For patients with serious progressive illness, the decision to move from curative to supportive care is challenging. It can be devastating for some, a relief for others, but it will be stressful for those involved, including physicians and their medical teams. Guidelines and educational programs are available to clinicians on delivering bad news, discussing advance directives, and arranging end-of-life care. However, less is known about talking to patients when the disease progresses despite all appropriate and available biological treatment, yet the patient is not immediately terminal. These conversations are particularly challenging when the benefit of continued treatment is uncertain and when it involves substantial burden or risk of harm. At this point, which may be early or late in the disease, there is often a shift in treatment goals from prolonging survival to improving quality of life.

Communicating at the transition is difficult. Surveys of cancer patients show that 70% perceive their oncologist as a major source of support, but over 80% have trouble communicating with them [1,2]. Up to 20% of oncologists rate their communication competence at transitions as low. Several factors may contribute to making these dialogues challenging. Family members may ask physicians and patients to “do everything possible.” Health care systems are organized and financed around biotechnical tests and treatments rather than end-of-life care [3]. Physicians, by selection or training, may lack the knowledge, skills, and attitudes required for these conversations [4,5].

The Bayer Institute for Health Care Communication has developed a workshop for clinicians on communicating at the transition from curative to palliative care. This event occurs most commonly in cancer care, and much of what we know about these transitions is drawn from the oncology literature. We used this body of literature as well as the general medical literature on communication to develop our approach, which is described in this paper.

Communication Skills at the Transition

Our approach to communication at the transition comprises 4 steps (Table 1). The Relate and Review steps are for relationship building and information exchange and ideally occur at every visit. The Revise and Reflect steps are for redefining the goals and methods of care and are used in transition conversations. Each step involves the application of specific skills or actions.

Relate

The Relate step includes 4 key competencies: (1) demonstrating readiness to listen, (2) eliciting concerns and resources, (3) expressing empathy, and (4) establishing preferences for information and decision making. Demonstrating readiness to listen is a nonverbal skill that involves minimizing physical barriers to communication (eg, noise, bed rails, desks, charts), making eye contact, and facing the patient at an angle over shared space so that each person can look away as desired. Nonverbal communication through body posture, eye contact, and voice tone is a major element of empathy and rapport [6,7].

Eliciting the patient’s full range of concerns is the second Relate competency. This not only involves discussion of symptoms and treatments, but also functional status, ideas about what might be wrong, feelings and attitudes about the disease and treatment, and expectations of what will happen. Stewart et al summarizes these skills in the mnemonic “FIFE,” which stands for Function, Ideas, Feelings, and Expectations (Table 2) [8]. They also showed that these and related patient-centered care skills result in improved self-rated patient health status and reduced diagnostic tests and referrals [9].

The third Relate skill is expressing empathy. Most physicians elicit concerns appropriately with open-ended questions but then block additional disclosure and discussion with premature explanations, decisions, or reassurance [10,11]. Physicians often block a patient’s expression of emotion, fearing that they do not have the time or the expertise to respond [11]. The appropriate response is a simple empathic statement, which does not add significant time to the interview [12] and is highly correlated with positive health care outcomes [13]. Fogarty et al asked 123 women with breast cancer to watch 1 of 2 videos of a physician giving information to a woman with breast cancer. One of the tapes runs an extra 40 seconds because the physician makes 3 or 4 empathic statements. Patients watching the tape including empathy statements rated themselves less anxious and perceived the doctor as more pleasant, caring, and helpful than the patients watching the tape without empathy statements [14]. The elements of...
responding empathically are summarized in the “NURS” mnemonic (Table 3): Name the feeling, Understand and legitimate the feeling, Respect coping efforts, and Support the patient [15]. Most patients express gratitude and resume the visit in response to physician empathy.

Eliciting the patient’s preferences for information and participation in decision making, the fourth Relate skill, simply means asking patients how much information they would like to have about their condition and treatment (eg, “Are you the sort of person who likes lots of details or more the big picture ...”). Some patients exercise their right to information by delegating it to someone else, such as a family member. Patients can also be asked about their preferences regarding decision making (eg, “Do you like to decide things on your own, or do you like to have recommendations ...?”) [16]. Another useful question is, “Do you have any family or cultural preferences for medical care that I should know about?” The information can guide the clinician as he proceeds on to the next steps.

<table>
<thead>
<tr>
<th>Table 1. Communication Skills for Transitions to Palliative Care</th>
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<tbody>
<tr>
<td><strong>Relate</strong></td>
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<tr>
<td>Look ready to listen</td>
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<tr>
<td>Elicit patient concerns without interruption</td>
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<tr>
<td>Express empathy</td>
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<tr>
<td>Establish preferences for information and decision making</td>
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<tr>
<td><strong>Review</strong></td>
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<tr>
<td>Ask before you tell</td>
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<tr>
<td>Give information effectively</td>
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<tr>
<td>Describe the transition</td>
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<tr>
<td>Outline the future</td>
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<tr>
<td><strong>Revise</strong></td>
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<tr>
<td>Revise the definition of care</td>
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<tr>
<td>Revise the goals of care</td>
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<tr>
<td>Foster and maintain realistic hope</td>
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<tr>
<td>Share control of decisions</td>
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<tr>
<td><strong>Reflect on how the transition affects:</strong></td>
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<tr>
<td>Your roles with patients</td>
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<tr>
<td>Your relationships with patients</td>
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<tr>
<td>Resources you draw on for patient care</td>
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<td>Rewards you experience from patient care</td>
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The Review step includes reexamining information about the nature and stage of disease at diagnosis, intent of treatment thus far, and results of treatment. This is important because patients and their physicians may have a different level of understanding in these 3 areas. For example, Quirt and colleagues interviewed 100 lung cancer patients at various stages of the disease and their treating oncologists.

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<tr>
<th>Table 2. Eliciting the Patient’s Perspective on Illness (“FIFE”)</th>
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About a third of patients thought that their disease was less extensive at diagnosis than their oncologists did. Of those patients, a third believed that they were being treated with curative intent, while their oncologists were treating them with palliative intent [17]. The goal of the Review step is to reach a shared understanding of these data and their meaning. The 4 skills in this step are: (1) ask then tell, (2) give information, (3) describe the transition, and (4) outline the future.

The most effective way to begin giving information is to find out what the patient already knows or understands about their disease and treatment. This technique can avoid unnecessary review of information, uncover misunderstandings for correction, and provide opportunities to answer questions.

The second Review skill is giving the new information. As in other “giving bad news” situations, patients appreciate hearing information about treatment failure in a caring but straightforward way [18]. New information should build on the patient’s prior understanding and be given in digestible “chunks” with a minimum of jargon. There should be short summaries and pauses every few minutes to answer questions. Some physicians record the visit on a stage-specific template with prompts for extent of disease, intent of treatment, and treatment results, with a copy for the patient, as adjuncts to this discussion [19,20]. To check new understanding, ask patients what they will tell friends and family when asked, “What did the doctor say?”

Describing the transition and outlining the future are the remaining Review skills. Describing the transition means calling attention to the findings and their meaning:

“The disease hasn’t responded like we hoped—I wish there were better treatments. We won’t be able to remove it or cure it. Some other treatments might slow it down a bit, but could also make you feel worse.”

The word “wish” is strategically used here; wish acknowledges that it will not happen, while hope implies that with sufficient effort or luck, it could happen [21]. The mention of other treatments introduces the next skill, outlining the future. Patients may fear abandonment by their medical team if disease-modifying treatment is stopped. Patients may also
feel guilty about failing treatment or giving up, disappointing those who have supported them through vigorous and costly treatments [5,21–26]. The goals of this skill are to make sure that the patient does not feel abandoned by the medical team and to assure the patient that care and treatment will continue, but with different goals and methods [10,27].

“I can explain the choices we have and what you might expect from each. I can help decide, but I need to know what you hope to gain from more treatment. That way, we can tailor it to fit your needs.”

**Revise**

The Revise step is central to the transition dialogue and includes (1) revising the definition of treatment, (2) revising the goals of care, (3) fostering and maintaining realistic hope, and (4) sharing control of treatment decisions.

Revising the definition of treatment proposes to define treatment as now aimed at a broader target [10,27–29]. Whereas treatment was once aimed at curing or controlling disease, it is now aimed at improving quality of life. Disease-modifying treatments may be used in the service of specific palliative goals such as relieving pain or temporarily restoring function.

Revising the goals of care, the second Revise skill, is the identification of specific goals within the broader treatment target. These goals can be found by revisiting the “FIFE” questions (Table 2). What does the patient really enjoy doing now? What does he find most important? What prevents him from doing those things? If he was to “hope for the best but prepare for the worst,” what would those be now? If cure or control of disease are not possible, what is the next best thing to work toward [10,18]? Some examples of new goals for the patient are staying out of the hospital, keeping as comfortable as possible, maintaining a usual role or function, doing a special activity or event, reconciliation with others, and attention to psychological and spiritual needs. Revising treatment goals requires agreement and cooperation by the entire treatment team. This can be as simple as shifting attention and language away from the disease process (“Your X-rays show you are improving”) and toward relief of suffering and maintaining function (“I can see you are able to sit up longer today.”) [29]. Family meetings (with the patient’s permission) are useful for giving information and answering questions about revisions in care goals.

The Revise step also deals with the issue of hope. Patients rarely lose hope but the objects of hope (what you hope for, when, and how) and the sources of hope (medicine, family, faith, other people) may change as the disease progresses [30]. For example, the initial hope may be for a cure, then for time with family, then for relief of pain, and finally for a peaceful death at home. Physicians who define hope in terms of disease progression or treatment response may experience treatment failure as a loss of hope, and unintentionally communicate their loss of hope to patients and families. Alternatively, physicians can generate and influence realistic hope by asking what the patient is expecting and then wondering aloud how closely that goal can be approximated, and what is needed to do so [31].

A patient hoping to attend a granddaughter’s college graduation became unable to travel due to weakness and shortness of breath from progressive heart failure. She did not improve with adjustment of her medications or short courses of intravenous inotropic agents. When asked what making the trip meant to her, she said she needed to deliver a personal message to her granddaughter. Once they were clear about her goal, the team arranged for the hospital’s media department to help the patient make a video of her delivering the message, which was sent to the granddaughter’s home for arrival in time for the graduation.

In this example, the medical team found a way to join with the patient and help her achieve her goal. This approach generates choices and actions, connection with others, expression of ideas and feelings, and a sense of meaning and self-efficacy.

The fourth Revise skill is sharing control of decisions. Patient preferences for participating in decisions vary [32], but those who take an active role appear to have better health outcomes [33]. Simply offering treatment choices to women with breast cancer decreases their distress [34].

**Table 3. Components of the Empathy Statement (“NURS”)**

<table>
<thead>
<tr>
<th>Name the feeling</th>
<th>“You look [angry, frightened, sad] about this.”</th>
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<tr>
<td></td>
<td>Note that accurately naming the feeling is not critical, since patients will provide clarification, especially when asked “Have I got that right?”</td>
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<tr>
<td>Understand the feeling</td>
<td>“It’s understandable you’d feel that way.”</td>
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<td>This is preferable to “I can understand” because some patients will reply, “No, you can’t, unless you’ve been through this yourself.”</td>
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<tr>
<td>Respect the patient’s attempt to cope</td>
<td>“You’re doing the right thing by getting it checked out.”</td>
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<td></td>
<td>Note that any healthy response qualifies as coping; the default is coming in for help.</td>
</tr>
<tr>
<td>Support and partner with the patient</td>
<td>“I look forward to helping you with this.”</td>
</tr>
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<td></td>
<td>Support and partnership, or expressing a desire to work together on a problem, is therapeutic.</td>
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Adapted with permission from Smith RC. Patient-centered interviewing: an evidence-based method. 2nd ed. Philadelphia: Lippincott Williams & Wilkins; 2002.
the other hand, major challenges to shared decision making exist. The limitations of language, both qualitative and quantitative, make it very difficult for physicians to explain probabilistic information without bias [35]. Physicians (with or without clinical prediction rules) are not very good at predicting when an individual patient will die [23], or disclosing a poor prognosis to the patient [25]. To achieve shared decision making, physicians and patients must agree on the relevant medical terms and meanings; make their values and beliefs about the disease and treatment explicit; be able to restate problems and brainstorm solutions; and be willing to make concessions [36].

Reflect
The Reflect step consists of self-awareness skills to help physicians consider the impact of the transition on their approach to patients. The skills are important because physicians have little opportunity to debrief their patient care experiences with colleagues or receive feedback about their communication and interpersonal skills. When treatment shifts from disease-modifying to primarily palliative care, physicians can experience change in roles, relationships, resources, and rewards for doing work.

Role is defined as personal or professional accountability. During disease-modifying treatment, physicians are expected to optimize certainty about the diagnosis and best treatment options, to carefully control the risks and burdens of treatment, and ultimately to bear major responsibilities for the outcomes of care. During and after the transition, physician roles change from bearer of facts to witness and guide, from controller of care to explorer and negotiator of possibilities, and from responsibility for care outcomes to care processes—that is, how care decisions are made and communicated.

The doctor-patient relationship and how it changes at the transition is addressed in the second Reflect skill. Physicians find an emotional distance that is appropriate for most patients, but this balance of tenderness and steadiness is challenged when treatment stops working and patients die of their diseases [37]. Physician reactions can include shame, grief, and avoidance of patients, or a single-minded pursuit of success measured only in biological terms [5,22–26,38]. Physicians must also learn to respond to patient anger, disagreement, and distrust in constructive ways without becoming angry, defensive, or apologetic [10,21,28]. Building skills for self-awareness of blind spots and hot buttons in patient care, particularly around suffering, death, conflict, and healing, can help physicians maintain emotional equilibrium and avoid burnout [38–40].

A third Reflect skill is identifying resources that can be drawn on in working with patients at the transition. Resources include the physician’s own personal and self-care resources [41].

An oncologist reported that he uses an administrative task, signing a death certificate, as a personal closure ritual. As he reviews the patient’s care, he considers what he has learned about diagnosing and managing the disease as well as what he learned about himself as a person and a doctor as a result of caring for the patient.

Other resources include experiences with “good deaths,” discussions with peers and colleagues, and educational programs [40,42,43].

The final part of Reflect is to identify satisfying aspects of working with patients transitioning to palliative care. Many physicians find this work challenging, engaging, and personally rewarding [44].

Summary
Communication at the transition from curative to palliative care is difficult. In general, basic communication skills for clinicians include eliciting patients’ concerns, expressing empathy, giving information effectively, and assessing preferences for participation in treatment decisions [2,10,18,27,28,30]. Additional communication skills are required when disease-modifying treatments stop working and no further treatments are available. These skills include making a personal connection, achieving a shared understanding, aligning treatment goals and methods with the individual patient’s hopes, and becoming aware of personal strengths and weaknesses in working with patients at the transition. The steps Relate, Review, Revise, and Reflect summarize this approach.

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References


