

EDITORIAL

Physician-Patient Communication—An Actionable Target for Reducing Overly Aggressive Care Near the End of Life

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Despite advances in screening and management, more than half a million Americans will die from cancer this year. Observational studies indicate that many of these patients will receive aggressive treatments near the end of life,^{1,2} raising concerns about deleterious effects on quality of life and costs,³ along with questions about what factors contribute to this unfortunate pattern. Given that patients' preferences for aggressiveness of care can depend on their understanding of prognosis, a key question is whether physician-patient communication about prognosis is sufficiently robust, given that cancer care near the end of life is a situation that can naturally challenge the capacity of even the most highly skilled clinician. Prior studies have suggested that patients with advanced cancer often inaccurately view the intent of treatment as curative rather than palliative or have inappropriately optimistic prognostic expectations,^{4,5} but questions remain regarding the extent to which patients truly misunderstand vs knowingly disagree with their physicians regarding prognosis, as well as whether certain subgroups are particularly vulnerable to misunderstandings in this setting.



Related article

In this issue, Gramling et al⁶ report an interesting cross-sectional study that describes survival expectations among 236 patients with advanced cancer and their 38 oncologists from 9 practices. Patients were participating in a broader trial of an intervention to improve clinical communication. The study reports high rates of discordance in prognosis, with over two-thirds of patient-oncologist ratings being discordant. The researchers specifically distinguish intentional discordance (knowing disagreement with oncologists' opinions) from unintentional discordance, finding that only 1 in 10 patients with discordant opinions was aware that their oncologist's expectations differed.

Discordance was even more common among nonwhite patients and detectable in this sample because of its magnitude, despite inclusion of relatively few minority patients. Discordance was observed in 21 of 22 nonwhite patients and all 6 Latino patients. That this was unexplained by measures of socioeconomic status is notable and suggests a need to improve the provision of culturally competent care in this setting.

It is particularly sobering that most cases of prognostic discordance occurred despite oncologists recalling having "completely" thorough discussions about prognosis with patients. That virtually all of the patients in discordant dyads wished to be actively involved in treatment decision making, and that 70% of such patients had prognosis-relevant care preferences (ie, the desire to involve palliative care when the end of

life was near), suggests that this discordance may have a meaningful impact in terms of causing decisions to diverge from patients' true underlying values and preferences.

As the authors discuss, this study has some limitations, including the possibility that the self-reported data collected might reflect some distortion of true beliefs. For example, some patients might have provided overly optimistic prognosis ratings related to superstitions about predicting death. Nevertheless, we believe this article advances our understanding in this critically important area and highlights that physician-patient communication is an actionable target for intervention to reduce overly aggressive care near the end of life.

Although the data presented in the study cannot explain why patients do not accurately perceive their oncologists' prognostications, a rich body of research exists to help in this regard. The insights of that broader body of research are essential to inform interventions seeking to increase and improve physicians' frank delivery of bad prognostic news, as there are enormous challenges from both sides of the news-delivery equation in this setting.

On the one hand, substantial challenges exist on the side of physicians, or the news deliverers. A subdiscipline of sociology called conversation analysis has long demonstrated that, especially in face-to-face contexts, there exist social-interactive norms that make the delivery of bad news a "dispreferred" social action.⁷ This means that, even when physicians are experienced with delivering bad prognostic news, even when they believe it to be warranted, and even when they are prompted to do so (eg, via training or intervention), such social-interactive norms bias physicians to nonetheless avoid or delay bad news and, if it gets delivered, to variously qualify or mitigate the bad news.⁷ This is supported by research finding that, even when patients with advanced and/or incurable cancer explicitly request survival estimates, physicians only provide frank answers 37% of the time, favoring instead inaccurate answers (40.3%) or none at all (22.7%).⁸ Relative to bad news, the "preferred" social action is the delivery of good or hopeful news, which tends to be performed more frequently, promptly, and directly. As Helft⁹ described, to maintain patients' hope, oncologists tend to engage in necessary collusion, which involves avoiding or delaying discussions of definitive, numerical prognostic estimates of life expectancy in ways that take advantage of the progressive degree of prognostic certainty and patients' incremental receptivity to concrete prognostic information.

On the other hand, challenges also exist on the side of patients, or the news receivers. We know that patients with incurable cancer infrequently explicitly ask about prognosis,⁹ which places more burden on physicians to initiate bad-news

delivery (which, as noted above, is dispreferred). Additionally, and importantly, patients with curable vs incurable illnesses report different expectations and desires regarding prognostic information.¹⁰ While patients with advanced and/or incurable cancer universally report wanting some level of prognostic information (and wanting physicians to be honest), most of these patients report wanting qualitative information (eg, their illness is incurable or life limiting), and fewer report wanting concrete, quantitative information about likelihood of cure and life expectancy (eg, statistics and timeframes).⁹⁻¹² This can be explained by patients' desires to maintain hope, which is an essential element within prognostic discussions.¹¹

Research in conversation analysis has strongly argued that successful communication interventions (eg, involving the delivery of bad prognostic news) must be built up from the detailed transcription and analysis of audio or videotapes of actual care, of the sort collected in the VOICE trial,¹³ though not reported in detail in the current manuscript.^{7,14} Self-reports of communication behavior substantially differ from observed realities. For example, self-reports by patients with advanced cancer regarding how much prognostic information they want do not accurately reflect the nuances of such desires as they play out in actual care.¹² This is due, in part, to the fact that, while physician-patient communication is highly systematic and organized, such organization is extremely complex and largely nonintuitive, to the point where the alteration of single words or phrases (and/or their ordering) significantly affects patients' perceptions and behaviors.¹⁵ We have virtually no understanding of how the frank provision of bad prognostic news is naturally organized, which substantially complicates its intervention, especially when it might involve completely unnatural communication behaviors. For example, physicians might be encouraged to individually assess patients for their news delivery needs. While

patients with advanced cancer report wanting physicians to ask patients about the types and amounts of prognostic information they want,¹⁰ it is unclear how, where, or when this should happen in the course of visits.

Therefore, the work of Gramling and colleagues⁶ has made an important contribution by identifying the great need for improvement in physician-patient communication in this setting. However, much more work remains to develop specific interventions likely to have true impact. We find it telling that the current study pooled the data from the 2 arms of the VOICE trial,¹³ which evaluated a multimodal intervention to promote high-quality communication, because there was no difference in prognostic discordance between patients in the 2 arms. We hope that, in future reports, we will learn that the intervention had an impact on other meaningful outcomes. In any case, we especially look forward to future analyses reporting details from the rich data set of audio recordings these researchers collected of clinic visits after the intervention, which will be informative regardless of the outcome of the trial itself. We believe the lack of difference between the study arms in terms of frequency of prognostic discordance is a testament to the complex and multifactorial challenges in this particular context.

The National Cancer Institute, Institute of Medicine, and American Society for Clinical Oncology all call for improved communication with patients with incurable, life-limiting illnesses. The study in this issue by Gramling and colleagues⁶ provides clear evidence of the ongoing need for improved communication in the context of advanced cancer. After all, promoting more realistic prognostic estimates is a critical step toward improving patients' quality of life and preference-concordant illness management decisions, including the reduction of overly aggressive treatments that many patients will otherwise continue to receive.^{11,13}

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Published Online: July 14, 2016.
doi:10.1001/jamaoncol.2016.1948.

Conflict of Interest Disclosures: None reported.

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