

## MEDICAL EDUCATION

### Which Critical Communication Skills Are Essential for Interdisciplinary End-of-Life Discussions?

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#### Abstract

Conversations about dying and end-of-life (EOL) care are the most challenging of all communication scenarios. These conversations include discussions about diagnosis and prognosis, treatment goals, and EOL wishes, goals of care, and plans for the future. Research has identified critically important skills involved in holding such conversations, and protocols have been established that can assist those discussing these important issues. Often several discussions and professionals from multiple disciplines are needed to ensure that EOL conversations are effective and comprehensive. In this article, we review what is known about the skills and strategies necessary for meaningful and effective EOL conversations and emphasize the valuable role of interdisciplinary approaches to these discussions. Advance care planning (ACP), which refers to patient decisions about desired care should the patient lose decisional capacity, is included as a type of EOL discussion in this article.

#### Skills and Approaches Needed for End-of-Life Conversations

In the last 30 years, numerous strategies and frameworks for end-of-life (EOL) discussions have been developed and used with success. Triggers for, methods of, barriers to, and issues in EOL discussion have been well described.<sup>1-3</sup> Some approaches that are widely referenced and accepted are the SPIKES 6-step protocol,<sup>4</sup> the ABCDE plan,<sup>5</sup> and VitalTalk.<sup>6</sup> Others are described in Robert Buckman's 1992 seminal book, *How to Break Bad News: A Guide for Health Care Professionals*,<sup>7</sup> and "The Serious Illness Conversation Guide."<sup>8</sup> Several of these approaches focus on informing the patient and family about the patient's condition and prognosis and are therefore directed at physician skills, while VitalTalk provides resources for all clinicians involved in serious communication scenarios. Recently, the literature has supported collaborative models in which communication is rooted in teams rather than in the physician-patient dyad and conversations are ongoing rather than singular.<sup>9-11</sup>

Elaborating on the principles of this work and realizing that there is more to EOL discussions than the relaying of difficult information, we offer associated clinical advice to professionals from all disciplines regarding conversational skills and team-based

approaches that can facilitate EOL discussions. Clinicians have the responsibility to provide opportunities for discussion and information to patients, caregivers, and surrogates throughout the trajectory of serious illness<sup>12</sup>; such conversations occur in the context of an uncertain, emotional environment<sup>13</sup> and require core communication skills of sensitivity and empathy—skills that professionals in all disciplines should cultivate.<sup>14</sup>

### **It Takes a Team**

Dying involves much more than medical concerns and decisions—there are psychological, social, spiritual, and financial concerns that require the efforts of an interdisciplinary team. The ideal team would include professionals from medicine, nursing, chaplaincy, and social work or similar fields to address the medical and psychosocial and spiritual needs of the patient and family. Institutional protocol may assign responsibility for completion of advance care planning (ACP) forms to the chaplain or social worker. A systematic review of social workers' ACP responsibilities identified a number of duties, including initiating discussions, advocating for patients' rights, providing patient or family education or counseling, facilitating communication, conflict resolution, and documentation.<sup>15</sup> The team nurse can provide ongoing medical monitoring, evaluate treatment effectiveness, and instruct patients about treatments and medications. The [chaplain](#) is charged with addressing the spiritual implications and significance of the prognosis and with meeting patients' spiritual needs.

At least two team members should be present during discussions with the patient and family about goals of care, prognosis, treatment options, and ACP. The physician might be assigned to share information while the social worker or chaplain attends to emotions and ensures that everyone's voice is heard. Physicians can draw from the expertise of colleagues from other disciplines (eg, social work, psychology) in motivational interviewing, solution-focused brief therapy, and cognitive behavioral therapy to help the patient or family to make behavioral or attitudinal changes and medical decisions.<sup>16</sup> Optimally, a "family" meeting involving the patient, others the patient wants present, and the full interdisciplinary team is held soon after the determination of a life-threatening illness to share information and develop a patient-centered plan. Often multiple follow-up conversations are required.<sup>17</sup> Indeed, time limitations have been cited as a major barrier to ACP; a study at Brigham and Women's Hospital in Boston found that these conversations can require 22–26 minutes.<sup>8</sup> Thus interdisciplinary teams offer great value by dividing responsibilities among team members to alleviate the pressure on the physician to "do it all."

Effective teams work together to communicate information and provide support to the patient and family. These goals are accomplished through synergistic and interdependent interaction of team members.<sup>18</sup> Leadership is task dependent, with tasks determined by the patient's individual situation.<sup>18,19</sup> Intra-team communication of people

to contact, new information, and plans is essential and must be timely. The team must be a united front in addressing and advocating for holistic, patient-centered goals.

### **Strategies for Successful EOL Communication**

Being well-informed about the patient's medical history and present situation before holding any discussions related to serious illness is not just a good practice; it is crucial for successful EOL communication. The patient and family must have complete confidence that opinions and recommendations given in a setting often characterized by extreme emotions and conflicting perspectives are supported in every detail. Securing the patient's and family's confidence is key, especially when there is no long-term relationship. Knowing in advance what other involved clinicians think and recommend, what therapies have been attempted, the known results and side effects, and the social and emotional environment for care is critical for success. Patient preferences, values, quality of life factors, coping abilities, and cultural determinants are also crucial information. Such preparedness can also help avoid misinformation and misunderstanding between the patient and family. When planning a conversation related to the EOL, using a *who, what, when, where, and how* structure can be helpful.

*Who?* Ask who the patient wants present at this conversation and plan for any psychosocial or family issues that might affect the discussion. Family members may have differing attitudes towards the patient's wishes, and it is easy for conversations to be derailed by their opinions, conflicts, needs, and emotions. EOL situations bring prior family issues and conflicts to the surface, creating a dangerous oil slick of angst and emotion that must be navigated. As clinicians, we have responsibility both to acknowledge such issues and conflicts and to continually and patiently bring the focus back to the patient and the current situation. Family members obviously feel loss at these moments and should be comforted while not distracting from the patient's needs. Interdisciplinary care is at its best at these moments because the unique contributions of each profession enable the team to address the complexity of the situation.<sup>18</sup> However, it may be necessary for the social worker or chaplain to address family conflict outside of a meeting or to make referrals for more intensive counseling.

Clinicians often know the inevitable outcomes of advanced illness and are tempted to "go there" early. Patience is a key skill in holding these conversations. If possible, "arriving" at the prognosis together brings peace and understanding. Laying out care options helps engage the patient and family, but we must avoid misleading them by characterizing each option with expected outcomes and side effects.

*What?* Clinicians should have a goal in mind prior to the conversation. Goals might be delivering serious news, clarifying the prognosis, establishing goals of care, or communicating the patient's goals and wishes for the EOL to those in attendance. Often some [discussion of prognosis](#) is important in the first meeting, but how much is said on

this topic should be based on the patient's preferences. Two questions are important when opening a meeting at which information about the illness will be shared. First ask, "Tell me what you understand about your illness and your prognosis?" Then ask, "How much information do you want?" The latter question can be challenging because patients and families will not know what information we have to share. Ascertain whether they prefer all the details or just the summary and bottom line recommendations. Often at this point a warning statement is appropriate: "John, I think we need to have a serious discussion. I'm afraid there is some serious news." Watching the reaction to that statement can help establish the pace, tone, and content of the rest of the discussion.

*When?* Time constraints are often cited as a barrier to EOL communication.<sup>1,20</sup> EOL discussions are challenging to integrate into routine hospital rounds or office visits. Therefore, they should be scheduled when there is time to patiently listen, reflect what you hear, seek understanding, make suggestions, and talk about next steps. A squeezed-in conversation, usually driven by urgency, is rarely efficacious or time effective. When incomplete, other conversations will be required, and ground is often lost.

*Where?* Ideally, EOL conversations are held in a quiet room without interruptions. Realistically, such conversations are often held at the bedside due to the patient's condition or lack of space. Regardless, it is important somehow to sit down. Standing above an ill person adds to his or her feelings of vulnerability. Sitting means that we care and that we will not exit as soon as possible.

*How?* Semistructured discussion plans usually work best. Begin with some goals for this discussion as described above but be flexible depending on the dynamics and the patient's needs. It is important to remember that the patient is the most important team member and that his or her preferences and informational needs guide the meeting. Communication should be adapted based on what is acceptable to the patient.<sup>10</sup> Surgeon and author Atul Gawande popularized the term "explain-aholics,"<sup>21</sup> and, indeed, clinicians often assume this role. We know so many things from lab details to CT scan results to treatment options to prognosis.

To avoid taking charge of the conversation, even when it is approached with a set agenda and information to be shared, several strategies are useful. One is the "listen first" approach. The clinician makes herself actively listen by asking an open-ended question and responds to what is heard rather than controlling the conversation. Another strategy is to keep in mind the "20% rule"—that patients might remember about 20% of what is said in the first serious illness or EOL discussion because their minds are reeling with emotions, impairing their memory. Silence can be golden in these conversations. Allow time for the patient to truly hear what is said and to react emotionally. Emotions should be acknowledged, whether manifest in tears, anger, or sad withdrawal. Normalize patients' feelings and encourage them to share more about what they are feeling.

Finally, being direct, confident, and calm can be comforting. (“Mary, there are no more treatments that we can expect to extend to your life.”) Wait, listen, and respond. Only so much can be processed in a single conversation; therefore, serial conversations are usually needed to allow processing time and present aliquots of digestible information. (“Let’s both think about what we just discussed and talk again on Tuesday.”) This approach does not have to require more time overall.

Postconversation hallway conversations with family and friends are to be avoided. If appropriate, return to the room with everyone to address those questions. If not, words could be interpreted through someone else’s lens. “Well, I talked to Dr. Jones, and she told me...” This is known as “splitting” and allows others’ agendas to take hold.

### **Incorporating EOL Communication Skills Training into Medical Education**

It is common to hear that some clinicians are “naturals” at EOL conversations. However, caring, empathy, and communication can be learned like any other clinical skill. As mentioned earlier, numerous training programs are available. Skills training programs ranging from seminars to workshops have been augmented by online training.<sup>22</sup> Ariadne Labs has developed a serious illness community of practice (a social platform supporting practitioners caring for patients with serious illnesses) and a “Serious Illness Conversation Guide.”<sup>23</sup> The [Conversation Project](#) offers a free basic skills course for health care professionals and numerous resources for both patients and professionals wanting to have conversations about EOL care.<sup>24</sup>

Studies have found that structured communication tools when used in EOL conversations can increase the frequency and documentation of such discussions and contribute to concordance between the care desired and the care received.<sup>25,26</sup> Unfortunately, evidence related to the value of skills training is limited by poor reporting and weak methodology.<sup>27</sup> Chung and colleagues found consistent but very low-to-low quality evidence that training in EOL communication improved self-efficacy, knowledge, and communication scores compared to no formal training.<sup>28</sup> While training has shown to be somewhat beneficial, experience appears to be the best teacher. Drawing from the core established principles of EOL communication and the experiences of those around us (including team members from other disciplines), we can consciously and continuously improve our own skills.

### **Conclusion**

Communicating with patients and families facing the EOL is challenging and time consuming. Clinicians can draw from multiple models and mentors as they develop their communication skills. Team-based efforts hold the most promise for facilitating the communication needed to provide information, explore options, develop plans and goals, and ultimately provide holistic, patient-centered care. Honing the essential skills for

these common yet critical conversations has tremendous ability to influence the lives and well-being of our patients and their families.

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