father as much as possible. Therefore, treatment (procedures BBB, medication CCC, DDD care) will not bring benefit to him. It will not cure the disease so we will not do it. In other words, we will continue to provide the best care and not abandon him. We are hoping that he will not be in pain and be as comfortable as possible.
	I recommend that we will do the full treatment with the hope of getting better from this illness using therapies (procedures EEE, medication FFF, GGG care). However, his health may not be able to recover from this illness in the end. The treatment team will continue to take care of him and may need to discuss this again in the future.
	Do you agree?
	Do you have any questions?
Document	

Italicized parts are the additions by the expert panel

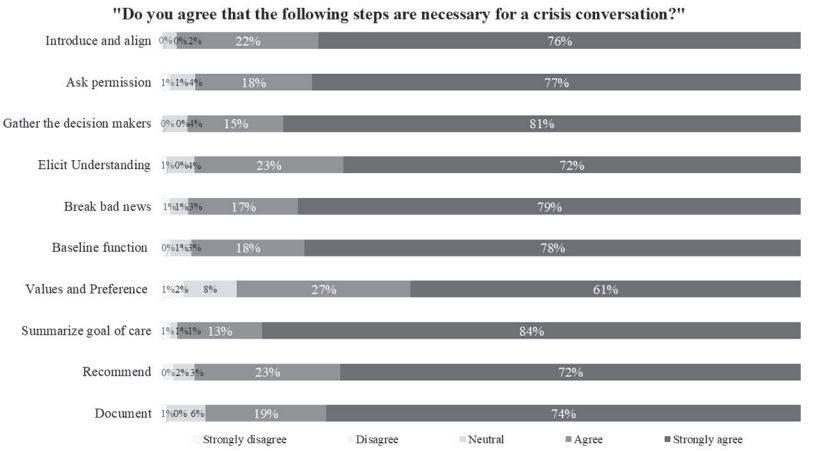

Figure 2. The perceived necessity of each component in the crisis conversation guide by Thai emergency physicians.

Table 2. Characteristics of Thai emergency physicians participating in the survey

Characteristics	Participants (n=180)	%
Female	102	56.7
Age (years old)		
21 to 30	21	11.7
31 to 40	133	73.9
40 or more	26	14.4
Region of Thailand		
Bangkok Metropolitan area	72	40.0
Southern	31	17.2
Northeastern	27	15.0
Northern	19	10.6
Middle	17	9.4
Eastern	7	3.9
Western	7	3.9
Year of clinical practice (years)		
3 to 10	117	65.0
10 or more	63	35.0
Average frequency of crisis conversation		
Less than 2 per month	32	17.8
2 to 4 per month	46	25.6
More than 4 per month	102	56.7
Prior training in communication	93	51.7
Prior training in palliative care	61	33.9

was identified as discussing "values and preferences" (159 participants, 88.3%). These specific results are reported in Figure 2. Additionally, the perceived necessity of asking each individual "values and preferences" question is demonstrated in Figure 3. Apart from the acceptability data, 40 physicians also submitted 56 free-text comments about the guide.

In Stage III: Refinement. The panel clarified and added instructions for the guide and underlined the key phrases for each step. These adjustments were made in response to comments that detailed concerns about the challenge of using the guide in nuanced situations such as adding the instruction regarding the adjustable conversation guide, underlining the key phrases for the main idea of each step, and noting that essential communication skills were required throughout the conversation. The expert panel also rearranged two steps in the guide to increase practicality according to survey suggestions, which was to 1) moved the discussion of "baseline function" earlier, which facilitates a closer connection with the family, and 2) followed this discussion with the step "elicit understanding". For the "explore values and preferences" step, the panel grouped questions by "recommended conversations", "further questions", and "alternative conversations". The final refined version of the Thai crisis conversation guide is shown in Figure 4.

Discussion

In the present multistage mixed-method study, the authors refined a crisis conversation guide for use by emergency physicians in Thailand. Compared to the original guide, significant cultural adaptations included the addition of the "gather the decision makers" step and modification of clinical approaches within the "explore values and preferences" step. The present study demonstrates that the patient-centered approach of the existing crisis conversation guide is culturally acceptable when adapted outside the United States despite differences in language, sociocultural

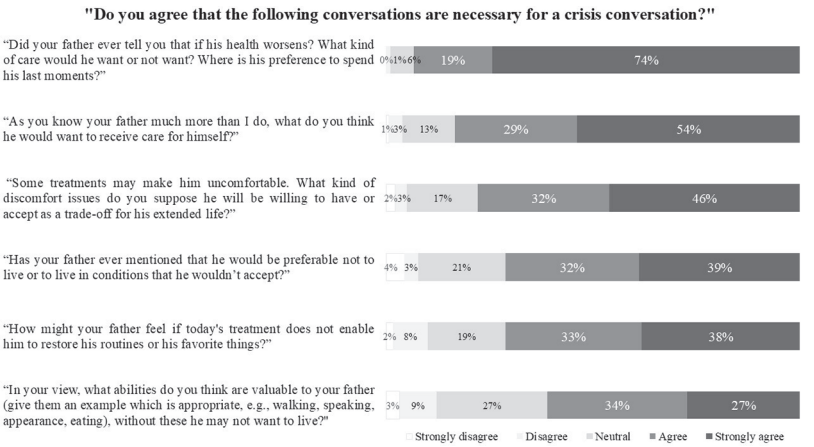

Figure 3. The perceived necessity of asking each of the six patient's preferences and values questions in the crisis conversation guide by Thai emergency physicians.

Crisis Conversation guide for Thai Emergency Physicians	
Instruction • Goal: To provide patient-centered recommendations regarding intubation to patients who were at high risk for poor outcomes, after establishing that no advanced care plan or living will exist. • This conversation Guide and sample can be adjusted to the actual situation. • In addition to the conversation guide, a crisis conversation requires essential communication skills, such as empathic communication, throughout the conversation as well. • This conversation guide was developed to communicate with the patient's family during a crisis situation, and most critically ill patients are unable to communicate on their own. If the patient can communicate, this crisis conversation guide can also be used to communicate directly with the patient. • The underlined parts indicate the main of each step.	
Step	**Conversation**
Introduce	**(Introduce yourself and role)**
Ask permission	I would inform you of some important information about [patient]. [Patient] is very sick. We have to decide quickly together about the care that is most appropriate for [patient] and family.
Gather the decision makers	Would you need someone to be here with you or make decisions together?
Baseline function	I would like to know what [patient] was previously able to do for his daily activities by himself.
Elicit Understanding	What do you know about [patient]'s illness?
Break bad news	[Patient] is now having difficulty breathing due to a lung infection. Because of his previous health issues, I am concerned that his response to treatment might not be good. There is a high chance of getting worse and dying.
Explore values and preference	**(Recommended conversation)** Did [patient] ever tell you that if his health worsens? What would he want or not want for his medical care? **(After receiving their answers, the doctor may ask further questions.)** Where is his preference to spend his last moments? What do you think about this need?
	(Alternative conversations might be applied according to the situation.) • As you know [patient] much more than I do, what do you think he would want to receive care for himself? • How would [patient] feel? If after today, our treatments are unable to help [patient] return to doing his favorite things or his routine activities. (give an appropriate example, walking, speaking, appearance, eating, etc.) • In your view, what abilities are valuable to [patient], without these he may not want to live? (give an appropriate example, walking, speaking, appearance, eating, etc.) • Some treatments may make him uncomfortable. How much discomfort do you suppose he will accept as a trade-off for his extended life? • Has [patient] ever mentioned that he would be preferable not to live or to live in conditions that he wouldn't accept?" (give an appropriate example, being bedridden, unable to communicate, unable to eat, etc.)
Summarize goal of care	From what we have discussed, I understand that AAA is what [patient] values the most. If after the full treatment, he won't be able to AAA, he might not be able to accept. Did I understand correctly?
Recommend (As physicians are health professionals for patients and their families. The physicians could ask for opinions from the primary physician or another specialist as well.)	**(Applied as appropriate)** • I recommend that we should focus on reducing suffering and help [patient] as comfortably as possible. Therefore, treatment (procedures BBB, medication CCC, DDD care) will not bring benefit to him. It will not cure the disease, which we will not do. In other words, we will continue to provide the best care and not abandon him. We are hoping that he will not be in pain and be as comfortable as possible. • I recommend that we will do the full treatment with the hope of getting better from this illness. Using therapies (procedures EEE, medication FFF, GGG care). However, his health may not be able to recover from this illness in the end. The treatment team will continue to take care of him and may need to discuss this again in the future.
	What do you think?
	Do you have any questions?
Document	

Figure 4. Refined crisis conversation guide in Thai (translated into English).

attitudes, and healthcare systems.

Regarding the addition of the "gather the decision makers" step, this addition was completed because Thai culture values and prioritizes family, community, and spirituality over the principles of respect for individuality and autonomy that are central to medical practice in United States[15-19]. Studies report collectivism and filial piety to be the primary values typically found in Asian societies[18,20]. As a result, Asian patients tend to rely on family discussions for decision making[18,20,21]. Seriously ill Asian patients value care that includes family and community responsibility in decision-making[20]. In many Asian countries, including Thailand, a "beneficent" medical decision requires that all parties, including the physicians, the patient, and the patient's loved ones, balance everyone's feelings with the patient's preferences[18,20,22]. Joint decision-making with physicians and family is associated with better social and spiritual well-being, quality of life, and care coordination[20]. Additional studies positively correlate the well-being of Thai elderly with strong relationships with their communities such as harmony, interdependence, acceptance, and respect[23,24]. Even the term "independence" in reference to the well-being of Thai elderly is associated with community

relationships such as being a giver and devoting oneself to others and performing activities without burdening others[24]. Later on at the end of life, studies report that interpersonal relationships continue to provide meaningful support and contribute to a good death for Thai patients such as having a good relationship with family, being surrounded by the love and care of their families and having a good relationship with medical staff[15,16]. In contrast to studies from other countries, Thai people place less importance on their individual needs such as preparation for death, life completion, and being respected as an individual[15,19]. Instead, Thai people consider the concept of "kreng jai" , which mean balancing consideration for other people with self-interest, which has no direct English translation[25]. Informed by these studies, and in accordance with the panel's recommendation based on survey responses, the authors added the new step of "gather the decision makers" to reflect that many parties participate in the decision for a patient's medical care in Thailand.

With respect to the "explore values and preferences" step, adjustments were made to reflect that relationships and communities are deeply entwined with "autonomy" in Thai life. Many Thai people believe that all states of being are impermanent, uncontrollable, and will eventually disappear, including individuality, happiness, and even suffering[26]. This spiritual framework encourages Thai people to avoid clinging to their possessions and physical conditions and provides a natural coping mechanism for navigating an illness[24,27]. Thus, Thai society encourages the renunciation of self-interest, so the concept of individual autonomy is infrequently used. Instead, the importance of assisting the community and abiding by spiritual beliefs grows significantly throughout one's life[17].

The outcome of the present study survey demonstrated cultural disparities through communication on the patient's values or quality of life. The original conversation guide emphasized questions regarding the patient's values or quality of life that reflected a concept of autonomy based solely on individual patient preferences and disregarded other people's concerns such as "What abilities are valuable to the patient?", "If the patient was unable to return to his favorite activities...", and "How much discomfort do you think he will accept?"[22]. This notion of autonomy was entirely inconsistent with Thai beliefs and thus, less applicable to Thai people. Many survey responses indicate that this issue is challenging to understand for several reasons, including the preference of family members to label the patient as strong[27]. However, in the "explore values and preferences" step, the survey findings and the panel agreed that the most necessary question in crisis decision-making mentions the patient's preferences such as "Did the patient ever tell you what he would want or not want...?". These results prompted the expert panel to suggest that the physician provide appropriate and concrete examples of quality of life, such as walking or eating, to communicate the patient-centered goal of care.

Finally, another interesting cultural adaptation to the conversation guide was the replacement of "the best care" with "the appropriate care for the patient and family". The meaning of "the best care" for a serious illness is vague, and could refer to care focused solely on the patient's comfort or care that provides the highest level of medical interventions such as feeding tube, blood transfusion, and breathing machine[18,28]. At the end of life, traditional beliefs typically influence the preferred place of death, often at home or in a hospital[15,29]. The panel agreed that the revised phrase, "appropriate care for the patient and family", can help explore the family's vision for the patient's care, reduce conflict, and convey the physician's respect for the family.

The present study has important implications. For clinicians and researchers, this is the first study to implement goals-of-care conversations in Thai emergency medicine. According to the study results, the implementation of crisis conversation in the emergency medical setting seems feasible and beneficial. Emergency providers require attentive training and real-time refinement of their personalized conversations. For policymakers, emphasis on shared decision-making during medical crises should occur not only at family meetings or general practice appointments, but also in emergency situations.

The Thai crisis conversation guide requires additional refinement studies, including externally validated research in real-world clinical practice in emergency medical situations and with Thai patients and families. Further, the impacts of this crisis conversation guide on the patient and the emergency healthcare system must be studied. Lastly, the application of this crisis conversation guide by other healthcare personnel, such as paramedics, may warrant additional study.

For limitations, firstly, the study methodology has biases, particularly the retrospective self-reported nature of the survey itself. The translation processes

also have the potential for bias due to differences in language proficiency and translator biases. Measurement bias and inconsistent interpretation might result from a lack of inter-rater reliability checks in qualitative analysis, the exclusion of incomplete surveys, and the loss of survey reliability or validity measurements. Secondly, the present study of a niche topic resulted in a selection bias for the expert panel, which required remote online meetings and may limit interaction and affect the intricacy of their discussion. Thirdly, survey participation was voluntary and uncompensated, which may have resulted in self-selection bias. Only one group of 500 members of TCEP was invited to complete the survey, although these 500 physicians are the most active among the 1,400 members. However, the demographics of the study sample population grossly reflects the demographics of the field of Emergency Medicine in Thailand, which is majority female and predominantly young, in their 30s, due to the field's relative short tenure among specialties in Thailand, which was founded 20-years ago[30]. Fourthly, the authors conducted the study with only eight Thai clinical practice experts and 180 survey responses from 500 Thai emergency physicians. This sample size limited generalizability and was insufficient to characterize overall Thai linguistic and cultural communication, particularly in clinical practices. A large-scale multicenter study with an adequate sample size to account for variance throughout the country may be necessary for national generalization. Fifthly, time is a concern for overworked Thai emergency physicians. The survey respondents indicated that they needed to try this conversation guide during real-life crisis conversations before they could provide more feedback regarding practicality. Finally, emergency physicians in Thailand do not receive regular or curriculum-based palliative care training. Survey participants' responses may reflect their own clinical and personal experiences rather than a formal understanding of palliative care and communication principles. However, experts from both disciplines attempted to refine this conversation guide in the context of this gap. This crisis conversation guide would also be relevant for Thai emergency physicians without palliative care training or experience.

The authors' overall conclusion is that the culturally adapted Thai crisis conversation guide was refined and reported to be acceptable by more than 88% of Thai emergency physicians. Gathering the decision makers was crucial to this acceptability, as were modified approaches to exploring patient-centered medical care. The actual clinical application within Thai emergency physicians' crisis conversations is still unknown.

What is already known about this topic?

The best practice of the serious illness conversation in the emergency department is called the crisis conversation in English. Due to the linguistic and cultural effects of communication and conversation, Thai emergency physicians can adopt the crisis conversation guide in their practices.

What does this study add?

The serious illness conversation in the emergency department, called the crisis conversation, was culturally adapted to Thai. Over 88% of Thai emergency physicians reported accepting the cultural and linguistic adaptation of an existing English crisis conversation guide.

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Authors' contributions

TP, TT, SS, and KO and participated in conceptualization, project administration, and methodology. All authors provided manuscript editing. TP, TT, and KO performed data curations. TP, TT, SS, and KO analyzed and interpreted data. TP, TT, and KO performed the visualization and validation of data. KO was the overall project supervisor. All authors read and approved of the final manuscript. TP acted as guarantor.

Data availability

The data generated or analyzed during the present study are included in this published article. Other data used to support the findings of this study are available from the corresponding author upon request.

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Conflicts of interest

Dr. Kei Ouchi received consulting fees from Jolly Good, Inc., a virtual reality company, which had no relation to this manuscript. Other authors have no conflicts of interest to declare.

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