

LESS IS MORE

Softening Our Approach to Discussing Prognosis

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We tend to cringe when we hear “So, how much time do I have, doc?” Yet prognostic discussions are a core skill of being a compassionate physician, preparing patients and families to live with serious illnesses, and enabling informed medical and personal decisions. The first challenge of prognostic communication is the inherent and unavoidable uncertainty, that the exact trajectory of health (or illness) is unknowable. Thus, clinicians are inaccurate prognosticators, overestimating by up to a factor of 5.¹ We have difficulty making accurate short-term time-based prognostic estimates for common diseases, such as congestive heart failure, and can be off by as much as 1 to 2 years.² Compounding this uncertainty, we worry about upsetting our patients with too much or unwanted information. On one hand, patients say that they want to know their prognosis and report that it is one of their highest priorities.³ On the other hand, patients also say that they are unsure about how much they want to know and give mixed messages about how much they want to talk about it.⁴ As one patient said, “I ask the question, and then I don’t want to know the answer. But the question is out there, and then I am devastated.” Uncertain about the information and not wanting to cause emotional harm, we hesitate to talk with patients about their futures. We watch colleagues hesitate with statements such as “Well, I don’t have a crystal ball” or “You know I can’t tell you that,” or “Only God knows,” or “We are very bad at predicting this sort of thing.” But we also worry that our patients do not have the prognostic information that they need, however imprecise. And perhaps worse, we worry that patients perceive that we cannot handle the tough discussions they need from us.

We propose that to succeed in prognostic communication, what clinicians most need is not precision about the time ahead or the fortitude to discuss it, but rather a softened approach. To do so, we recommend communicating a prognosis by pairing our hopes and worries:⁵ “I am hoping that you have a long time to live with your heart disease and I am also worried that the time may be short, as short as a few years.” We have found this approach to be popular with colleagues—they like it and incorporate it into practice quickly.

It works well for several reasons. First, by expressing hopes and worries, clinicians incorporate “I” statements, such as “I am hoping” or “I am worried.” These statements share the feelings, beliefs, or values of the clinician rather than an objective prediction of the future. Originating in Carl Roger’s nondirective approach to therapy and the parenting literature of the 1960s,⁶ “I” statements acknowledge that the viewpoint expressed is personal. They contrast with “you” statements, which focus on the person being spoken to: “You

could live for as short as a few years with your heart disease.” By framing the prognostic disclosure as subjective, “I” statements make it easier for clinicians to discuss a prognosis. Clinicians don’t need to “know” the prognosis, they just need have an opinion. “I” statements also normalize discussions. Emotions are universal and all clinicians can be expected to have hopes, concerns, and worries about their patients. Using “I” statements, clinicians who otherwise see that it is not their role to discuss a prognosis (shouldn’t the oncologist say it?) feel more comfortable sharing concerns: “From what I can see, I am worried...”

Second, pairing hope and worry expresses the inherent uncertainty in prognostication. Naming an outcome without insinuating that it is the only possibility leaves open the chance that clinicians can be wrong. Decreasing the focus on being accurate and expressing uncertainty helps clinicians, patients, and families have conversations about the future. Clinicians avoid overstating or understating information and can feel freer to deliver a prognostic estimate despite its uncertainty. Patients and families benefit by getting prognostic information and hearing it in a context that allows for hope. When clinicians empathically deliver prognostic information and allow for hope, patients are less emotionally overwhelmed and more easily discuss and tolerate hearing a prognosis.

Third, pairing hope and worry as “I” statements promotes connection and partnerships with the patient and family. All too often, the patient and the medical team land in a tug of war. On the one side stands the patient and their family, fighting to live. On the other side stands the medical team, trying to convince the patient that he or she is inevitably getting sicker. In a tug of war, neither side can imagine easing its effort. The patient fights to stay positive. The medical team, similarly stuck, pulls the patient to simply accept the prognosis. An unfortunate and common manifestation of this dynamic is when the medical team asks the patient over (and over) again about a code status, even after the patient has clarified their preference for resuscitation. What is needed to move forward in these situations is for clinicians to ease this tug of war, put down the rope, and place themselves alongside the patient, hoping and worrying together. By offering opinions with an “I” statement, we invite the patient to join a discussion instead of pulling the rope. By giving voice to hope, we align with patients by letting them know that we understand their feelings and that we want better health for them. By naming our worries, we shift the orientation of the discussion to face the problem—the uncertain future of their illness—together. The problem is not a patient who cannot accept the prognosis, nor is it the pessimistic clinician.

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cian who has given up hope. The problem is the disease, which is advancing despite everyone's efforts.⁷ To guide patients through a serious illness, we must recognize our own limitations about knowing the future and join patients in a more humble position of hoping and worrying together.

In summary, pairing hope and worry as "I" statements enables clinicians, patients, and families who are facing serious illnesses to find a shared language for prognosis. This language is important because serious illnesses give us a lot to talk about. Like running a race,

living with a serious illness requires preparation. Knowing the length of the race is only one part of planning. The grade, the curves, the bumps, the changes in terrain, the texture of the trail, where the crowds will stand to infuse energy, the other people running the race—these factors are as important as the distance. Equally important is how these factors change over the course. Will it be steep and slow up front, in the middle, or at the end? By releasing our focus on knowing and predicting the future and instead sharing our hopes and worries, we can begin these discussions.

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