4 skills from psychiatry that can improve end-of-life care

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Palliative care inherently involves difficult topics and, therefore, requires an unusual communication skill set. Fortunately, these skills are not unique to palliative care, and elements of psychiatry, in particular, relate. Two physician specialists in end-of-life care provide insights into this commonality, focusing on ways to remain patient-centered and build and convey empathy.

The AMA Code of Medical Ethics provides additional guidance on end-of-life care, such as opinion 5.1, “Advance Care Planning,” to help physicians aid patients in planning for decisions about care in the event of a life-threatening illness or injury, and opinion 5.2, “Advance Directives,” to help implement a patient’s goals and preferences when the patient lacks capacity.

Following are highlights from an article in AMA Journal of Ethics® (@JournalofEthics) by Indrany Datta-Barua, MD, an associate psychiatrist at Chicago Psychiatry Associates, and Joshua Hauser, MD, associate professor of medicine and director of the palliative medicine fellowship at Northwestern University Feinberg School of Medicine. They outlined elements of psychiatric training that can be applied to palliative care.

“We propose that these similarities exist due to the intimacy of the clinical relationship in palliative care and psychiatry, the affectively charged clinical situation in which care occurs, and the primary role of patient-clinician relationships in decision-making and treatment,” the authors wrote.

They focused on four key skills.

Recognizing countertransference. Transference involves feelings the patient has about the physician that have been “transferred” from other significant relationships. Likewise, countertransference refers to emotions the physician experiences evoked by the patient.

The physician “might have feelings that could be expressed as, ‘I am afraid,’ and maybe, ‘I will lose hope,’” the authors wrote. “She fantasizes that the patient will feel the same, possibly due to her identification with the patient and perhaps to avoid the discomfort of her own fear and hopelessness.

The goal is to draw out the patient's underlying concerns and preferences—without the clinician imposing his or her own."

Practicing active reflection and active listening. Active reflection calls for developing awareness of feelings of countertransference alongside one's clinical decisions and behaviors so the physician can separate her needs from those of the patient. Active listening involves verbally reflecting statements back to the patient and giving the patient the opportunity to correct or add to the physician's analysis to clarify the patient's preferences and goals.

Remaining silent and neutral. Silence—such as pausing instead of immediately responding to a patient's statement—provides time and mental space to reflect while also producing clinically useful information.

"Deliberate silence can often allow the patient (or family) to reveal herself in ways that more immediate verbal reactions might impede," the authors wrote. "These uninterrupted glimpses into our patients' inner lives that silence can afford are vital in conversations about dying and end-of-life care, because, as in psychoanalysis, it is our intention to remain neutral and facilitative."

Naming the emotion. Before a physician can translate values into a recommendation, she must first demonstrate an understanding of the emotions in play. Naming the emotion—for example, acknowledging a family member's frustration from having a long wait time in the exam room—can assure patients and their relatives that they are being heard and enable them to be more receptive to the physician's recommendations.

Ways to teach and learn

"As with many skills in palliative care, these communication skills are learned formally in the classroom and at the bedside. In the classroom, role play and simulation are approaches to teaching these skills," the authors wrote. "At the bedside, role modeling … parallels the clinical skill of naming the emotion; as we name the emotion with patients, so we can also name the emotion (and name the skill) with each other as clinicians."

More help here

The cited AMA Journal of Ethics article is part of a themed issue on the physician's role in healthy dying. The AMA provides additional resources for end-of-life care, including an AMA STEPS Forward™ CME module that includes a template for talking with patients about advance directives.