Discussing Palliative Care with Patients

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Palliative care focuses on relief of suffering, psychosocial support, and closure near the end of life. Even experienced physicians often struggle when initiating complex, emotionally laden discussions about palliative care with seriously ill patients and their families. We use two hypothetical case scenarios to illustrate how physicians can initiate these discussions and to emphasize and illustrate several communication techniques.

Physicians can elicit a patient's concerns, goals, and values by using open-ended questions and following up on the patient's response before discussing specific clinical decisions. Physicians can acknowledge patients' emotions, explore the meaning of these emotions, and encourage patients to say more about difficult topics. Physicians should also screen for unaddressed spiritual and existential concerns. Some patients may make statements or ask questions that are difficult for physicians to respond to. We provide examples of responses that align the physician with patients' wishes without reinforcing unrealistic plans. Exploring such difficult issues may lessen feelings of aloneness even when the physician cannot "fix" the problem,

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metastases was adequately controlled with around-the-clock opioids.

Physician: What is your understanding of where things stand now with your illness?

Mr. A.: I know that the cancer is growing in my liver and that things don't look good.

Physician: Yes, I wish that the liver lesions had gotten smaller. (Pause.) Tell me what is most important to you now.

Mr. A.: I want to spend as much time as possible at home with my family.

Physician: How is your family coping with all of this?

Mr. A.: (Starts crying.) My daughter is afraid to be with me because of all the bruises and the black eyes.

It is easy to imagine several ineffective ways that a physician might have responded in case 1. The physician might not have checked the patient's understanding of his prognosis or inquired about his concerns, but instead talked about the biotechnical aspects of care, such as the results of clotting studies. When the patient said that "things don't look good," the physician might have exhorted him not to lose hope and directed the discussion to experimental chemotherapy. When the patient began to cry, the physician might have tried to protect himself and the patient and squelched the discussion by turning the conversation to how adjusting the heparin dose might resolve the bleeding that frightened his daughter. More constructively, the physician could continue to explore Mr. A.'s experience.

Physician: What would you like to say to her when she is afraid?

Mr. A.: (Still crying.) I want her to know that it is still me and that I love her more than she can ever know.

Physician: You love her so much, it must feel terrible to think about leaving her. (Pause.) How can your time with your daughter be as meaningful as possible?

What communication techniques contribute to the success of this physician–patient interaction? The same simple techniques that physicians are trained to use in everyday clinical encounters can facilitate discussions in palliative care. These techniques include exploring the patient's perception of illness and prognosis by using open-ended questions and by asking follow-up questions that incorporate the patient's own words.

In this interview, the physician first elicits the patient's concerns, goals, and values rather than discussing specific clinical decisions. Aviewt,ons. Aviewt,r. oowoowi76t nswn:

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important to have a physician who was spiritually attuned to them (18). More direct follow-up ques-

care, discussing how angioplasty might improve her health, so that she would not need to depend on her daughter. As an alternative, the physician could have said that her daughters obviously loved her deeply and were glad to help her. Instead of limiting discussion through reassurance, the physician began to explore the patient's concerns by building on her statements:

Physician: In what ways do you feel like a burden?

Mrs. D.: I am terrified of being alone when my daughter is at work. What if something happens and I suddenly can't breathe? My daughters have to work, and they can't spend their whole lives caring for me. Yet I don't want to go to a nursing home.

Physician: You sound very distressed about the possibility of a nursing home. What is the worst part of that for you?

When this line of inquiry is complete, the physician might explore the patient's other main fear of being unable to breathe as her condition deteriorates:

Physician: What terrifies you the most about your breathing?

Mrs. D.: The feeling of suffocation is so frightening. I am not at all afraid of death, but I am terrified of drowning along the way.

Instead of immediately trying to reassure the patient, as the daughter did, the physician encourages the patient to say more about her concerns. The physician uses Mrs. D.'s own words about being a burden or going to a nursing home or suffocating to further probe her concerns. Physicians naturally want to reassure patients. However, reassurance may deter patients from disclosing their concerns and emotions in enough detail that they can be understood (7). In addition, offering reassurance prematurely before fully understanding patients' concerns may paradoxically increase their worry about the future. Eliciting and openly discussing Mrs. D.'s fears enables the physician to develop a comprehensive, individualized plan to address her problems. Although Mrs. D. did not want major surgery, she agreed to angioplasty to relieve ischemia-related dyspnea and allow her to be more active. In addition, the family and social worker would look into geriatric day care so that Mrs. D. would not be alone during the day.

Because Mrs. D. was terrified about feeling short of breath, the physician reassured her that severe shortness of breath could be relieved in the future. The physician suggested having the daughters learn to administer morphine to her at home if needed.

Mrs. D.'s daughter: Wait, you're not giving up on her, are you?

Physician: Absolutely not! Morphine is one of the most effective medicines we have to relieve shortness of breath. I will explain more in a minute. But first can you tell me what you mean by "giving up"?

The physician's initial response to the daughter is an unqualified expression of nonabandonment (20) and a clarification of the role of morphine to palliate shortness of breath. He follows this with an open-ended question to clarify the daughter's perception of "giving up." Later, the physician can explore the daughter's concern about the use of opioids by asking, "What have you heard about morphine to relieve shortness of breath or pain?"

Another objection is that, in a multicultural society, patients have very different attitudes toward discussing death. In particular, some cultures believe that discussion of death hastens its occurrence (26, 27). Thus, advance planning about end-of-life care may be inappropriate for patients from these backgrounds. Usually, it is still possible to talk sensitively about alleviation of suffering, concerns about the future, or how serious illness is managed and discussed in their culture. Because people vary within every culture, each patient and family needs to approached as individuals. The approaches recommended in this paper, which encourage the physician to listen carefully and allow the patient's concerns to drive the discussion, ensure respect for patients' values.

Conclusion

In conclusion, palliative care is important to consider throughout the course of serious chronic illness. Interviewing techniques, such as asking open-ended questions about end-of-life issues, building on and exploring patient responses, and addressing the associated emotions, can help initiate difficult discussions about palliative care. In addition to addressing physical suffering, physicians can extend their caring by acknowledging and exploring psychosocial, existential, or spiritual suffering. As patients struggle to find closure in their lives, active listening and empathy have therapeutic value in and of themselves.

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