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Applying Motivational Interviewing Techniques to Palliative Care Communication

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Abstract

Palliative care relies heavily on communication. Although some guidelines do address difficult communication, less is known about how to handle conversations with patients who express ambivalence or resistance to such care. Clinicians also struggle with how to support patient autonomy when they disagree with patient choices. Motivational Interviewing (MI) techniques may help address these responses. Specifically, MI techniques such as reflective statements and summarizing can help reduce a patient's resistance, resolve patient ambivalence, and support patient autonomy. Not all the MI techniques are applicable, however, in part because palliative care clinicians do not guide patients to make particular choices but, instead, help patients make choices that are consistent with patient values. Some elements from MI can be used to improve the quality and efficacy of palliative care conversations.

Introduction

Communication is a main component of palliative care. Palliative care clinicians pride themselves on being able to talk about topics that other clinicians find difficult, such as spirituality and dying. Physicians consult palliative care clinicians or teams to deliver bad news, discuss goals of care, and negotiate conflict. Palliative care training programs focus on teaching communication skills. These skills can be viewed as specialized palliative care procedures, analogous to bronchoscopies in pulmonology or catheterizations in cardiology.

As the field of palliative care has matured, communication strategies have developed to guide common tasks. For instance, SPIKES[1] (**Setting** up the interview, assessing the patient's **Perception**, obtaining the patient's **Invitation**, giving **Knowledge** and information to the patient, addressing the patient's **Emotions** with empathic responses, **Strategy**/**Summary**) provides a step-by-step guide to delivering bad news, and von Gunten et al. have developed strategies for discussing code status.[2] Others have written about how to provide prognostic information and discuss goals of care.[3–5]

While these strategies are invaluable, there is an assumption that patients or family members are willing to discuss end-of-life decisions and have thought about values and goals. These strategies do not directly address resistance or ambivalence— two common situations in palliative care consultations. Conversations may be stalled when patients show resistance to discussing the future because they fear dying or disagree with the clinician's point of view and, thus, argue against a treatment plan. Even clinicians who are skilled negotiators may be unable to support and empathize with patients or families who make decisions that are incongruent with what the palliative care team believes is best. For example, when a family elects to place an enteric feeding tube into a 95-year-old relative with advanced dementia who has had a severe stroke, even clinicians with the best communication skills may find it hard not to try to convince the family to change their position—a technique that rarely turns out well.

Sometimes, patients and families are ambivalent and unable to make a decision. In palliative care family meetings, patients and families are often forced to make decisions between two options, neither of which is optimal (e.g., dying in the ICU vs. dying at home). In addition, patients often have competing values that change as their symptoms vary from day to day. A clinician's expression of empathy may not be enough to help patients make decisions about which they feel deeply ambivalent.

Skills developed from behavioral science may help palliative care clinicians work with resistance and ambivalence.

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Motivational Interviewing (MI) is an approach initially developed in the 1980s to help problem drinkers stop using alcohol. It has been applied successfully in a number of different settings, including primary care, correctional, and addiction treatment[6,7] Palliative care clinicians may find some MI techniques useful for their communication toolkits. This paper describes the principles of MI and their relevance to palliative care, and suggests some ways that core MI skills—specifically, reflective statements, summaries, exploring values, naming resistance, and querying extremes—can be used in palliative care. While palliative care practitioners already use some of these skills, MI-specific suggestions for employing them may enrich palliative care communication.

A caveat about applying MI to palliative communication is that, while the discussion is based on the standard MI texts,[8] our recommendations are based as much on experience as evidence. MI has been shown to increase rates of behavior change, and there is some evidence that specific MI skills, such as reflection, can increase the likelihood of its effectiveness.[9] However, patient reactions to some specific MI techniques have been less commonly studied.

Philosophy of MI: Collaboration, Autonomy, and Evocation

Motivational interviewing is a set of specific behaviors directed by a guiding philosophy. This philosophy emphasizes partnership and eliciting patients' internal motivations. It relies on three principles: 1) collaboration, 2) autonomy, and 3) evocation.

Collaboration. The first tenet means physicians and patients should work together as partners to reach a common goal. Unlike traditional medical encounters, in which clinicians view themselves as providing expert opinions to patients, clinicians view patients as experts in their own lives.

Autonomy. The second tenet translates as respect for patients' ability to make their own decisions. In general, telling people why and how to behave is not effective in helping them change.[10] Instead, MI-trained clinicians treat patients as autonomous and having the freedom to decide whether and how to adopt new behaviors for themselves.

Evocation. The third tenet leads clinicians to elicit information from patients about internal motivations and help them reflect on the advantages of and barriers to change. Patients are more likely to change when they, rather than health care providers, express their values, goals, and ideas for change.[10] Clinicians, in turn, strive to elicit patients' own internal motivations to make their own decisions rather than educating or warning them about what they should or should not do.

Principles of MI: RULE

Four key principles, represented by the acronym RULE, serve as a guide to implementing the MI philosophy: 1) **Resist** the righting reflex, 2) **Understand** the patient's motivation, 3) **Listen** to the patient, and 4) **Empower** the patient.

Resist the righting reflex. The first principle refers to clinicians' reflexive reactions when they see patients making decisions that clinicians' feel are not in the patients' best interest. In a primary care setting, patients who smoke might know about the negative health effects of smoking, yet be fatalistic about their chances of developing cancer and, therefore, have no interest in quitting. In a palliative care setting, patients might be making choices that are unlikely to extend life and will impair quality of life. There also are times when patients do not want to discuss a difficult topic, even if the clinician feels it is time to do so.

When confronted with such resistance, clinicians often automatically attempt to help or correct—"right"—patients by providing medical advice and information. Unfortunately, research shows that this "righting reflex" can increase patient resistance by eliciting more arguments against change.[11] To be consistent with MI philosophy, clinicians are encouraged to resist the urge to address patients' resistance by educating or correcting their perceptions. Instead, MI suggests that clinicians acknowledge resistance and explore the values behind it.

Understand the patient's motivation. The second principle encourages clinicians to approach their patients with the spirit of open-mindedness and curiosity about patients' individual experiences and motivations. Motivations drive behaviors. When clinicians understand patients' unique motivations, they can better guide those patients toward choices that are consistent with patient values.

Listen to the patient. Supporting the above principle is the third principle, in which clinicians seek to create safe environments in which patients and families feel accepted and free to express their emotions and beliefs. In this setting, individuals are able to work through conflicts and weigh the tradeoffs that they may need to make as diseases progress.

Empower the patient. Using the fourth principle, clinicians can empower patients or family members in the decision-making process and narrow the power differential that naturally exists. Empowering occurs, in part, when clinicians support patients' self-efficacy or confidence that they need to accomplish a task, such as making a difficult decision. Self-efficacy may be especially important in palliative care settings, where difficult decisions are frequent.

MI in Palliative Care

The MI philosophy and principles fit easily into palliative care. Most of palliative care involves discussing patients' values and priorities.[2] Palliative care training programs emphasize listening to patients, understanding patients' motivations and values, and empowering patients to ensure that treatment plans match treatment goals.

Although the MI approach has similarities to palliative care communication, there is a fundamental difference between the two. For behavior changes such as smoking, excessive alcohol consumption, or physical activity, there is a clear and objective goal: to stop unhealthful behaviors or adopt healthful behaviors. When clinicians listen to patients and help them explore their ambivalence, patients often are more willing to change. MI, in this instance, is directional—clinicians guide patients to objective goals (e.g., a smoker toward quitting). However, in palliative care consultations, there is no objectively correct answer about what constitutes a good death for the patient. Therefore, MI cannot be directive when used in palliative medicine. The skilled palliative care clinician enters a conversation without a predetermined goal (i.e., "to get a DNR") but, instead, approaches it with an open attitude that elicits the patient's values and seeks to assist patients or proxies in making autonomous choices that will be consistent with those values.

Operationalizing MI: Reflections and Summaries

The four basic skills that MI practitioners use to promote the above philosophy and principles are 1) open-ended questions, 2) patient affirmations, 3) reflections, and 4) summaries. Some of these techniques also are well-known to palliative care clinicians. For example, both MI and palliative care educators focus on using open-ended questions to explore patient goals and values. Affirmation also is common to MI and palliative care communication.[5,12] Giving praise allows clinicians to recognize and show respect for patients. Reflections and summaries, and the way they are formed and used in MI, however, may be less familiar to palliative care, and thus, are discussed below.

Reflections. Reflections are critical to MI. Reflections are restatements of patients' words or guesses at what patients meant. Physicians who reflect are, in essence, acting as mirrors for patients to hear back what they have said. Hearing someone repeat back to you what you are saying may increase insight and self-reflection (this is a principle of psychotherapy). For example, if a patient is struggling with talking to family members, rather than asking, "So, you've found it hard to talk to your family about death?" a clinician might state, "You feel like you need to tell your family that you think about death, but get strong messages from them that they do not want to talk about it." Reflections are not meant to be directive, but to allow patients to elaborate on their concerns. Motivational interviewing theory recommends the use of at least two reflections for every question.[13]

Reflections have many purposes. First, reflections can convey empathy and show that clinicians are listening, rather than just gathering information. Second, reflections are a way to highlight patients' emotions and beliefs, and to provide opportunities to explore their values further, which may lead naturally to resolution of ambivalence. Third, reflective statements, like open-ended questions, encourage patients to talk more (and clinicians to be quiet). When the clinician reflects, and allows silence and time for the patient to respond, the patient can explore the complexity of his or her thoughts. The reflection allows the patient or family member to present what is important in the context of his or her life. Similarly, reflective statements empower patients to take control of the conversational platform.

The typical clinical encounter involves clinicians asking a question, the patient answering, followed by further questions from clinicians. This format reflects clinicians' agendas, rather than patients', and can inhibit patients from telling their stories. Reflections allow patients to control the story and what they want to talk about. Telling stories and allowing patients to steer the conversation often reveals sources of ambivalence (see below).

Reflections can be simple or complex. Simple reflections paraphrase what the patient said and do not add meaning or interpretation. Table 1 illustrates a simple reflection in a discussion about smoking. Complex reflections, on the other hand, go beyond what patients say and include clinicians' thoughts about patients' underlying emotions, values, or beliefs. These reflections can be riskier, because clinicians can be incorrect in their interpretations; however, these also can be more effective in helping patients resolve ambivalence. Table 2 illustrates such a dialogue with a patient who has been newly diagnosed with metastatic cancer.

Table 1. Simple Reflections

Clinician: What are your thoughts about the smoking these days?
Patient: I know I really need to quit, but it is so hard.
Clinician: *(reflection)* You know you need to do it, and I hear you that it's hard.
Patient: Yeah. I've tried before and not been able to do it. My wife keeps telling me that I need to quit. Maybe I should try again.
Clinician: *(reflection)* You're thinking about giving it another try.
Patient: Yeah, I'm sick of paying so much money for cigarettes every week, and this nagging cough I have . . .. I tried the patch and the gum before, and they worked for a while, but the cravings got so bad . . ..
Clinician: *(reflection)*You want to quit and yet the cravings get so bad.
Patient: Yeah, the urges are so strong. I'm not sure what I can do about that.
Clinician: *(reflection, asking permission)* You feel a little stuck about the cravings. Would it be ok if I made a suggestion?

Many questions can be changed into a reflection simply by re-ordering the sequence of words or changing the vocal inflection at the end. For instance, the *question* "So, you're not sure you want to have a feeding tube?" can be transformed into a *reflection* by saying, " You're not sure you want to have a feeding tube." It will seem natural for newer practitioners of MI to preface these reflections with "It sounds like . . ." or "I'm hearing you say that . . .," but learners are encouraged to drop the preface as they become more advanced. This takes the focus further off the clinician and places it with the patient's concerns.[8] The dialogues in Table 3 illustrate how reflections can reduce defensiveness and often yield more information.

Summaries. Summarizing, another core MI skill, is simply a set of reflections gathered together and presented to the patient. Summaries help patients and families organize their experiences. A summary statement often ends with a question, to check accuracy with the patient. Summaries can be used to make the transition from exploration to information-giving and decision-making. Table 4 is an example.

Using MI Skills in Difficult Situations: Resolving Ambivalence and Reducing Resistance

Ambivalence occurs when an individual holds two conflicting desires at the same time.[14] Ambivalence is considered

Table 2. Complex Reflections

Patient: I just don't know how I'm going to tell my kids about this. They will be devastated.
Clinician: Your kids are pretty important to you.
Patient: Yes, I love them and want them to be ok. It's my job to protect them. But I know they have to know.
Clinician: So, you want to protect your kids, and yet you know that keeping the truth from them wouldn't help them.
Patient: No, I know it wouldn't. I'm worried about telling them, but I know I have to. So how do I talk to my kids about this?

Table 3. Questions vs. Reflections

Asking

Clinician: What happened last year when you decided to have the feeding tube put in?

Family Member: Well, they told me that he needed it. And I didn't want him to starve to death.

Clinician (asking): So, you were worried that your father would suffer if he didn't get the tube?

Family member: Yes. They told me he would starve without it.

Reflecting rather than asking

Clinician (reflecting): So, you were worried that your father would suffer if he didn't get the tube.

***Family member*:** Yeah, I was, but I don't feel like it's worked so well. His life has been terrible the past year. He's still gotten pneumonia twice this year. I just don't know.

Clinician (reflecting): You were trying to do everything you could for your dad. You're still trying to do that. It's hard because you see that the tube hasn't been working so well to give him a good life.

Family member: Yes. I really want what is best for him and am not sure the feeding tube is the answer.

a normal and expected part of behavior change.[7] For example, a patient might want to quit smoking for her health and to be a role model for her children but still enjoy smoking and wants to avoid the pain of quitting. Patients might have underlying ambivalence but compartmentalize their positive and negative views, and thus, not feel motivated to resolve their ambivalence. However, when ambivalence is highlighted and made conscious, patients usually will feel the urge to resolve the ambivalence and make a decision.[15]

Table 4. Transitional Summary

Patient: All these doctors keep asking me questions, and I don't know what to do. How can they expect me to make such big decisions? It's all so complicated.

Clinician: *(reflection)* These decisions feel pretty overwhelming to you. Let's take it one piece at a time to make it a bit easier. What have the doctors told you about the cancer?

Patient: They say any more chemo would just kill me. That chemo was just terrible anyway, plus I've had all this pain. I can't stand the pain anymore.

Clinician: (reflection): Getting the pain in better control is pretty important. What else is important to you these days?

Patient: Well, I want to see my grandkids and spend time at home instead of in the hospital all the time. But I don't want to just go home and die either.

Clinician: (reflection): You don't like to be at the hospital, but you're afraid that going home means that you're giving up.

Patient: Yeah, they just keep talking about hospice. I don't want to just give up. I know there's no chemotherapy but if I get something where there's a chance that I'll get better, sure I would do it.

Clinician (summary): So, just to make sure I've got this right, you've heard from the oncologists that they have no more chemotherapy to offer. You've been through a lot of pain, and an important priority for you at this time is to have your pain controlled. You also want to spend time with your family. However, staying alive as long as possible is also important as long as you don't have to spend all of your remaining time in the hospital. Do I have that right?

Patient: Yes, that's about right.

For instance, with a patient who is a smoker, the clinician does not have to tell the patient reasons to quit—he or she already knows about the risks and has good reasons to quit. A more effective approach might be to explore both sides of such a patient's ambivalence by asking about good and not-so-good things about smoking. This will help highlight the patient's core values so he or she can weigh them against the benefits of his or her current behavior.

Exploring goals and values fits naturally in palliative care communication; applying such exploration to help patients address ambivalence may be new. Patients might have a goal of not being in pain at the end of life. They also could value living—as long as they can continue doing so regardless of discomfort. Using reflections and summaries to explore how these goals and values are consistent or inconsistent with current choices may help patients make the best decisions for themselves. A clinician using MI might ask a patient to explore each side of the decision in depth; for example, exploring the benefits and burdens of being in the ICU on a ventilator before discussing the decision to enact a DNR order (Table 5).

Another tool to address ambivalence is to query extremes of the best and worst outcomes of a decision (even if that decision is merely to have a discussion). Querying extremes is helpful, as patients might view the decision as less scary when they have explored the most- and least-optimistic scenarios. They also might gain clarity if one is more heavily weighted than the other. For instance, if a patient is reluctant to discuss DNR, the palliative care clinician might ask, "What is the best thing that could happen if we talked about it? And what is the worst thing?" From this exploration, the patient might realize that the best outcome could be making a decision that is consistent with his or her idea of a good death and the worst outcome is to suffer grief in thinking about his or her own death. She may realize from this exploration that risking

Table 5. Discussing Values and Goals

Clinician: To summarize what we've talked about so far, you're willing to accept some treatments like CPR if there's a chance of them working, and also that you wouldn't want to be kept alive on machines in the ICU and be a vegetable if they don't work. Can you tell me a little more about why?

Patient: I don't think it's living if I can't be awake to see my kids. Plus, I don't want my family to see me like that and have to take care of me forever that way.

Clinician (reflection): To you, being alive means being able to be awake and to recognize your family.

Patient: That's right.

Clinician (open-ended question exploring values): What would be hard for you about deciding not to accept life support or things like CPR?

Patient: It would feel like I was giving up. I don't want to give up. I want to live as long as I can.

Clinician (reflection): Knowing that you can have CPR gives you a sense of hope. What else gives you hope?

(discussion continues)

temporary distress—that is, thinking about death—is worth having a good death.

Patient resistance is another situation in which MI skills, such as naming or reframing the resistance, may be useful. Resistance is when patients actively or passively push against what clinicians are suggesting and indicates dissonance in the patient-clinician relationship. Patients can express resistance directly by arguing or interrupting, or indirectly by shrugging or becoming quiet. These verbal and nonverbal behaviors indicate that patients are not comfortable or in agreement with the topic under discussion. For instance, clinicians may want to discuss DNR when the patient and family find the topic emotionally traumatic. When clinicians continue to push them to talk about it, rapport can be damaged, and the patient may be even less likely to discuss it in the future.

MI recommends "rolling with resistance," rather than arguing against it. When a patient argues against a course of action, the clinician's natural response is to argue for it (the "righting reflex" as discussed above). This leads patients only to argue more strongly for the other side. Table 6 highlights this scenario. Rather than trying to convince patients, clinicians using MI would use reflections to let patients talk more about their experiences, which can help resolve the resistance. In the same scenario, the clinician uses reflections to roll with resistance, thereby defusing it (Table 6).

In addition to using reflections to roll with resistance, clinicians can reframe the discussion by first validating the point of view and then adding new definition or perspective. For example, a patient with advanced metastatic cancer may say, "I feel so good today, and I even got out of bed. Maybe I shouldn't enroll in hospice." Reframing this, the provider might respond: "It's great that you feel strong and energetic today. I understand it can be hard to talk about hospice on a day like today. It is confusing when you feel great on some days and on other days, you don't."

Motivational interviewing also stresses respect for personal autonomy, including decisions about when, where, and with whom to have important discussions. Patients who show resistance to these discussions may be overwhelmed by the responsibility of decision making, do not want to know about bad news, or prefer other family members to make decisions for them. To address this resistance, clinicians might ask permission before providing information, offer choices about what kind and how much information patients want to hear, and allow patients to defer decisions to family members.

Finally, clinicians can name the resistance and then shift focus or change the topic. "Forcing" someone to discuss a topic rarely results in a productive conversation and can harm the relationship. Clinicians can do this overtly by saying, "I am sensing you do not want to talk about this right now. There are reasons to and reasons not to discuss it. I want you to know I will talk about it whenever you are ready. What would you like to talk about with me today?" This strategy builds rapport and leaves the door open for later conversations.

One final challenge clinicians face, besides dealing with ambivalence and resistance, is being open to decisions that are different from what the physician would recommend. Although palliative care consultants may be called in to "get a DNR," doing this does not always match the patient's values. A clinician leading a family meeting may disagree with a patient's choice to seek aggressive treatment when comfort care might result in a better death. MI techniques, particularly reflections and summaries, are tools that help clinicians explore a patient's or family's world with a sense of curiosity and respect. This helps clinicians not *show* judgment and also not *feel* judgment.

Table 6. Rolling with Resistance: Confronting vs. Rolling

Confronting

Clinician: What have you heard about hospice?

Patient: My aunt was in hospice. It was terrible! All they wanted to do was give her that morphine. She died two days after she got into hospice, just because they were pushing that morphine on her.

Clinician (confronting): Actually, that's not what hospices are about. They only want to give you medications just to help your pain, not to hasten death.

Patient (angrily): I just know what I saw is all. I'm not going to give up and just go into some hospice.

Rolling with resistance

Clinician: What have you heard about hospice?

Patient: My aunt was in hospice. It was terrible! All they wanted to do was give her that morphine. She died two days after she got into hospice, just because they were pushing that morphine on her.

Clinician: (reflection) Your aunt's experience was not good. You wouldn't want that to happen to you.

***Patient*:** Yeah, I don't want to be all doped up. That's all they do to you in that hospice.

Clinician*: *(reflection) It's pretty important to you that you have control and can decide whether and how you get medication.

Patient: Yeah. I want my pain controlled but I sure don't want to be drugged up.

Clinician: I want you to have good pain control too and to help you be awake and enjoying life as long as possible. In my experience the hospice I work with is pretty good at both those things so it might be different than the one your aunt had experience with. Would it be OK if I tell you a little more about it?

Patient: OK.

Clinician: In the hospice I work with the nurses work pretty closely with the patient to make sure that they are feeling as good as possible. If it is important for you to be awake and alert, that would be their goal too and they'd give you as much or as little medication as you wanted.

Patient: Hmmmm . . .. Well, does insurance cover it?

If clinicians are feeling judgmental, they could acknowledge their feelings and then remember to support patient autonomy so patients do not feel judged. Motivational interviewing philosophy and skills, including the collaborative approach, support for patient autonomy, empathy, and investigating the patient's own values non-judgmentally, help with this process. Clinicians can embody these principles by using reflections to nonjudgmentally explore a patient's values and goals.

How Do Clinicians Know They Are Doing It Well?

It is unrealistic to expect palliative care clinicians to become skilled MI counselors. However, a few simple changes (e.g., making reflections rather than asking questions) can have a great impact on their conversations. Criteria that clinicians can use to determine their successful use of MI include:

- Letting patients talk as much as clinicians;
- Keeping question-asking to a minimum and using reflective statements; and
- Providing advice only after asking permission to do so.

Conclusion

As palliative care consists mostly of challenging communication, tools to address ambivalence and resistance may enhance conversations with patients and families near the end of life. MI provides skills that could help palliative care clinicians address roadblocks skillfully. MI techniques such as collaboration, support for autonomy, and evocation can be used to help patients make decisions that are congruent with their values and goals. In particular, reflections and summaries can help clinicians explore ambivalence, address resistance respectfully, and empower patients. Using MI techniques in palliative medicine could improve patient decision making at one of the most important times in a patient's life.

Author Disclosure Statement

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