Bridging the Gap:

Physician–Patient Communication in Palliative Care
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SUMMARY

Palliative care is the active, comprehensive treatment and care of patients with serious illnesses that may be chronic, debilitating, life-limiting, or life-threatening, regardless of the prognosis. Palliative care is not only a philosophy of care but is a highly structured system for delivering care. Life-prolonging therapies and treatments to maintain quality of life and comfort form the foundation of palliative care, and comfort treatments through palliative care can be provided to patients of any age and regardless of life expectancy.

A team-based interdisciplinary approach to patient-centered care is used in palliative care that includes palliative care and other specialist physicians, nurses, pharmacists, nutritionists, social workers, clergy, and counselors. This type of patient-centered care is used to help patients and families in various ways, for example, by offering a venue to discuss treatments, facilitating patient–physician communication, providing emotional support for patients and families, and assisting with the coordination of care across healthcare settings or in the patient’s home.

Good physician–patient communication in palliative care leads to various patient-reported positive results: increased satisfaction, better outcomes, improved understanding, and increased adherence to treatment. Physicians who know how to communicate well and who establish good relationships and comfort levels with patients can also achieve personal benefits such as decreased job distress and less emotional stress and burnout. However, physicians do face barriers to addressing emotions and concerns, to communicating difficult news, and even to communicating the prognosis. These barriers are discussed in this article, as are the values added when these barriers are overcome.

Various models described in this article can help practitioners to overcome barriers to good communication. The SPIKES model contains six steps (SPIKES is an acronym for Setting, Perception, Invitation, Knowledge, Empathy, Summary/Strategy) and helps in preparing, discussing, and concluding conversations that involve delivering difficult or bad news. The Education for Physician on End-of-Life Care (EPEC) model is based on the SPIKES model and also contains six steps. Another model, ASCEND (Anticipate, Summarize, Concerns, Explore and Explain, Next Steps, Document), is a “short, behavior-based, adaptable approach” for initiating complex end-of-life discussions. The ASCEND model has been improved by the addition of a technique called motivational interviewing. Use of these methods by healthcare professionals to optimize preparation for communicating with patients in palliative care can increase the efficacy and decrease the emotional burden of these conversations for both physicians and patients.

Finally, tips for physicians are listed to initiate successful encounters with patients, create a comfortable environment, have positive conversations, elicit patients’ goals, provide information about any change in status of the disease course, finish conversations, and, importantly, offer hope.
INTRODUCTION

Definition of Palliative Care

What exactly palliative care means may be confusing because, as with many medical specialties, this term has changed over the years, varying from supportive care to pain management to symptom management. Palliative care can be defined as the active, comprehensive treatment and care of patients with serious illnesses that are chronic, debilitating, life-limiting, or life-threatening, regardless of the prognosis. According to The National Consensus Project for Quality Palliative Care, “The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life [QoL] for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is both a philosophy of care and an organized, highly structured system for delivering care.”

Palliative care is an integral part of healthcare designed to achieve the best possible outcomes, including optimal QoL and function. A foundational element of palliative care is the concurrent administration of aggressive life-prolonging therapies, along with QoL and comfort treatments. In contrast with patients who receive hospice care, patients who receive palliative care are not necessarily at the end of life when “there is nothing else to do.” Patients of any age, regardless of life expectancy, can receive comfort treatments through palliative care to address various symptoms and to help deal with the side effects of medical therapies. These wide-ranging symptoms of disease and side effects of treatments are both physical and emotional, and may include nausea, loss of appetite, constipation, shortness of breath, fatigue, depression, anxiety, and problems with sleep. Palliative care occurs at the same time as other treatments and does not depend on the course of the disease, as illustrated by the chronic conditions that are under the umbrella of palliative care: HIV, AIDS, and cystic fibrosis, along with diseases of the heart, lung, and kidney. In most cases, palliative care is initiated in the hospital setting; however, the patient can move from the hospital to another type of care facility or to the patient’s home. Most insurance plans help to pay for palliative care treatments.

Palliative care is a central and critical component of high-quality, evidence-based healthcare that helps patients by

- Providing a venue to discuss treatment choices
- Facilitating intensive communication between patients, family members, and healthcare providers, including extensive time spent listening to the concerns of patients and their caregivers
- Providing emotional support for patients and families
- Assisting with the coordination of care across various settings

To help ensure that all of these aspects of care are available to patients and families, a team-based interdisciplinary approach to patient-centered care is employed that includes palliative care and other specialized physicians, nurses, pharmacists, nutritionists, social workers, clergy, and counselors. Interdisciplinary teamwork helps to prevent discrepancies in information
provided to patients and to aid in identifying patients’ needs. All members of the interdisciplinary team caring for patients share the responsibilities of

- Striving to elicit patients’ needs and goals
- Understanding and clarifying patients’ needs and goals
- Advising patients on how to address their needs and achieve their goals

How Hospice Care Differs From Palliative Care

“All hospice care is palliative care, but not all palliative care is hospice care.” Patients in hospice care typically have 6 months or less to live and, in some hospice programs, can no longer be receiving curative treatments (e.g., cancer treatments, with the intent to extend life). Hospice care always includes palliative care. For example, pain and other symptoms are controlled to the degree possible so that patients can remain alert and comfortable, and support services are provided to family members. Hospice care also includes a spiritual aspect. The main goals of hospice care are to help provide patients with comfort, dignity, and peace. Hospice care can occur in a patient’s home, hospital, skilled nursing facility, or hospice center.
BARRIERS TO COMMUNICATION FACED BY PHYSICIANS

Most physicians, including specialists, face barriers to communication with patients and families. Physicians do not receive formal training during residency about communication, and even physicians who routinely deliver difficult news admit that they are unsure of their ability to do so properly. Moreover, physicians who specialize in palliative care often must perform the challenging task of communication “clean-up” with patients who have not had a proper discussion (ie, an “honest talk about the diagnosis and prognosis”) previously with a physician.

In the practice of palliative medicine, a lack of communication skills can have profound negative effects on the psychological adaptation to an illness for both patients and families. Many complex challenges related to physician–patient communication arise in interactions with patients who are facing a life-limiting illness, for example:

• Communication with each patient and each family is a unique experience.
• Patients and their families are experiencing a sense of tragedy.
• Patients and their families commonly articulate complicated problems.
• Patients present with varied desires, belief, and cultural practices.
• Patients may not completely convey their wishes about how much information they would like to receive.
• Relaying difficult or bad news is a stressful, psychologically difficult task, even for physicians who routinely deliver it.

Value of Good Communication to Physicians

The overall value of good communication is supported by the following, as reported by patients: Better outcomes, increased satisfaction, improved understanding, increased adherence to treatment, and decreased litigation. In addition, and despite the challenges, physicians who know how to communicate effectively and who establish a good relationship and comfort level with patients can achieve personal benefits:

• Physicians who feel more comfortable with their communication skills report less job distress.
• Physicians with higher levels of personal accomplishment report less emotional stress and burnout.
• Physicians who take the time to deliver bad news in a caring, professional manner not only support their patients emotionally during a difficult time but also experience a sense of personal reward and satisfaction. In addition, unhelpful interventions are avoided.
BARRIERS TO ADDRESSING EMOTIONS AND CONCERNS

Patients’ Emotions and Concerns

Conversations in which physicians must deliver bad news may need to be initiated on more than one occasion:

- At diagnosis
- At prognosis
- On receipt of subsequent test results
- When changes occur in the patient’s physical or cognitive function
- When no other disease-modifying therapy is available
- When there is a transition from home care to a care facility
- When there is transition to hospice care

Physicians often avoid delivering bad news because of a lack of comfort, time, or competence. Conversations that discuss difficult or bad news are laden with emotion for everyone involved—physicians, patients, and families. The concern that dealing with emotions will take up too much of the physician’s time is a legitimate one. However, evidence suggests that when emotional cues are missed, clinical interactions actually take up more of the physician’s time. Patients who are most in need of discussing emotional issues are least likely to spontaneously reveal their concerns, and patients with anxiety or depression are reluctant to initiate discussions about these problems. Thus, more responsibility is placed on the physician who is delivering the difficult news.

Value of Addressing Patients’ Emotions and Concerns

In patient-centered communication, attention is on establishing partnerships with patients, exploring and establishing common ground, understanding psychosocial factors, and understanding how the patient experiences the illness. Both verbal and nonverbal behaviors help to facilitate the exchange of information, build trusting partnerships with patients, decrease unnecessary utilization of healthcare resources, and facilitate recovery from illness. Physicians can work to develop emotional trust with patients so that they feel free to discuss their concerns. Dealing with patients’ emotions helps to decrease anxiety, prevent depression later in the course of the disease, and improve patient satisfaction.

Families’ Emotions and Concerns

Patients may or may not want family members involved during conversations with members of the healthcare team, and patients and family members often have differing needs for information. The literature shows that some patients want family present during discussions of the prognosis and other difficult communications, but other patients do not. In yet other instances, patients may want bad news delivered to their family, trusting that a family member will disclose the appropriate information to them.
Patients and family members often have differing needs for information during discussions that include bad news. For example, in a study of terminally ill patients with cancer, family members were often interested in hearing about the prognosis and what to expect as the disease progresses, whereas patients wanted information about daily living and symptom control. Caregivers also often need information about day-to-day management and problems, and about what may happen at the time of death.

Value of Addressing Families’ Emotions and Concerns

In some situations, it may make sense to have separate discussions to allow the physician to have the opportunity to explore individual informational needs. Consistent information should be provided to patients and families by the physician. Any desires on the part of a patient or family member to shield or protect each other from prognostic information should be explored by the physician. Patient preferences should be respected by the physician, including who should be and who should not be present during discussions, who will make decisions, and how a consensus will be reached.
BARRIERS TO COMMUNICATING THE PROGNOSIS

Research has shown that physicians are poor at discussing the prognosis in life-limiting illnesses.\(^4\) Physicians are generally reluctant to discuss the prognosis and prefer to do so only when patients bring it up.\(^7\) Thus, many patients, including those with end-stage disease, have not had prognostic discussions with their physicians. Also, when these discussions do take place, physicians often communicate an overly optimistic prognosis or only provide vague statements without a specific time estimate, even with patients who express a desire to hear the truth.\(^7\) In contrast, many patients overestimate the prognosis, including those who are told the truth.\(^7\) Physicians may worry so much about being inaccurate in regard to prognostication that they withhold information until the patient is so close to death that accuracy is assured.\(^7\)

Value of Communicating the Prognosis

Patients may want to know the prognosis when there is a new diagnosis or a change in their status. Although patients may need this knowledge for physical, emotional, financial, legal, or existential reasons, they may hesitate to ask questions for fear of the answers.\(^4\)

Examples of Negative Results of Poorly Communicating the Prognosis\(^7\)

- When prognostic uncertainty is expressed by physicians, patients often mistakenly place themselves in the most optimistic prognostic group.
- Patients who inappropriately believe in the curability of their cancer are more likely to choose alternative and aggressive treatments.
- A lack of an established rapport and inability to effectively deliver bad news to patients with cancer on the part of oncologists is a possible explanation for administration of futile chemotherapy at the end of life.
OVERCOMING BARRIERS: GO-TO ALGORITHMS ALREADY IN PLACE

Various models exist to help with effective communication in palliative care. The SPIKES (Setting, Perception, Invitation, Knowledge, Empathy, Summary/Strategy) model, developed by Robert Buckman, contains six steps to help physicians and other healthcare professionals to prepare, discuss, and conclude conversations that deliver difficult or bad news. Optimal preparation for conversations in palliative care, including those about the prognosis and goals of care, can increase the efficacy of these conversations and decrease the emotional burden for physicians and other healthcare providers.

### The SPIKES (Setting, Perception, Invitation, Knowledge, Empathy, Summary/Strategy) Model

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<tr>
<th>SPIKES</th>
<th>Definition</th>
<th>Statement(s)</th>
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<tr>
<td>Setting</td>
<td>Physical and temporal context in which the news is delivered</td>
<td>Use an open-ended question, such as, “What have you been told about what is happening?”</td>
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<tr>
<td>Perception</td>
<td>Obtaining patients’ current understanding of their medical condition</td>
<td>“Are you someone who prefers to know all of the facts about your illness, or do you want only a general description?“</td>
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<td>“How much information would you like me to give you about your diagnosis and treatment?”</td>
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<td>“Would someone in your family want this information, that is, someone you would be comfortable with knowing?”</td>
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<td>Invitation</td>
<td>Empowering patients to define the amount of detail they prefer</td>
<td>“How does this information make you feel?”</td>
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<td>Knowledge</td>
<td>Communicating the difficult information clearly and simply, and with a pause at the end of the delivery</td>
<td>“Unfortunately, I have some bad news to tell you.”</td>
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<td></td>
<td>“I’m sorry to have to tell you…”</td>
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<td>Empathy</td>
<td>Connecting with the patient emotionally, which involves understanding the patient without presuming to know exactly how the patient feels</td>
<td>“How does this information make you feel?”</td>
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<td></td>
<td></td>
<td>“I imagine this must be difficult...”</td>
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<tr>
<td>Summary/</td>
<td>Making clear follow-up plans regarding goals, treatments, and ways to access resources</td>
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<tr>
<td>Strategy</td>
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The Education for Physician on End-of-Life Care (EPEC) communication model also contains six steps and is similar to and based on the SPIKES model.10

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<tr>
<th>EPEC (Education for Physician on End-of-Life Care) Model10</th>
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<td>1. Getting started and preparing for the interaction</td>
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<td>2. Assessing the patient’s knowledge about the illness</td>
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<td>3. Gauging and determining the amount of information the patient desires</td>
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<td>4. Delivering the difficult or bad news</td>
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<td>5. Responding to the patient and family</td>
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<td>6. Discussing a follow-up plan and treatment options</td>
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Another model used to help in palliative care communication is ASCEND (Anticipate, Summarize, Concerns, Explore and Explain, Next Steps, Document). ASCEND is a “short, behavior-based, adaptable approach” for addressing key medical communication issues, more specifically, complex end-of-life discussions.11 Of course, this model, like any other, in no way replaces experience or training in communicating; however, the ASCEND pathway is beneficial because it can be taught in a 1-hour seminar (or Internet webinar) and can be reinforced with inexpensive products (eg, laminated pocket cards and posters).

In the SPIKES model, some language is used that may not be as comprehensive and memorable as the ASCEND mnemonic. Compared with SPIKES, ASCEND has more positive connotations and has been modified more.11

The ASCEND model has been improved with the supplementation of motivational interviewing (MI). MI was initially developed in the 1980s to help patients with a drinking problem stop alcohol use and has since been applied successfully in different settings (eg, primary care and addiction therapy). Some MI techniques have been shown to “help reduce a patient’s resistance, resolve patient ambivalence, and support patient autonomy.”12 The philosophy behind MI emphasizes the partnership between physicians and patients and the eliciting of patients’ internal motivations. MI is based on three principles12:

1. **Collaboration**: Physicians and patients should work as partners to reach a common goal. Unlike traditional medical encounters, in which physicians view themselves as providing expert opinions to patients, physicians view patients as experts in their own lives.

2. **Autonomy**: Physicians respect patients’ ability to make decisions. Patients are treated as autonomous, with the freedom to decide whether to and how to adopt new behaviors.

3. **Evocation**: Physicians elicit information from patients about internal motivations and help patients reflect on the advantages of and barriers to change. Patients are more likely to change when they, rather than the physician, express their values, goals, and
ideas for change. The physician, in turn, strives to elicit patients’ internal motivations to make their own decisions rather than educate or warn patients about what they should or should not do.

Four key principles serve as a guide to implementing the MI philosophy\textsuperscript{12}:

1. **Resist the righting reflex** (the automatic attempt to help or correct the behavior): Resist reacting to patients acting in ways that are not necessarily in their best interests. Patients in palliative care might be making choices that are unlikely to extend life and may impair QoL.

2. **Understand patients’ motivations**: Be open-minded and curious about patients’ individual experiences and motivations. In understanding patients’ unique motivations, and because motivations drive behaviors, physicians can better guide patients toward choices that are aligned with their values.

3. **Listen to patients**: Seek to create safe environments in which patients and families feel accepted and free to express their emotions and beliefs. In safe settings, patients are better able to work through conflicts and weigh the tradeoffs that they may need to make as the disease progresses.

4. **Empower patients**: Empower patients or family members in the decision-making process, and narrow the power differential that naturally exists between patients and physicians. Empowering occurs, in part, when physicians support patients’ self-efficacy or the confidence that patients require in order to accomplish a task, such as making a difficult decision. Because difficult decisions need to be made frequently in palliative care, self-efficacy is especially important.

The following three key components are addressed through the ASCEND + MI pathway, which allows for proper, shared, and successful decision-making by the physician–patient/family team\textsuperscript{19}: Identification of patient preferences, clear explanations of important medical information, and development of a consensus around a treatment plan.
## ASCEND Communication Pathway, With Added MI Techniques

(During the encounter, a family member may serve as a “proxy” for the patient)

### Anticipation
- First, set goals for the interaction (eg, to assess the patient’s understanding of the condition).
- Include the care team.
- Have everyone be seated.
- Introduce all participants by name and include their roles.
- Assess the patient’s capacity and desire for information.
  - Use open-ended questions to encourage the patient to talk more. The team can understand the patient’s motivation by listening to the patient.\(^\text{12}\)

### Summary
- Encourage the patient to summarize his or her knowledge of
  - The disease or condition
  - Current treatments
  - Expectations
- Provide any information or clarification that the patient needs.

### Concerns
- Before relaying new information, pause to identify any specific concerns of the patient.
  - Acknowledge all concerns, even if they cannot be addressed immediately.
  - Use at least two reflections\(^*\) for every question to help patients to elaborate on their concerns, to help them to believe they have autonomy, and to lead to evocation.\(^\dagger\),\(^\text{12}\)

### Exploration/Explanation
- Depending on the goals of the interaction and the needs of the patient\(^\text{12}\):
  - Present new information.
  - Explore possible goals and preferences, and provide recommendations based on them.
    - Define short-term and long-term risks and benefits, and possible alternatives.
    - For options with uncertain benefits, recommend a “trial of treatment.”
  - Use patient affirmations\(^\dagger\) to show that the patient is respected and to empower the patient in decision-making.

### Next Steps
- Define a clear plan, which should include ways in which to
  - Address conflict or uncertainty
  - Monitor progress

### Documentation
- Document A-S-C-E-N, and the amount of time spent on the encounter.
- Encourage patients to take notes about the information provided and write down any questions.

\(^*\)Reflections are restatements of the patient’s words or guesses at what the patient meant to say that are used to reflect back to the patient what he or she has said.\(^\text{12}\)

\(^\dagger\)In evocation, information is elicited from patients about internal motivations to help them reflect on the advantages of and barriers to change. Patients are more likely to make changes when they express their own values, goals, and ideas for change. In turn, the clinician should strive to elicit the patient’s own motivations rather than express what the clinician thinks the patient should do.\(^\text{12}\)

\(^\dagger\text{Affirmations allow physicians to recognize and show respect for patients.}\(^\text{12}\)
TIPS FOR PHYSICIANS

General Tips

- When getting test results with potential difficult or bad news, schedule a follow-up appointment instead of having the patient wait for a phone call.4
- Keep phrases in mind that you want to use during the conversation, but do not use them as a script.4
- Avoid the use of superficially reassuring phrases such as “don’t worry.”4
- Use open-ended questions to explore the patient’s goals and values.12
- Summarize; that is, gather and present a set of reflections to the patient. Summaries can help patients and families organize their experiences, and can be used to make the transition from exploration to giving information and making decisions.12

Initiating a Successful Encounter

The physician can prepare for an encounter by determining the answers to the following questions7:

- Who will provide the information?
- Who will receive the information?
- At what physical location will the information be given?
- How much information does the patient want to know? How much information does the family want to know?
- Does the patient want family members involved during discussions of medical care?

A physician who is an expert in the patient’s condition should provide the information. The healthcare practitioner most involved in the patient’s care, or the one with the most established relationship, is best suited to give difficult or bad news.7 Be sure to have a working knowledge of potential areas of discussion to avoid being caught by surprise or appearing uninformed.7

Creating a Positive Environment

Physicians can create a supportive environment and indicate that they have ample time for the encounter.7 Physicians can show that they have ample time by sitting down, removing any objects obstructing everyone’s view, making eye contact, and intently focusing on the patient and family.7 Physician also can7:

- Select a private, quiet, and comfortable setting that is free of distractions.
- Not rush the conversation, because doing so usually leads to decreased satisfaction; a higher proportion of talking by the family compared with talking by the physician increases satisfaction.
- Use appropriate body language during discussions.
**Having a Positive Conversation**

Physicians can begin the conversation by assessing the patient’s and family’s understanding of the medical situation to help ensure a shared understanding and provide the opportunity to correct any misconceptions:

- Patients generally desire information about their diagnosis, treatment, and prognosis. However, physicians should ask patients *how much* they want to know before giving information.
- Patient satisfaction is higher when information is given at the patient’s pace and level of detail desired.
- The amount of information provided at one time should be limited, with physicians giving no more than three pieces of information without a break.
- Patient goals, values, and concerns should be elicited by physicians with the use of open-ended questions that focus on the psychological aspects of the illness. Areas of poor understanding should be clarified and any new information summarized.
- During discussions of difficult or bad news, the patient’s emotional cues should be explored by the physician through the use of empathic statements and appropriate nonverbal behaviors expressing empathy. Openly communicating empathy will help to decrease the patient’s anxiety.
- Patients and families place a value on the physician checking for comprehension, and they emphasize that there should be time throughout the discussion to ask questions and discuss topics that are not clear.

**Eliciting Patient Goals**

Physicians need to be able to:

- Provide examples of the potential goals of care
- Begin with open-ended questions
- Follow up with specific questions
- Acknowledge the uncertainty of the situation and the fact that goals may change
- Ask the patient for specific goals and tasks

The patient may want to achieve a specific personal goal; for example, a patient may have the goal of attending his or her daughter’s wedding in 6 months. To elicit the patient’s goal, the physician might say something such as “From our talks before and from my conversations with your daughter, it seems like an important thing for you at this stage is to attend her wedding.”

**Relaying Changes in Status**

Patients may want to know the prognosis when there is a new diagnosis or a change in their status, but may hesitate to ask questions for fear of the answers. A helpful start would be for the physician to say something such as “Some patients want to know about any change in the prognosis. Is that something that would be helpful to you?” This question gives the patient the
option of not hearing about it. If the patient wants that information, the physician may present the best estimation using ranges of time (eg, hours to days, days to weeks, weeks to months, months to years). Of course, if the prognosis changes, the physician should initiate another conversation with the patient.

**Ending the Conversation**

At the end of the discussion, the information should be summarized by the physician and a plan made for future care. Family meetings to discuss difficult or bad news often do not provide a definite clinical direction; therefore, a plan for interim care and future meetings should be established at the conclusion of the discussion. Meetings between physicians and patients and their family members should be frequent, because increased frequency of meetings has been shown to increase patient satisfaction.

**Offering Hope**

Many physicians worry that being truthful about the prognosis may contribute to a loss of hope. Healthcare providers, patients, and families rate the provision of hope as very important, even in situations involving a terminal prognosis, and report increased stress when told that “nothing more can be done.” Providing hope does not mean that physicians must do whatever is necessary to preserve the idea of a treatment effect or a cure. At all stages of illness, physicians can provide hope and a positive outlook even in the face of a poor prognosis:

- Such hope should be realistic and should focus on topics such as goals of care, symptom control, and supportive resources, rather than on unrealistic expectations. For example, patients who are terminally ill want reassurances that their physician will take care of them, and not abandon them, and that they will not suffer.
- Such practices are consistent with the psychological hope theory, in which hope is defined in terms of selection of goals, identification of pathways, and motivation to attain goals. Patients with high hopes are able to identify attainable goals, find alternative pathways, and summon the motivation and energy to achieve their goals.
- However, in situations in which the desired goals are unattainable, as in the case of patients who are dying, it is beneficial to focus on alternative, attainable goals.
- Physicians can help patients realize these new goals and maintain hope by providing clear information, controlling symptoms, and helping to maintain functionality.
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<th>Meaning</th>
<th>Example</th>
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<tr>
<td>Acknowledgment</td>
<td>Naming an emotion or a communication barrier</td>
<td>“It sounds like you are angry.”</td>
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<tr>
<td>Exploration</td>
<td>Probing for more information</td>
<td>“Tell me more.”</td>
</tr>
<tr>
<td>Empathy</td>
<td>Expression of understanding of another’s experience</td>
<td>“I can’t imagine how difficult this is for you.”</td>
</tr>
<tr>
<td>Legitimation</td>
<td>Validating an opinion or emotion</td>
<td>“Most people would feel the same way.”</td>
</tr>
<tr>
<td>Summarize</td>
<td>Rephrasing and confirming what was said</td>
<td>“Let me make sure that I’ve heard you correctly…”</td>
</tr>
<tr>
<td>Firing a warning shot</td>
<td>Alerting the patient to impending bad news</td>
<td>“Mr. Smith, I’ve looked at your lab results, and I’m afraid they are not good.”</td>
</tr>
<tr>
<td>Use “I wish” statements</td>
<td>Using a statement that allows alignment with a patient’s desires, but implicitly acknowledges that it is not likely to occur</td>
<td>“I wish we had a way to make you better.”</td>
</tr>
<tr>
<td>Delivery of no more than three pieces of information before pausing for a break</td>
<td></td>
<td>“Your father is very weak and has not been eating or drinking for the past several days. Unfortunately, I don’t think he is going to recover and be able to eat on his own. He will likely continue to decline and become less responsive over the next few days. I’ve just shared a lot, are you still with me?”</td>
</tr>
</tbody>
</table>
CONCLUSION

Physicians who take the time to have important conversations in a caring and professional manner can provide emotional support for patients during difficult times. In contrast, a lack of communication skills by physicians who practice palliative care can have profound negative effects on patients’ psychological adaptation to a serious illness. Patients are not only experiencing a sense of tragedy but are also facing complicated medical and personal issues.

Physicians often avoid delivering difficult or bad news because these conversations are laden with emotions for everyone involved. Physicians who use patient-centered communication to establish partnerships with patients, establish common ground, and understand how patients experience serious illness can develop emotional trust with them. Doing so will help to decrease patients’ anxiety, prevent depression later in the course of the disease, and improve patient satisfaction.

Physicians also need to consider and respect family dynamics and to provide consistent information to patients and families. It is important for physicians to respect the patient’s preferences as to which family members should and should not be present during discussions, which family member will make decisions, and how a consensus will be reached.

This article describes several models to help physicians with preparing for and having effective conversations with patients in palliative care: SPIKES, EPEC, ASCEND, and ASCEND + MI. These models use the mnemonic device to help physicians recall the steps in each. All of these models focus on a collaborative environment between the physician, patient, and family. The key components of SPIKES and EPEC are obtaining the patient’s current understanding of the medical condition; empowering the patient to define the amount of detail he or she prefers; connecting with the patient emotionally; and making clear follow-up plans about goals, treatments, and access to resources so that the patient does not feel abandoned. The ASCEND and ASCEND + MI models focus on collaboration between physician and patient, understanding the patient’s motivation, listening to the patient, and providing the patient with autonomy regarding making decisions.

The last section of this article provides various tips for physicians. Some forethought on preparing for the encounter can help; for example, through conversations with the patient, the physician can determine how much information the patient wants to know and how much information the patient wants family members to be given. The physician can create a supportive environment by selecting a private, quiet, comfortable area for the conversation and not rushing. To elicit patient goals, physicians can provide examples of the goals of care, acknowledge the uncertainty of the situation and the fact that goals can always change, and ask patients about their specific goals. Finally, physicians can help patients realize their goals and maintain hope by providing them with clear and accurate information, controlling their symptoms, and helping to maintain their functionality.
REFERENCES


