

Confronting Therapeutic Failure: A Conversation Guide

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ABSTRACT

We reflect on the impact of bad news on both clinician and patient in the setting of cancer treatment failure. We review the classic six-step SPIKES (setting, perception, invitation for information, knowledge, empathy, summarize and strategize) protocol for giving bad news that has been widely adopted since it was first published in this journal in 2005. The goal of such

a conversation guide is to describe both the process and the tasks that constitute vital steps for clinicians and to comment on the emotional impact of the conversation on the clinician. Confronting therapeutic failure is the hardest task for oncologists. We offer practical tips derived from a thorough review of the evidence and our clinical experience. *The Oncologist* 2015;20:946–951

Implications for Practice: Discussing the failure of anticancer therapy remains a very difficult conversation for oncologists and their patients. In this article, the process of confronting this failure is broken down into various components, and practical tips are provided for clinicians following a classic protocol for breaking bad news. Also addressed are the emotions of the oncologist and the reasons why these conversations are typically so hard. These insights are based on solid research intended to deepen the therapeutic connection between physician and patient.

INTRODUCTION

We have made great strides in the treatment of cancer, and these advances have drastically changed the landscape of oncology practice. Options for cancer-directed therapy have expanded, and the promise of new drugs has infused more hope into conversations with patients with advanced solid tumors. We talk about a “Lazarus” effect when we describe exceptional survivors who were near death and have resumed productive lives after enrolling in drug trials. These stories of success propel us to coach patients to keep trying one after another chemotherapeutic drug or to enter a phase I study, hoping to squeeze a little more time. The message we convey to patients, and the mantra we use to guide our recommendations, is that there is always something more that can be done and there is little to lose by trying. At times, this is a dance of collusion, in which patients and doctors tiptoe around the elephant in the room, choosing instead to focus on action solutions or “fixes,” hoping against hope to postpone the finality of death [1, 2]. Some argue this hope is therapeutic and that it assists patients and their loved ones in coping with the emotional pain triggered by anticipating the final separation. Others take a bleaker, but more realistic, view, one that posits that talking only about anticancer treatment, instead of considering the big picture, distracts both the patient and the doctor from confronting their feelings of helplessness and grief and risks leaving patients and their

loved ones unprepared for the final weeks or months [3–8]. In our essay, we reflect on our conversations with patients about therapeutic failure in the era of ever-expanding treatment options.

Accompanying scientific discoveries of new cancer treatments are behavioral studies that provide important insights into the lived experience of patients with cancer. Patients are increasingly better informed and more willing to assume an active role in their care by participating as equal partners in decision-making, reporting adverse effects of cancer treatment, and sharing concerns and worries [9]. Numerous studies have also shown that patients want to have conversations about end-of-life care and expect their oncologists to initiate these discussions [10–12]. Oncologists, too, have adapted to changing times: they are more flexible in their relationships, more likely to work in teams, more aware of the emotional toll of their work, and eager to tailor their recommendations to best meet the needs of individual patients. Working in teams is beneficial to the patient by providing perspectives and recommendations from professionals trained in various health-related disciplines (e.g., pharmacist, palliative care clinician, nutritionist, respiratory therapist, oncology nurse) and is also beneficial to the oncologist. Teamwork allows each person to express their sorrow and obtain validation, insight, or support when facing an extremely challenging situation and

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conveys an important message of community that mitigates the stress and sorrow experienced by each individual professional.

In an ideal setting and without even considering the pressures of clinical practice, oncologists would plan their communication strategies with the same attention to detail they show when writing chemotherapy orders, by recognizing process tasks (e.g., identifying who needs to be present for a discussion or adapting prognostic estimates to help patients understand the odds of success or failure of a given treatment), deciding on strategies (e.g., empathizing, providing information about a certain treatment), and using well-honed communication skills (e.g., normalizing, validating affect, asking for clarification) to craft sustained therapeutic relationships. Plenty of tools are available to assist the busy oncologist, such as cognitive maps, mnemonics (e.g., CLASS [context, listening, acknowledge, strategy, summary], NURSE [name, understand, respect, support, explore emotions], SPIKES [setting, perception, invitation for information, knowledge, empathy, summarize and strategize]), and checklists, each designed to help clinicians during stressful conversations in which memory alone might not be sufficient or anxiety prevents them from being at ease and remaining in control of the interview [13–16]. Models of comanagement between oncologists and palliative care clinicians offer oncologists a chance to share the emotional load of clinical care and give patients access to experts in symptom management and supportive communication [17–19]. Yet, it seems that all these advances in the science of both oncology and palliative care have not made it any easier to have the most difficult conversation: the talk about stopping anticancer treatment. Death is still very much the enemy and represents the ultimate therapeutic failure.

Classic studies, conducted more than a decade ago and still quoted frequently, suggest that oncologists consistently overestimate the benefit of anticancer treatment and the life expectancy of patients with advanced solid tumors. This belief can cloud their objectivity and help them rationalize decisions to continue anticancer treatment until the very end of life [20–23]. It is still hard for patients, family caregivers, and oncologists to be certain that it is time to shift gears and transition to symptom-based management. Patients often fear that stopping anticancer therapy will lead to their being abandoned by their oncologists, and some oncologists recognize that they withdraw from patients who are dying [24–27]. Cancer patients might notice that the oncologist seems less engaged or distracted and could fear that interrupting or discontinuing anticancer treatment will mean they will also lose important therapeutic connections. Oncologists describe feelings of grief starting when they receive test results showing that a cancer treatment did not work and experience the period of “holding” this news as particularly stressful [4]. In candid interviews with oncologists, Granek et al. [4] found that they talked about the impact of patient loss on their treatment decisions (e.g., “maybe I got that case after someone had just died and I was in a more aggressive mode,” or “maybe I undertreated someone because I just saw a patient with terrible toxicity”). Oncologists have also reported that patient loss affected their level of distraction with patients and their motivation to improve care for subsequent patients [4]. Rob Buckman [1], an early champion of communication skills training for cancer clinicians, warned

oncologists that they needed to acknowledge the devastating effect that therapeutic failure has on them as physicians and that failure to do so could lead to continuing anticancer treatments in the setting of futility. However, how can oncologists possibly work through these complicated feelings of guilt and disappointment and still manage to stay on time and provide a cheerful and reassuring presence?

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In the next section, we revisit the classic SPIKES protocol published in this Journal in 2005, focusing on the nuances involved in discussions of cancer treatment failure. This protocol has become a classic teaching tool for oncology trainees. It provides an easy to remember six-step guide for patient-centered communication of bad news, allowing the oncologist to follow the patient’s lead and interests and to uncover important psychosocial issues that are relevant to their care, while maintaining control of the clinical interview and expressing support at each step.

STEP 1. S—SETTING UP THE INTERVIEW

Having a plan and strategy is very helpful, as is a “mental rehearsal” for stressful tasks [14]. Studies have shown that physicians experience anxiety before giving bad news and feelings of helplessness when confronted with extreme suffering [28, 29]. The complex feelings associated with therapeutic failure, including feelings of personal failure, can blunt the clinician’s ability to respond empathically and provide the emotional support that is so desperately sought by patients. Sometimes the physical setting of the interview leads the oncologist to hesitate or the unexpected appearance of many relatives will cause unwanted distractions. Helpful and now “classic” guidelines include arranging for privacy, involving key family caregivers, making a connection (verbally and nonverbally) with the patient, and managing time constraints and interruptions [14]. It is also essential to include the key members of the interdisciplinary team, including social workers, chaplains, and other specialists, especially if they have formed important relationships with the patient and family caregivers.

The key aspect of the preparation, when it comes to discussing treatment failure, is for the oncologist to be absolutely sure no more anticancer treatments are left to try that have a chance of producing a meaningful benefit. Reviewing the clinical case with a colleague, presenting the case at a tumor board, and/or discussing with an expert in the field are all valuable techniques to assuage doubt and guilt. Experiencing feelings of helplessness, sadness, guilt, or disappointment in the face of suffering is an unavoidable experience for clinicians who work with seriously ill patients [3]. Learning to recognize such feelings and accepting them as useful “data” are important first steps toward establishing a therapeutic connection, one that can sustain patients and family caregivers even when chemotherapy has failed.

Reframing feelings of helplessness and taking perspective are two important steps that facilitate expressions of empathy: “I was feeling terrible about having failed her and needed a little time and distance to realize I was caught up in my own emotions. At the next visit I was able to listen to her and validate her feelings and help her think about her goals and this helped me feel useful again” [3]. They also serve to steady the oncologist, who can then use various cognitive strategies to tailor the information and provide guidance and reassurance.

STEP 2. P—ASSESSING THE PATIENT’S PERCEPTION

The next step hinges on asking the patient what he or she understands and expects (“before you tell, ask”) [14]. Clinicians should use open-ended questions to create a reasonably accurate picture of how patients perceive their situation and to explore what matters most and gives their life meaning [14, 30]. Using value-based questions, such as “what is important to you in the time we have ahead?” is explicit and signals to patients that the oncologist is willing to talk about and listen to them describe their hopes, as well as their worries. The key task, when it comes to discussing the news that no further anticancer therapy is available, is to explore the patient’s awareness of his or her prognosis [31]. Jackson et al. [31] offered a detailed step-wise approach that stresses the partnership between the clinician and patient. Asking simple exploratory questions, such as “what is your sense of how you are doing?” or “how worried are you?” can help set the stage for the serious exchange that will follow. The key task for the clinician is to align himself or herself with the patient. “Let’s think together what is likely to happen” sends a clear message that the conversation cannot be avoided and that the patient will be supported by the clinical team [31].

Patients with advanced cancer might have little understanding of the seriousness of their condition and little prognostic understanding, or, alternatively, they might have complete clarity. One cannot make any assumptions based on the extent of previous treatments, education, or emotional resources. In some cases, a symptom such as a headache might alert the patient to the possibility of having brain metastases, but often, no legitimate physical warning sign is present, and the news of disease progression is experienced as a terrible and unexpected catastrophe. In the context of therapeutic failure, the clinician needs to feel connected to the patient, and the most common pitfall is rushing the conversation, without taking time to explore the patient’s and family caregivers’ understanding and hopes for the future.

STEP 3. I—OBTAINING THE PATIENT’S INVITATION

When a clinician hears a patient explicitly ask for information, it can lessen the clinician’s anxiety about divulging bad news [14]. Patients who appear to be ready to handle such serious news are easy partners, but those who remain ambivalent, unable, or unwilling to face the dire reality of the situation pose a challenge to even the most skillful communicators. Most patients live in between these two extremes, reflecting healthy coping mechanisms designed to ease them into acceptance of an impending death [31–33]. Practical methods are available for oncologists to prepare and coach patients for this difficult conversation. If a patient has received multiple lines of chemotherapy for an advanced solid tumor without clinical

improvement and is now scheduled for restaging scans, the oncologist can warn the patient that they will need to reassess the cancer treatment plan and have a “big picture” talk when they next meet. This could trigger anticipatory anxiety in the patient, but these feelings cannot be avoided. Instead of rushing to reassure the patient, the oncologist can acknowledge the suffering and, in so doing, confirm what the patient fears and probably already knows on some level.

In some situations, patient-physician teams have worked together for a prolonged period and have developed a method of negotiating the amount of information that will be shared and in what manner. In another scenario, a patient might be meeting a covering oncologist or emergency department physician for the first time. The difference between these two situations is the degree of personal attachment and responsibility the primary oncologist feels toward the patient, and it is precisely these feelings that Buckman [1] warned could get in the way of giving good advice.

The most problematic scenario confronting the oncologist is that of a patient and family who, in the face of imminent death, refuse to talk about stopping anticancer therapy that is demonstrably futile. This requires an urgent and deft approach that involves naming the dilemma of avoiding the topic and then proceeding with the information, despite not having obtained the patient’s permission. Once on this track, the clinician cannot backpedal and must stay the course and anticipate a possible emotional backlash. In his unforgettable teaching sessions, Buckman [1] proposed that oncologists practice using empathic responses toward themselves (“this is so hard”) to remain focused on the overarching goal and mission of providing, not only technical care, but also expert interpretation of information and guidance.

STEP 4. K—GIVING KNOWLEDGE AND INFORMATION TO THE PATIENT

When delivering bad news about therapeutic failure, it is important to remember that patients might accept the information more easily if given a signal or warning that bad news is coming. For each encounter, the physician should consider whether the patient expects to hear some news or might be completely unsuspecting of a disruption of the status quo. Advance notice with a warning can enable the patient to process the news more completely, ask questions of the physician, and reduce the shock that commonly follows these discussions [34]. In the setting of therapeutic failure, it can be especially useful to describe the news in the context of the ups and downs of the entire disease process and transition smoothly to talk of the “big picture.” Conveying medical facts can be improved by using nontechnical words, avoiding bluntness, giving the information in small chunks, and making explicit statements of nonabandonment [14].

A useful clinical strategy is to review the joint narrative that the patient, family, and clinical team have constructed together (i.e., the history of the illness with its successes and failures) and to emphasize the partnership and alignment. From this platform, the oncologist can impart, not only the medical facts, but also his or her expert interpretation and advice. It is absolutely crucial for the oncologist to state clearly that anticancer therapy has no additional role in the patient’s plan of care. The “knowledge” that is transmitted in this

conversation refers not only to the medical details of disease progression or drug toxicity, but also to the signal from the oncologist that consideration of further anticancer treatment will not restore the patient's good health and might even hasten his or her death. With knowledge that further chemotherapy (or any other form of anticancer therapy) is not helpful, the patient and family caregivers will need to reorganize their priorities, making life, and not treatment, the top item on their "to do" list. Together with the oncologist and other members of the professional team, patients and family caregivers can then craft a plan of care that focuses on optimizing function and preserving control over the remaining time. At this juncture, we have noted that patients will often ask the oncologist if he or she has dealt with similar situations in the past, wanting to hear stories of unexpected reprieves or "miracles." This calls for a compassionate response, one that acknowledges the patient's hope for a better future while, at the same time, reaffirms the need to switch gears and focus on palliation.

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STEP 5. E—ADDRESSING THE PATIENT'S EMOTIONS WITH EMPATHIC RESPONSES

One of the most challenging aspects of talking about the end of anticancer therapeutic options is adequately preparing for the emotions of the patient. These typically include sadness, fear, disgust, anger, and surprise and are expressed with facial expressions that do not differ very much across genders or cultural upbringing [37]. Observing and identifying emotions takes training and practice and is unfortunately not sufficiently addressed in most oncology training programs. Yet, the oncologist needs to be a keen observer to identify and connect to the emotions expressed by the patient, to recognize when to ask for clarification and when to remain silent, and to allow the patient to work through his or her grief.

The authors of the original SPIKES protocol advocated using three techniques to address the patient's emotions and reaffirm the therapeutic connection: (a) making empathic statements, (b) using exploratory questions, and (c) validating the patient's emotions. After identifying the emotion, empathic statements convey two important messages. The first is that the oncologist understands the emotion (and might even be experiencing it) and the second is to emphasize that the connection between them can withstand the impact of such emotions. The oncologist can say, "this is also very difficult for me" or "I was also hoping for a better result." Asking for clarification is a very useful communication technique in every setting and situation. In this setting, it can allow the oncologist time if he or she feels overwhelmed and can also help the patient to share his or her thoughts and feelings. Saying "tell me more" or asking "what worries you the most?" are sincere

and simple questions that cannot be misunderstood and gently nudge the patient to express concerns. Finally, the use of validating statements, such as "many other patients have had a similar experience" helps to normalize the patient's feelings and make him or her feel accompanied and understood [14].

Smith, an early proponent of patient-centered communication introduced the NURS mnemonic, consisting of four steps to address the patient's emotions and feelings [16]. In brief, the first step is naming or labeling the emotion. Clinicians simply repeat the feeling expressed by the patient, "it made you sad," or "you look teary eyed." This signals to the patient that the clinician heard the feeling and observed the emotion and that it is safe to express such sentiments. The next step is understanding, also called legitimating, a step that conveys to the patient that the clinician thinks the emotional reaction is reasonable. An example is to say "given what happened, it makes sense to me that . . ." The next is respecting or praising and appreciating another's plight. Verbal respect can be expressed by a simple phrase such as "thank you for being so open." The final step is supporting, also called partnership, a key step for oncologists who have invested in crafting important trustworthy relationships with patients and family caregivers. This simply conveys the fundamental message that "I am here to help any way I can."

STEP 6. S—STRATEGY AND SUMMARY

The final step in the algorithm is working with the patient to create an acceptable action plan. Patients who have such an action plan inevitably feel less anxious. When disease-modifying treatment options have been exhausted, crafting a plan of care involves exploring and reframing the patient's and family caregivers' hopes, wishes, and expectations [36]. At this crucial juncture in the course of illness, the oncologist's interest and level of engagement in creating the plan is probably as important as the plan itself. As we noted previously, the oncologist needs to address the fears of separation and abandonment that accompany decisions to stop anticancer therapy. Some oncologists offer to continue to monitor the patient in the outpatient clinic or office and remain engaged in the care of patients until death. Others refer patients to palliative and hospice clinicians and leave the management in the hands of their colleagues. Regardless of the plan for longitudinal and follow-up care, oncologists can maintain the connection with patients with a follow-up telephone call scheduled within 1–2 days. Even brief, weekly telephone calls can maintain the doctor-patient relationship and convey immense support to patients and their family caregivers.

DISCUSSION

Giving bad news is always difficult and perhaps more so if the oncologist has formed an attachment to the patient and family caregivers. Even senior physicians with decades of experience, report feelings of helplessness or sorrow that often lead to emotional exhaustion, a cardinal symptom of burnout [37–39]. In order to help patients, oncologists need to cultivate self-awareness, so as to recognize and identify their own emotions and take a proactive approach toward maintaining their clinical

effectiveness and humanism. Communication skills training can help by allowing clinicians to learn new techniques and receive constructive feedback or coaching from trained facilitators. Mindfulness training has been shown to alleviate stress and reduce burnout [40]. Group discussions that focus on the psychosocial aspects of care, either as part of clinical conferences or team debriefings, also provide safe mechanisms for obtaining support and insight through conversation with peers. Finally, teamwork with scheduled debriefings can provide insight and support and play a vital role in maintain morale and in creating a culture of compassionate collaboration.

The dreaded “there are no more options left for treatment” conversation can be made slightly easier by recognizing the components and tasks involved, by using a step-wise approach, and by involving other members of the clinical team. The messages we aim to convey to patients throughout the disease trajectory are that they need not worry alone and that the oncologist and other key members of the team will accompany them and provide expert guidance. Thus, oncologists must recognize that this, the most difficult of all conversations, is the one they cannot afford to delegate or miss. Some oncologists take pride in their ability to influence patients and families as they accept and cope with the dying process, and others maintain a more detached role [41]. Regardless of the orientation of the individual oncologist, the gravity of this clinical scenario demands a strategic and planned intervention that is patient and family centered, allows for emotional expression, and leads to a clear transition in the goals of care and treatment plan. When these conversations go well, patients and families report more satisfaction with medical care and

caregivers report less suffering during the bereavement period [12].

CONCLUSION

Even in this era of ever-expanding anticancer treatment options, the reality is that most patients with advanced cancer die of their disease. There are exceptional survivors who have been fortunate to live a decade with metastatic lung cancer or brain metastases from breast cancer and whose futures are still hard for us to predict. We welcome these challenges and hope to confront more of these dilemmas in the years to come. However, for now, it is readily apparent that we should continue to prepare ourselves and our junior colleagues to face the inevitable moment when we confront the failure of anticancer treatment and prepare ourselves to convey this information as sensitively and humanely as possible. The issue of addressing therapeutic failure with patients, specifically in the context of previous therapeutic success, haunts all members of the oncology team. The SPIKES algorithm can steady the clinician divulging such sad news, and colleagues with expertise in bereavement and supportive care can comfort both the patient and the physician. Rob Buckman, one of the creators of SPIKES said it best: “there is no doubt that we can be successful as physicians even when—and particularly when—the treatment fails” [1].

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EDITOR'S NOTE: See the related commentaries on pages 852 and 854.

For Further Reading:

Timo A. Pfeil, Katsiaryna Laryionava, Stella Reiter-Theil et al. What Keeps Oncologists From Addressing Palliative Care Early on With Incurable Cancer Patients? An Active Stance Seems Key. *The Oncologist* 2015;20:56–61.

Implications for Practice:

The findings of this study suggest that oncologists recognized that they run the risk of nourishing patients' overly optimistic views in not talking openly with them. It would be better to prepare the patient proactively for decisions toward the end of their disease trajectory and to accept one's own emotional response not as a detractor from objective clinical reasoning but rather as source of true empathy and an important nonmedical factor in the decision-making process. The findings of this study call for better educational activity regarding communication skills and ethical concerns near the end of life and for dealing with oncologists' emotional involvement.