CONVERSATIONS WITH PATIENTS: SETTING GOALS WITHIN THEIR VALUES - HOW TO APPROACH

Commentary by Gerald Harriman, DO

INTRODUCTION

Imagine yourself, alone in a foreign country, not knowing the language, and trying to communicate with someone—attempting to get directions. What do you experience? Frustration? Fear? Anger? Abandoned? Emotions leading to give up? A similar scenario exists for numerous patients seen every day in our healthcare systems. Neither side knows what the other is saying, let alone the meaning of their words. How many times do we have a daily experience of talking with others within our own culture and language and yet still not be able to understand the meaning? We need to take the time, or more realistically, make the time, to communicate with our patients to understand their preferences for the type of care they want to receive, or even not receive, as the case might be.

As shown by numerous articles in the medical literature, patients want to talk to their doctor about what is important to them when making decisions regarding their care; that is good. Unfortunately, this same literature shows that physicians are poor at communicating with their patients surrounding these issues, although they recognize and believe in its importance. Patients are looking to their doctor to initiate these talks, doctors believe it is important, but yet don’t accomplish it. This is a significant disconnect that simply cannot continue.

How else can a physician know how to treat their patient with regards to their care surrounding these issues unless they know them? Patients want to be known and understood as well as wanting to know and understand.

Reinke et al, studied by questionnaire 376 advanced COPD patients and their practitioners. They described the quality of end-of-life discussions between the patient and clinician. The findings are enlightening, frightening and sobering.

Reinke and his colleagues found that clinicians addressed well by conversation, only around one-third of the time, on the topics of talking with the patients on the details and feelings of getting sicker with their illness and on things in life that are important to them. On the contrary, the topics either addressed poorly or not at all in 80% or higher, included involving the patient in decisions, talking about what dying might be like and their life-expectancy.

One other additional important finding, the longer the patient and physician relationship existed, the better their conversation involving the patient in decisions for when they are incapable of participating in these discussions. This is a resounding vote for continuity of care.

Centers for Medicare and Medicaid Services (CMS) approved and funded beginning January 2016, new E/M codes for physicians to use to offset the cost of this counseling service with their patient. The usual documentation requirements apply, of course. Regrettably, in the first year so far, as reported by CMS, only 14% of physicians who sees patients over the age of 65 have billed for these services.

A recent survey, conducted by The John Hartford Foundation, of physicians in 2016 exposed their views on end-of-life and conversations vis-à-vis advance care planning with their patients in a Medicare-based population. Several salient points from the survey results reveal: though viewed as extremely important to have these conversations (nearly 89% of them), yet most felt inadequate to conduct the conversation due to lack of proper training and not to know how to perform it. Let the reader note: There are learnable solutions to these shortfalls.

They also found that physicians with training (62%) in these discussions, or interestingly, if they had the same discussion with their physician, had a far greater likelihood of having them with their patient. And nearly all (95%) said they believe the new Medicare benefit for advance care planning is important, yet as already mentioned, only 14% have billed Medicare for doing so.

The most common reasons cited for not having these discussions were: lack of time in the office, perception of conflict between patients and family wishes, question the proper timing and the uncomfortableness of the talk, along with a mixture of not wanting to give the sense the physician is giving up on the patient or to cause a patient to give up on hope. Nearly 50% of the physicians admit that frequently or sometimes don’t know what to say during these end-of-life dialogues. And a clear 75% of the physicians surveyed believe it is up to them to have this conversation.
So, the physician knows it, believes it, but is uncertain of when to have it and how to do it. If it were a procedure we were talking about, there would be plenty of CME courses offered to remedy the lack of knowledge and skill. But this is more of a distinct process, and therefore, perceived as one that physicians either naturally have it or don’t have it, not realizing it is completely learnable.

A useful and practical, point-of-care tool resource is VITALTalk—a trademarked communication web-based guideline for these conversations. There is also a smartphone app that can be purchased to assist in training for these talks.

What is the solution to the conversation dilemma? How does the busy physician have this imperative dialogue? There is interest by physicians to know how to communicate with their patients.

First off, the physician needs to know the patient’s goals. It makes sense that to get somewhere you must know where you are going. Another way to say it for our purposes, get to know the patient’s goals and preferences. How do you do that? What do you ask about? It’s simple, just ask. Take the time and ask; they are waiting for, their trusted medical professional to ask. This kind of communication is seen increasingly as a central proficiency by medical specialty boards.

Remember, the Maslow corollary; patients want to be known and understood.

The obvious corollary to asking is listening. Physicians need to be reminded of this since as a general rule they interrupt their patients after just 18 seconds while taking the initial history. Listen is the operative word for talking with patients about their concerns. It allows the listener to go along with them in the conversation.

At the same time as knowing what to say, it is equally important for the clinician to know what not to say. Avoid words, actions or body language, that is vague, misleading, too technical or builds a barrier to patient understanding, which prevents further open and clear communication to avert “decision paralysis,” or improper conclusions and decisions.

As good as a physician may be clinical, it can all be nullified by misguided words and actions.

So how does the effective clinician have this conversation with their patients? What is an effective approach to solving this dilemma?

There are several approaches that have been studied, most of them in the context of delivering “bad news.” They have several similar elements of any serious talk, which can easily be used and adapted for talking with patients about their wishes and goals.

**SET THE SETTING**

First, set the setting. If possible, use a chair, get on their level and talk “eye-to-eye.” This shows interest, and it is sensed by the patient as a dedicated time of the clinician being “at the moment” and not in a hurry, or distracted and allows for easier eye-to-eye contact. So, sit down and then, importantly, listen. Avoid contact with a computer or smartphone during the conversation, unless it is being used along with the patient or with their permission to show results or research findings or educational materials for them.

**BE COMFORTABLE.**

With this, I mean, convey a comfortable approach allowing for the patient to be more open to reveal their thoughts, feelings, fears, wishes. Therefore, to know how to deliver serious news or to discuss serious topics (or at times to be silent and let the moment speak for itself), the practitioner needs to learn and practice these skills. Communication is not a “born-with” talent but a learnable skill and proven to make a difference, and make you into an expert.

**BE TRUTHFUL.**

The patient deserves the truth. As difficult as it may be, this helps them to restructure the time they have left and plan for special occasions or visits or trips that may be missed out because they didn’t know what to expect. Importantly, this may give them a chance to redefine hope. It allows them to have meaningful conversation with those around them, especially if in the context of end-of-life.

**BE OPEN.**

If you don’t know what to say, then ask what and how much the patient wants to hear. This will allow the patient to guide you in your explanation of the appropriate details, of course in terms and language they can understand. If necessary, assess a patient’s ability to understand and have decision-making capacity before progressing further, and have a surrogate decision-maker present.

**BE SPECIFIC. BE CLEAR.**

This is similar to avoiding ambiguity. There are well-known phrases physicians use that do not help in sorting through the murky waters of serious discussions. See Table 1. In their place, the clinician should use words and phrases that are clear, indicating the appropriate care that is to be delivered, or in some circumstances to be stopped or changed; again, be sure to include those continued measures to be provided to comfort the patient. It is best not to make assumptions; this creates the opportunity for not only misunderstanding but also unsettled emotions and constructs barriers.

Remember, patients are waiting to talk with their doctor, and they also want them to start this conversation.

**SO, WHAT TO TALK ABOUT? IT’S STRAIGHTFORWARD.**

Go back to the beginning: To understand your patient, ask the patient: “what are your goals?” Or more colloquially, what is the “line in the sand” or have you thought about “when enough is enough,” and what this looks like for you?

The patient and family will typically respond in a straightforward manner, especially after the proper atmosphere is created. If they don’t, then don’t panic but utilize open-ended questions to draw more response out of them. And continue to discourse for clarity, resolve direction and decision.

Now with their goals known; how does that translate into care? At this stage, this is the optimal care; match the treatment to their goals and preferences.

The clinician’s experience can make all the difference presenting creative alternatives to reach the patient’s goals.
RESPOND TO THE EMOTIONS.

This may be the most difficult step for some clinicians but is necessary to work through with the patient. Techniques include validation of emotions, use of reflective listening, and showing empathy. These measures will also build and develop the doctor-patient relationship further, critical for ongoing communication and trust, entirely benefiting vital patient decision-making.

DEVELOP A MUTUAL PLAN & FOLLOW-UP.

The physician needs to be clear on the follow-up plan and assure the patient preparations are in place to be successfully implemented. Like so much of what we have talked about, this is not in a vacuum but occurs along with the patient and the people involved.

In summary, key communication with patients concerning their preferences can be accomplished in a deliberate, open, and clear manner so that the necessary care matches with the patient’s wishes, consistent with their goals and is completely based on their values.

<table>
<thead>
<tr>
<th>AVOID</th>
<th>USE</th>
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<tbody>
<tr>
<td>There is nothing more we can do—usually means to cure an illness but what is heard: there is nothing more to do at all</td>
<td>I wish there were something more we could do to cure the illness... then add, let us focus on what we can do to help you.</td>
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<tr>
<td>Would you like us to do everything possible?</td>
<td>How are you hoping we can help you? Then address their specific responses to clarify goals or preferences</td>
</tr>
<tr>
<td>Stop the machines</td>
<td>Stop the machines and use medical care to keep them comfortable</td>
</tr>
<tr>
<td>Withdrawal of care</td>
<td>Withdrawal of specific care and institute comfort measures only</td>
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RESOURCES

2. Psychologist, Abraham Maslow in 1968 described a hierarchy of needs, for every person. The need to know and understand is in the upper tier of the Growth Needs in his hierarchical pyramid, and is required to accomplish in order to reach the highest levels of aesthetic and self-actualization needs.
4. Http://www.vitaltalk.org
9. Ira Byock, Four Things That Matter Most. I forgive you, please forgive me, I love and thank you