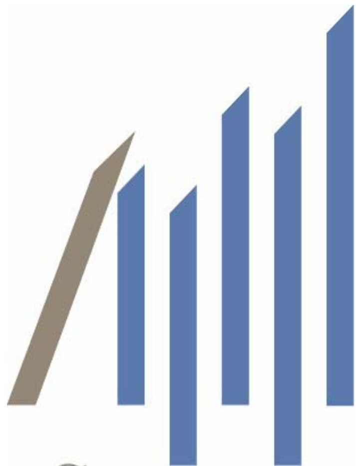

Person to Person:

Discovering Patient Wishes in Planning for End of Life — A Tool for Physicians

Facilitator Guide

by

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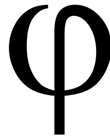

This work would not have been possible without the training and coaching provided to us by Lindagail Campbell of Lindagail and Associates, NLP Institute of Oregon. Additionally, much of our approach is modified with permission from the Master Practitioner Workbook prepared by

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The Human Touch

'Tis the human touch in this world that counts,
The touch of your hand and mine,
Which means far more to the fainting heart
Than shelter and bread and wine;
For shelter is gone when the night is o'er,
And bread lasts only a day,
But the touch of the hand and the sound of the voice
Sing on in the soul alway

Spencer Michael Free

INTRODUCTION

Since the introduction of the Patient Self Determination Act of 1991, physicians and other health care providers have struggled with obtaining information from patients and their families about care wishes at the end of life. A number of research studies have assessed barriers and successful strategies from the perspectives of the patient and the physician. And yet, the knowledge from these studies has not led to significant increases in numbers of people who have completed advance care plans. To complicate the problem, even when an advance care plan is available, it may not be sufficiently prescriptive to guide decision making within the existing context of care, nor may family and physicians agree on the meaning of the words on the page. Additionally, many of the ethical dilemmas faced in our acute care settings surround conflicting beliefs about the patient's wishes and values regarding care for the end of life. Key to understanding end of life care wishes is the relationship between the patient and physician. It is through getting to know the person, their life experiences, and their values that the physician can be assured of managing the patient's care congruent with the patient's values and wishes.

How can busy physicians get to know the patient and the patient's care wishes in today's busy practice? In a recent research study, "Living and Healing During Life Threatening Illness," physicians often mourned the loss of time allotted to building relationships with patients and families. They also describe this loss of relationships as a source of personal stress. However, patients and families who participated in "Living and healing During Life-Threatening Illness" indicated that a compassionate physician who "connects" makes a difference for the patient and family and may even lead to a decrease in their suffering. People feel respected, valued and heard.

You may know physicians who seem to "connect" well with almost every patient. They have the same time pressures and work expectations, but they seem to have special skills. Almost all of their patients and families describe them as "very caring" or "really listening" and being there for them. Are they able to do this because of a NATURAL ABILITY or because of LEARNED STRATEGIES that they use successfully? We have discovered in our research that those physicians seem to have mastered the COMPETENCIES of connecting and caring. These competencies can be learned and/or improved upon.

INTRODUCTION, Con't.

Physicians who demonstrate excellence in caring often will state that, "I didn't do much except I always "______________." These excellent skills are so much a part of the physicians' behaviors that they find it difficult to specifically describe their processes of connecting. However, when interviewed, the physicians could be very specific about the environment in which the strategy occurs, the behaviors which occur, the capabilities required, the beliefs and values that are a part of the process, and the identity or mission of the person. On physician demonstrating these excellent skills discussing the difficult topic of end-of-life care choices says, "It's like medicine; there are skills to be learned and ways to teach them. All of us have some ability, we just need to work at improving our skills."

This facilitator's guide, the accompanying videotape and suggested outline for a one-hour presentation are offered for your use as you teach other physicians to enhance their skills in connecting and in determining the end-of-life care wishes of their patients. Educators tells us that we learn best the more actively involved we are in the process. Thus, we have structured this as an interactive session.

The following reviews of three recent studies and the video are offered for your information and inclusion in a presentation on this topic.

PROPOSED SEMINAR STRUCTURE

Introduction and Literature Review	15 minutes
Video Segment of Physician with Patient	12 minutes
Participant Sharing (1 or 2 participants)	10 minutes
Video of Physician with Interviewer	10 minutes
Conclusion	5 minutes

Seminar Outline

INTRODUCTION AND LITERATURE REVIEW 5 minutes	Use above content. You may choose to have an overhead of the poem on the screen when the group is forming.
SHOW VIDEO 12 minutes	Introduce video of physician beginning a discussion about advance care wishes with a patient. This is an unrehearsed scene. Patient is currently healthy, but has several potentially life-threatening illnesses.
PARTICIPANT SHARING 10 minutes	Invite one or two physicians in the audience to respond to the following questions: ♦ What communication / relationship-building techniques have you found to be effective as you discuss advance care planning or end-of-life care issues with your patients and families? ♦ How have these techniques made a positive difference in your practice.
VIDEO OF PHYSICIAN WITH INTERVIEWER 10 minutes	The interview occurred immediately following the patient interaction. The physician described the approach he used to engage in establishing a trust relationship and achieve the goal of discussing end-of-life care wishes.
CONCLUSION 5 minutes	

Study #1

Marvel, K.M., Epstein R.M., Flowers, K., & Beckman, H.B.

Soliciting the patient's agenda. Have we improved?

JAMA, January 20, 1999 – Vol. 281, No. 3, pp. 283-287.

Twenty-nine board-certified family physicians had 300 visits audio-taped. Goal was to recruit 10 patients per physician to participate in the study. Nine of the physicians had advance training in family therapy and communication skills.

Reasons for the physician visits included patient concerns, physician requests for follow-up, and preventative visits. The mean length of the visit was 15 minutes.

The mean time for patients to initially express their concerns was 23.1 seconds before the physician redirected the conversation. This occurred after the patient expressed a single concern in 76% of the cases. Following the redirection, the patient went on to state additional concerns in only 33% of the cases. Physicians sought additional concerns in only 21% of the interviews. Patient concerns were completed in only 8% of the cases. For patients who completed expressing their concerns, they required only an average 32 seconds.

Authors conclude that soliciting all concerns may be significantly more effective and take only an average of 12 seconds longer than redirecting the conversation prior to achieving the patient's agenda of concerns.

Study #2

Suchman, A.L., Markakis, K., Beckman, H.B., & Frankel, R.

A model of empathic communication in the medical interview.

JAMA, February 26, 1997. Vol. 277, No. 8, pp. 678-682.

Transcripts and video-tapes of 21 primary care office visits were analyzed to determine empathetic opportunities presented by patients during the course of their office visits and the responsiveness of the physicians. The goal was to use the data to develop a model for empathic communication.

The researchers observed that patients infrequently verbalized emotions directly and were more likely to offer cues. If physicians asked them to elaborate, they became more direct making it easier for the physician to respond. However, in most interviews, the physicians did not respond to clues and direct expression of affect. They tended to redirect the conversation to the preceding topic – usually the exploration of symptoms.

The result of not attending to affective cues was missed opportunity to deepen the trust relationship between the physician and patient and to lose some potentially important cues to the meaning of the illness, the patient's values, and the relationship between the body and mind with this illness.

Study #3

Tulsky, J.A., Fischer, G.S., Rose, M.R., & Arnold, R.M. (1998).

Opening the black box: How do physicians communicate about advance directives?

Annals of Internal Medicine. 129:441-449.

Primary care physicians (n=56) were asked to identify a patient from their practice for whom they thought discussion of advance care planning would be appropriate. Patients were at least 65 years of age or had a serious medical condition. The encounters were audio-taped, transcribed verbatim, and analyzed by the research team.

Results:
Through a self-administered questionnaire, 95% of the physicians rated themselves as comfortable talking about advance care planning, but 61% stated that they rarely discussed advance directives in the outpatient setting.

Patients also responded to a brief self-administered questionnaire. Their ages ranged from 58-88 and 68% were male. They rated their overall health as follows: 25% good or excellent, 27% good, and 48% fair or poor.

The discussion regarding advance directive lasted a median of 5.6 minutes with a range of between 0.9-15 minutes. Physicians spoke a median of 3.9 minutes and patients only a median of 1.7 minutes during the interaction.

Percent of physicians who discussed these items are as follows:

- Reason for initiating the discussion – 93%
- Possibility of future conversation – 43%
- Discussion of advance directive forms – 55%
- Asked patients if they had any questions – 26%
- Told patients they could change their minds – 16%
- Acknowledge that talking about advance directives could be emotionally difficult – 29%
- Reassured patients that current health was not reason for discussion – 39%

Content of discussion included presentation of hypothetical dire scenarios, reversible scenarios, and uncertain scenarios. Only 20% of physicians discussed uncertain scenarios, and they tended to use vague language.

However, patients were very positive about the discussion. 96% felt the discussion had been worthwhile and 95% agreed that is was a good idea for doctors to talk to their patients about advance directives.

CONCLUSION

The physician uses a **FORGE** Approach in his interactions.

F = Focus on the Person

- Makes eye contact
- Sits close to the person at the same level as the person.
- Repeats the person's words to acknowledge having heard them.
- Understands he is there to help the person, not just treat the illness.
- Sees the work as more than a job.

O= Open to the person's needs and priorities

- Attends to patient's verbal and non-verbal cues.
- Modifies the approach based on patient responses.
- Asks open-ended questions.

R = Respect for the person

- Sees the person first and the illness as just part of the person.
- Seeks to treat the person by the "Golden Rule." Treats the person as he would want to be treated or would want a family member to be treated.

G = Goals are comfort and trust

- Seeks to establish rapport.
- Maintains a relaxed posture.
- Nods frequently.
- Speaks in a soft voice.
- Emulates person's tone.

E = Educating about the experience

- Provides information in language person can understand.
- Looks for indicators of understanding.
- Provides anticipatory counseling.

WHY SHOULD I FOCUS ON THESE SKILLS?

Why should we do this work? With our time pressures in health care, it is important to be efficient in our interactions and to focus our interventions more closely to the patient's goals.

By doing this, we can first of all derive personal satisfaction from feeling like we really connected with our patients and families. We can be even more successful in working with patients and families with less stress. Patients who feel you are really listening or really care about them, are more likely to describe fully their needs in less time. They trust you.

Secondly, they are likely to be less demanding of your attention because they have the feedback that you care and have heard their needs.

One physician participant in our project said, "It's like medicine; there are skills to be learned and ways to teach them. All of us have some ability, we just need to work at improving our skills."

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