Creating Hope in a Hopeless Situation
When care moves beyond cure

A communication manual for physicians offering quality at end-of-life care

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WHAT IS PALLIATIVE CARE?

When care becomes Palliative, the focus is on comfort and dignity, no longer on life prolongation.

Choosing comfort and dignity is not about giving up, it’s about shifting from cure to care.

It’s not about losing hope but reframing the hope; namely, an achievable hope of comfort care in the face of irreversible fatal illness. One has to always hope for the best but at the same time, be prepared for the worst.

To decide to prioritize quality of life over quantity of life, is never an easy decision to make, but knowing what patients desire in terms of quality of life will help them, their family and their doctors reach the optimal decisions, at the right time.

Palliative care is more about life then about death. Improving the quality of life at the end of an individual’s life is a priority goal of Palliative care.

*You matter because you are you
you matter to the last moment of your life,
and we will do all we can, not only to help you die peacefully,
but to live until you die.*

Dame Cecily Saunders
Founder Modern Day Palliative Care

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*We all must die. But if I can save him from days of torture, that is what I feel is my great and ever new privilege. Pain is a more terrible lord of mankind than even death himself.*

*Albert Schweitzer*
A good death has always been a primary human concern. People seek a comfortable death, one in which they can achieve satisfactory closure to their lives with both compassion and respect.

As such, it is not surprising that people in N.A. have the following common fears about the period of time leading to death:

1. unrelieved pain
2. poor symptom control
3. unwanted life prolongation
4. abandonment by health care providers

Unfortunately, clinical research proves that these fears are warranted. End-of-life medical care is rarely optimized. In their final days, many people suffer significant and unnecessary pain, as well as inappropriate and undesired life sustaining interventions.

Evidence also shows that physicians commonly do not know their patient’s end-of-life preferences, and if they do know their patient’s preferences they fail to carry them out.

Communication about the subject of death is often poor. Many physicians do not discuss end-of-life care with seriously ill patients even though most patients and families would welcome the opportunity. When conversations do occur it is often at times when patients and families are too distraught and, thus, incapable of either thinking clearly, or expressing their preferences and values. As such, physicians often miss important opportunities to calmly address patients’ concerns and fears.

This manual will introduce simple tools that can facilitate communication about these sensitive end-of-life issues. These tools can allow physicians to help their patients achieve a good death: one with a minimum of fear and pain and a maximum of closure, respect, and compassion.

- To know when death is coming and to understand what can be expected
- To be able to retain control of what happens
- To be afforded dignity and privacy
- To have control over where death occurs (at home or elsewhere)
- To have access to information and expertise of whatever kind is necessary
- To have access to spiritual or emotional support required
- To have access to hospice care in any location, not only in hospital

After all, we only have one chance to have a good death.
PALLIATIVE CARE

Palliative care is often brought in late in the disease process if at all and is marginalized within modern health care practices. Palliative Care appears as being a failure of the health care system as opposed to being a continuum with active compassionate patient centered care. Discussions can be put into the following context:

- exploring patient and family concerns about the future
- helping the patient gain control of care
- establishing shared goals of care
- focusing on the principles of a good death
- finding meaningful hope

Thus, discussing palliative care only when patients are highly likely to die soon, denies many patients who will benefit from this form of care. Physicians should take an inclusive approach where palliative goals of care can be shared in parallel with aggressive disease-oriented care, instead of an either/or, approach. (Figure I)

Palliative care is about quality of life at any point during the trajectory of an incurable illness. It is more about life then about death.

(Figure I)

PALLIATIVE CARE

*Traditional View*

<table>
<thead>
<tr>
<th>ACTIVE AGGRESSIVE INTENT</th>
<th>PALLIATIVE INTENT</th>
<th>DEATH</th>
<th>BEREAVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PALLIATIVE CARE

*Current View*

<table>
<thead>
<tr>
<th>ACTIVE AGGRESSIVE INTENT</th>
<th>DEATH</th>
<th>BEREAVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME</td>
<td>PALLIATIVE INTENT</td>
<td></td>
</tr>
</tbody>
</table>

CREATING HOPE IN A HOPELESS SITUATION

When the hope for a Cure is gone we must reframe or redirect the patient and family’s hope for something more realistic and achievable.

The hope for good, quality supportive care that aims for excellent comprehensive end-of-life patient centered service is achievable despite a fatal prognosis. These are the goals of palliative care.

It is not how long the time that one has left to live that is important, as the quality of that time. How can we as teams of health care professionals achieve these goals of quality at the end-of-life care where patient and families can hope for a peaceful, pain free, and dignified death? This manual is a step in that direction.

WE MUST HOPE FOR THE BEST BUT BE PREPARED FOR THE WORST

The key to achieving the goals of a good death is excellent communication. We must not negate families hopes or beliefs but help them prepare for the fatal outcome. The best setting is a family meeting with all providers of care present: doctors, nurses, social worker, physio, occupational therapists, etc. The patient should be invited if it is appropriate, and all members of the family and personal support network that is available to join in the discussions. These interested parties need to agree upon the goals of care with the patient and his/her family as soon as possible before the patient loses their ability to make decisions. The level of competency and the ability to make an informed consent is frequently threatened in patients who are hospitalized for advanced illness. Realistic goals of care cannot be negotiated nor agreed upon by all, unless this is done before the health crisis or the inevitable decline that so often awaits these patients who are critically ill. The hope that patient’s wishes and preferences will be respected is vitally important, and is the core value of respecting autonomy in clinical medicine.

The critical intervention sheet will help document these goals and discussions including code status and the other life sustaining decisions to reach optimal Quality of End Life Care. It should truly reflect the patients wishes and reflect what is documented in their advance directives.

The choices enhance patient and family control. Repeated meetings with them to monitor that the team is on track with the agreed upon goals of care will create a continuum of care that addresses both the personal and professional concerns of future treatments planned.

In the event of an incompetent patient the advance medical directive would be instituted and followed, with support of the substitute decision maker or mandatory. Thus avoiding uncertainty about the goals of care, and the patients preferences.

This will reduce the emotional discomfort of all those involved – professional and family care givers alike and that they will feel that the right things are being done. Ultimately, this will improve the quality of life so the dying patient can achieve excellent palliative/comfort care with dignity, peace of mind and even serenity.
Table II

FIVE POINTS TO RECEIVE QUALITY CARE AT THE END OF LIFE

1. To receive adequate pain & symptom control
2. To avoid inappropriate prolongation of life
3. To feel a sense of control for patient and family
4. To relieve personal burden on family
5. To strengthen relationship with loved ones

By addressing these 5 points for patients with a poor or guarded prognosis during a family meeting; hope in a hopeless situation can be achieved. These are all obtainable goals of care, especially if all members of the treating team are involved and consensus is reached.

THE CRITICAL INTERVENTION SHEET

Recently approved by the DPS to be part of every adult admission to our hospital – the Critical Intervention Sheet when properly completed will address points 2,3, and 4 of the list in Table II, providing quality care at the end of life.

Many patients have completed a Living Will or medical directive. It is estimated that at least 10% of Canadians complete a living will in their estate planning at a notary or lawyers office. It would be important to find out what their choices and preferences are should they become incapacitated. The Critical Intervention sheet acts as a tool to prompt the delicate discussion with patients and families. It is not an order form for code status and its limitations needs to be written in the orders on each patient. Families need to be informed with the patients agreement and should reflect the decisions outlined in existing living will documents. A recent copy of the living will should be placed in the chart. If none is available an advance directive should be completed by the patient / family during the admission.
**Document concernant les interventions critiques**

**Critical Intervention Record Sheet**

- **Nouveau / New**
- **Ce formulaire remplace un formulaire complété le : This form replaces a previous form completed**

<table>
<thead>
<tr>
<th>Date</th>
<th>Oui/Yes</th>
<th>Non/No</th>
<th>Inconnu / Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Le (la) patient(e) a un testament de vie - mandat**
- **Copy of Living Will placed in chart**
- **Le (la) patient(e) est compétent(e)**
- **The patient is competent**

**RESUSCITATION**

- **No Code Blue**
  - **Droit être clairement consigné au dossier du patient. Must write orders in the chart.**
  - **Date**

- **Call Code Blue**

**SOINS PALLIATIFS / SUPPORTIVE CARE**

- **Ne doit pas être initié Not to be attempted**
- **Ne doit pas être initié Not to be attempted**

<table>
<thead>
<tr>
<th></th>
<th>Oui/Yes</th>
<th>Non/No</th>
<th>(Si non, pourquoi?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTIBIOTIQUE INTRAVENEURS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INTRAVENOUS ANTIBiotics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAVAGE</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TUBE FEEDING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIALYSE</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>DIALYSIS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSFUSION DE SANG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLOOD TRANSFUSION</td>
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<td></td>
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<tr>
<td>HYDRATATION INTRAVENUESE</td>
<td></td>
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</tr>
<tr>
<td>INTRAVENOUS HYDRATION</td>
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<tr>
<td>PRÉLEVEMENT SANGUIN</td>
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<tr>
<td>BLOOD DRAWING</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Justification de la décision et autres commentaires:**

**Rationale for decision and other comments:**

<table>
<thead>
<tr>
<th>Lié de parenté: Relationship:</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>oui</th>
<th>non</th>
</tr>
</thead>
<tbody>
<tr>
<td>le (la) patient(e) the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>la famille the family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>autre other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Si la décision a été changée, compléter un nouveau formulaire et insérer celui-ci dans les notes d'évolution. If decision has been changed, complete a new sheet and insert this one in progress notes section of chart.**

**RÉSIDENT / HOUSE STAFF**

- **Signature**
- **Date**

**MÉDECIN COMPLÉTANT CE FORMULAIRE / ATTENDING PHYSICIAN COMPLETING FORM**

- **Signature**
- **Date**

**Deuxième médecin / Second Physician**

- **Signature**
- **Date**

* Dans les cas de perte fatale, une seconde opinion est requise (selon la directive des interventions critiques, section C). In case of medical futility, a second opinion is required (JGH Critical Intervention Policy, section C).
Suggested Questions for Advance Care Planning Discussions

Patient understanding of illness
   What do you understand about where things stand right now with your illness?
   What do you know about your treatment options?

Patient goals
   What is important for you to accomplish at this point in your life?
   As you think about the future, what is most important to you (what matters the most to you)?
   What are your hopes/fears for the future?
   If you were to die sooner rather than later, what would be left undone?
   What type of legacy do you want to leave your family/loved ones?

Patient values
   What makes life worth living?
   What would have to happen for your life to be not worth living?
   What nourishes your spirit?
   How do you feel about quality versus quantity of life?
   To what extent do you want your family/loved ones to have input in decisions that are made about your health care?
   What are your thoughts about pain control? Would you want your pain controlled even if it meant that you might not be as alert?

Personal experiences with illness, death, and dying
   Has anyone close to you died of an illness? What happened? What was it like for you?
   What other significant losses have you experienced?
   What would you consider a “good death”?

Spirituality/existential issues
   What thoughts have you had about why you got this illness at this time?
   Is faith (religion, spirituality) important to you in this illness and has it been important to you at other times in your life?
   Would you like to explore religious/spiritual matters with someone? Do you have someone to talk to about these things?
   Do you have any spiritual/religious beliefs that should be taken into consideration by your health care providers?
End of Life discussions are always sensitive but studies show that health professionals are reticent to raise the issues while patients and families on the other hand would like the doctor to invite an open and frank dialogue on prognosis and expected outcomes of treatment. The following are validated introductions to this process which introduces the critical interventions sheets and allows for broader discussions of goals of care.

### Talking Tips – Raising the Issue
#### When Patients Are Well
- Your health is very good, so this may be a good time to discuss your thoughts about your health care if you should become seriously ill in the future.
- I see from your chart that we do not have anyone listed as your mandatary. Talking about care at the end of life isn’t easy for most of us, but it’s important to decide how we want to be treated. I myself have made plans for the care I want.
- I have a policy of discussing end-of-life care with all my patients of your age. Have you ever thought about what treatments you would, or would not, like to receive if you become seriously ill and can’t speak for yourself sometime in the future?

### Talking Tips – Raising the Issue with Patients
#### Near the End of Life
- Now that you’ve had some time to adjust to the news of your illness, I’d like to discuss your hopes and wishes. We can talk about treatment options, benefits and risks. It will be important to discuss these issues with your family and/or close friends as well.
- I’d like to discuss what may happen now that you have this illness, and to help you make plans for the future. It’s important to talk about different treatments, including life support, and to make decisions now, with the help of your family and/or close friends.

See pg. 17 & 18 for setting goals and potential paths of care to help structure, interview and allow for patients and families express their preferences and values.
COMMUNICATION: HOW TO GIVE BAD NEWS

By using a structured approach for communicating difficult information the patient will be better prepared to hear and will more readily give permission for the sharing of the bad news, when they are ready. Remember, patients have an ethical right to limit the amount of information they are willing to receive. They have a right not to know, if they cannot cope with the truth.

The Six-Step Protocol
Adapted from Dr. R. Buchman

Step 1 – GET THE SETTING RIGHT

- Get the physical context comfortable!
- Where?
- Who should be there?
- Starting off – introductions, expectations, agenda

Step 2 – FIND OUT WHAT THEY ALREADY KNOW

- Open ended questions – What did previous doctors tell you? What did the tests show? What does it all mean?

Step 3 – FIND OUT WHAT THEY WANT TO KNOW

- There are people who need lots of information – others want none. What kind of person are you? Do you want your family involved in the sharing of information?

Step 4 – SHARE THE INFORMATION

- Decide on your agenda (diagnosis/treatment plan, prognosis, support)
- Start from the patient’s starting point (Aligning)
- Educating and informing to the extent desired
- Use English or French not Medspeak
- Reinforce and clarify the information
- Check your communication level (adult-adult, etc.)
- Listen for the patients’s agenda
- Try to blend your agenda with the patient’s
Step 5 – RESPOND TO THE PATIENT’S FEELINGS

Identify and acknowledge the patient’s reaction e.g. “Normal” emotional responses to receiving “bad news” - A classification of reactions seen in practices.

**TYPE A**
Minimal reaction
Calm, controlled, joking
Asking pertinent questions
Emotional denial

**TYPE B**
Quite upset
Breaking into tears
Expression of fears, concerns
Grieving the loss of good and healthy aspects of life

**TYPE C**
Angry reaction
Guilt about “why me?”
Feeling responsible for causation
Blaming someone or something
Emotionally labile

**TYPE D**
Disbelieving reaction
Argumentative or withdrawn
Denying diagnosis, test, procedure
Dazed state of emotional shock yet relief that diagnosis is mad at last.

Each patient may have one or several coping responses. Acknowledging and supporting these responses are critical.

Step 6 – GIVE A CLEAR FOLLOW UP PLAN

- Organizing appropriate referrals
- Hopeful but honest message
- Reframing the goals of care from cure to comfort
- Making a contract and follow-through with return appointment
- Avoid entering a “conspiracy of silence” or alliance with family members that require limiting your communication with the patient

The key is to break bad news in a way that facilitates acceptance and understanding, while minimizing the risk of unrealistic expectations, inappropriate denial and overwhelming distress.
THE
C-L-A-S-S
Protocol

The five Main Steps of Clinician-Patient Interviews

<table>
<thead>
<tr>
<th>Physical CONTEXT or Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>LISTENING SKILLS</td>
</tr>
<tr>
<td>ACKNOWLEDGE emotions and EXPLORE them</td>
</tr>
<tr>
<td>Management STRATEGY</td>
</tr>
<tr>
<td>SUMMARY and Closure</td>
</tr>
</tbody>
</table>

“You can add a touch of C-L-A-S-S to any medical interview”

THE
S-P-I-K-E-S
Protocol

For Breaking Bad News or Giving Important Medical Information
A variant of the basic C-L-A-S-S approach

<table>
<thead>
<tr>
<th>SETTING and LISTENING SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s PERCEPTION of condition and seriousness</td>
</tr>
<tr>
<td>INVITATION from patient to give information</td>
</tr>
<tr>
<td>KNOWLEDGE – giving medical facts</td>
</tr>
<tr>
<td>EXPLORE EMOTIONS &amp; EMPATHIZE as patient responds</td>
</tr>
<tr>
<td>STRATEGY and SUMMARY</td>
</tr>
</tbody>
</table>
**BUILDING COMMUNICATION SKILLS AROUND DIFFICULT ISSUES**

You Don’t Have to Say…
“I’m sorry….”

Representative Clinical Scenarios in Which Expressions of Wishes Might be Appropriate

<table>
<thead>
<tr>
<th>Clinical Scenario</th>
<th>Sample Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivering very bad news</td>
<td><em>I wish I had better news to give you</em></td>
</tr>
<tr>
<td>Responding to unrealistic hopes from a patient or family</td>
<td><em>I wish that were possible. It sounds like all of us would be a lot happier if that were so.</em></td>
</tr>
<tr>
<td>Responding to expressions of loss, grief, and hopelessness</td>
<td><em>It sounds like a terrible loss for you. I wish it hadn’t turned out this way.</em></td>
</tr>
<tr>
<td>Responding to disappointment in medicine or the physician</td>
<td><em>I can understand how disappointing this is for you. I too wish we had been able to do more for your mother.</em></td>
</tr>
<tr>
<td>Responding to demands for aggressive treatment when prognosis is very poor</td>
<td><em>It must be very hard to come to the intensive care unit every day and see so little change. I wish medicine had the power to turn things around.</em></td>
</tr>
<tr>
<td>Responding to medical complications or errors</td>
<td><em>This is so hard for you – just when our hopes were so high, for her to have this complication. I wish it had been otherwise.</em></td>
</tr>
</tbody>
</table>
“Am I dying, doctor?”

THE DIFFICULT QUESTION FROM PALLIATIVE CARE PATIENTS
AND POTENTIAL RESPONSES

What makes you say that at this point in time?

When people ask me that question, they usually say, “I am not afraid of dying, I am afraid of suffering until death.” Is that something you are concerned about?

You have been told that you illness is incurable, and so, it is likely that it will ultimately take your life, however, I don’t believe at this point you are in fact actively dying.

Let’s not look at the end point, but how we move from here to there. Let’s look at your quality of life and address issues of pain, discomfort and suffering and so on, and see how we can improve your quality of life.

It must be awful seeing that you are losing ground almost on a daily basis. Does that reflect your perception? Tell me more about it, please, if you can.

People with serious illness like yourself, have fear that the end might be near. Is that what you are concerned about?

My interest in helping you is not to give you a number or a “death sentence”, I want to give you hope, hope that we can improve your quality of life for whatever amount of life you have left.

When people ask me that question, it is usually based on fear. What specifically are you fearful of at this point? Pain? Abandonment? Suffering? ……

Many people I have spoken to, say they are afraid of suffering and of uncontrolled pain and a loss of control and dignity. Are these some of your concerns? Help me understand what’s really troubling you now.

If you are asking me how long you have to live, I cannot give you a time nor should I, because we really don’t know. Everyone is in an individual, and I have met people who have broken all the records, time wise, because they have had hope, purpose and a reason to live.

I know you are having a difficult time of it, but let me tell you this, I will do everything in my power to be here for you, and our team will respond to your physical, mental and spiritual anguish as best we can.

The hope I can give you is that we won’t abandon you. We are here to help you through this last chapter of your life, no matter how long it is and no matter how challenging it will be, we will be here for you.
# DEALING WITH CONFLICT IN CARING FOR SERIOUSLY ILL

A. Bach & R. Auld

## Table 1. Common Examples of Conflict

<table>
<thead>
<tr>
<th>Family vs Clinician</th>
<th>Clinician vs Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Son prefers life-sustaining treatment for patient</td>
<td>Physician thinks life-sustaining treatment would increase patient suffering</td>
</tr>
<tr>
<td>Husband is uncertain about patient’s wishes</td>
<td>Physician finds the husband is inconsistent when discussing patient’s wishes</td>
</tr>
<tr>
<td>Husband does not trust that clinician is acting in patient’s best interests</td>
<td>Nurse thinks family is not acting in patient’s best interests</td>
</tr>
<tr>
<td>Wife does not believe prognosis given by clinicians</td>
<td>Physician believes wife is in denial</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist physician wishes to continue interventions targeted at disease</td>
<td>Palliative physician wishes to focus on quality of life and patient goals</td>
</tr>
<tr>
<td>Physician wants to continue life-sustaining treatment based on small chance of cure</td>
<td>Nurse wants to focus on quality of life based on large chance of treatment failure</td>
</tr>
<tr>
<td>Physician thinks that medical decisions are his/her responsibility</td>
<td>Nurse thinks his/her input is excluded from decision making</td>
</tr>
<tr>
<td>Attending physician gives resident increasing responsibility</td>
<td>Nurse thinks that resident decisions are inadequately supervised</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughter thinks she knows patient wishes best</td>
<td>Son thinks medical options have not been exhausted</td>
</tr>
<tr>
<td>Wife has come to accept her husband’s imminent death</td>
<td>Daughter has just arrived from out of town, insists on not giving up</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient vs Clinician</td>
<td></td>
</tr>
<tr>
<td>Patient wants to try another chemotherapy regimen</td>
<td>Physician thinks that more chemotherapy is futile</td>
</tr>
<tr>
<td>Patient wants to live independently</td>
<td>Physician thinks patient’s debility requires assisted living</td>
</tr>
</tbody>
</table>
### Table 2. Pitfalls in Handling Conflict: Behaviors to Avoid When Dealing With Conflict

<table>
<thead>
<tr>
<th>Pitfall</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding or denying conflict</td>
<td>Issue may percolate, become worse; in long term, avoidance or denial creates perception of lack of leadership</td>
</tr>
<tr>
<td>Assuming that you know the whole story</td>
<td>Misses opportunity to improve mutual understanding</td>
</tr>
<tr>
<td>Repeatedly trying to convince the other party</td>
<td>Misses opportunity to understand true concerns and annoys the other person, who may stop listening</td>
</tr>
<tr>
<td>Assuming you know the other party's intentions</td>
<td>Labeling other party's character rather than focusing on behavior leads you to view him/her as inflexible</td>
</tr>
<tr>
<td>Holding the other party responsible for fixing the issue</td>
<td>Resolution more difficult unless both parties take responsibility for finding reasonable outcome</td>
</tr>
<tr>
<td>Proceeding as if the issue can be settled rationally or based on evidence</td>
<td>Ignores emotions that have been triggered by conflict</td>
</tr>
<tr>
<td>Declaring other party as ethically questionable</td>
<td>Condescending and potentially insulting to other party</td>
</tr>
<tr>
<td>Using anger or sarcasm as coercive threat</td>
<td>Creates resentment and undermines trust in relationship</td>
</tr>
<tr>
<td>Ignoring one’s own strong emotions</td>
<td>Emotions tend to leak out and become obvious to other party and may complicate negotiation</td>
</tr>
<tr>
<td>Proceeding in the heat of the moment</td>
<td>Strong emotions tend to narrow perspective and reinforce existing conflict</td>
</tr>
</tbody>
</table>

### Table 3. Useful Communication Tools for Addressing Conflict

<table>
<thead>
<tr>
<th>Tool</th>
<th>Useful Phrases</th>
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<tr>
<td>Active listening: Turn full attention to speaker rather than focusing on your own concerns or on counterarguments and provide feedback showing that you have understood</td>
<td>“What I’m hearing you say is that you want us to do everything possible to prolong your father’s life.”</td>
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<td>“It sounds like you are concerned about this patient’s suffering being made worse.”</td>
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<td>Self-disclosure: Reveal to listener some aspect of how you are feeling without blaming the other party for your emotions</td>
<td>“I am worried that even the best medical care will not be able to achieve your hopes.”</td>
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<td>“I need a few minutes to cool off because I’m irritated; but later we need to talk about the next steps.”</td>
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<td>Explaining: Provide listener with information about which aspects of the situation you are most concerned about</td>
<td>“My view of this situation is that providing intravenous fluid would give her, at best, a 50-50 chance of improving.”</td>
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<td>Empathizing: Provide listener with evidence that you understand his emotional state</td>
<td>“I can see that you care a great deal about what happens to your mother.”</td>
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<td>“This just feels like a sad situation.”</td>
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<td>“I think anyone would feel as worried as you given the circumstances.”</td>
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<td>Reframing: Describe situation as a mutual problem to be solved collaboratively</td>
<td>“Now I think we should look at the issue of intravenous fluid as not just ‘Do we do it?’ but as part of the bigger picture of her care.”</td>
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<td>Brainstorming: Propose potential solutions without critiquing them as a first step in problem solving</td>
<td>“Let’s try to come up with a few ideas about how to prepare for her death and then pick a few to work on.”</td>
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THE GOALS OF PALLIATIVE CARE

To achieve the best balance between quality of life and extension of life for the individual while respecting patient and family wishes.

- **Patient’s experience of illness**
  - Symptoms
  - Suffering
  - Hope

- **The illness**
  - Nature / status
  - Medical options
  - Nearness of death

- **Patient as person**
  - Wishes
  - Goals
  - Plans

- **Formulate goals of care**
  - General
  - Specific

- **Consider various treatments**
  - Burdens / benefits?
  - Patient’s wishes?
  - Consistent with goals?
Advance Directives

Respecting a person’s autonomy so that their values and choices can be taken into account in health care decisions even though they become incompetent or unconscious…

This is the goal of the Living Will.

In the competent person the paths of care can be negotiated on the basis of informed discussions of the burden and benefits of various treatment options. At some point Life Prolongation in the face of unbearable and irreversible suffering may not be a desired goal of care. The shift to supportive care or palliative care may become the most acceptable option.
Shortly after patients are given a terminal prognosis, there is usually a period of resolution and determination. Their attitude towards the disease is like the strategy of a military campaign, then after a long and heroic battle, their aspiration changes from hope for a cure to a hope for redemption. The attitude shifts from fighting the illness to alleviating lifetime of guilt, and forgiveness is often persuaded through religious and spiritual practices.

Dying patients grapple with their historical place in the world, and whether their life has been of value. The dying eventually evolve away from the struggle of fighting, their disease or seeking relief from being who they are, to just living for the time remaining. Gaining or adding something is no longer the issue. Now there is just being. Quality time becomes time for honoring connections and relationships. These are often times that the dying and their loved ones don’t know what to say.

Try to share the following communications to each member of your family and significant others if you feel it is appropriate:

- Ask for forgiveness
- Give forgiveness
- Thank them
- Tell them you love them
- Say goodbye

This shared work brings meaning and closure to the end of life. It offers moments of grace and serenity when words don’t come easily and one doesn’t often know what to say.

When said with love and compassion these precious moments can become sacred and cherished by all.