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Helping Patients to Understand Terrifying News: Addressing the Inner Lives of Physicians and Extending Beyond What We Know

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We read with interest the articles by Al-Samkari¹ and Abernethy et al² published in *Cancer*. Both articles emphasize that prognostic awareness is poor among patients with cancer, and we would add that the same applies to caregivers of these patients.³ Studies on prognostic awareness have consistently shown that this has been a problem over the last 2 decades—as Abernethy et al suggest, misunderstanding is the rule and not the exception—and that interventions promoting prognosis discussions have had little effect on patient understanding.⁴

We humbly provide several thoughts. Studies on oncologists' survival predictions are mixed.^{5–8} In a prior analysis of a cluster-randomized controlled trial evaluating a communication intervention in advanced cancer,⁴ oncologists were relatively accurate in predicting patient survival (C-statistic, 0.81).⁸ Other studies suggest that oncologists are relatively poor in predicting survival.^{5–7} Although information and prediction tools may be helpful, they do not directly address the inner lives of physicians or unexamined attitudes, emotions, values, or local norms that affect communication about prognosis and patient care.⁹ Physicians acknowledge psychological discomfort associated with disclosing a prognosis,¹⁰ yet the nature of this discomfort remains unclear. Addressing this discomfort is rare even in oncology training programs that employ communication skills programs. Physician attitudes, such as comfort with medical paternalism, are associated with higher use of

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chemotherapy and higher numbers of emergency department visits and inpatient admissions, even when researchers control for patient preferences.¹¹ Physicians' death anxiety may also make end-of-life communication and decision making more challenging,¹² and terminal patients of physicians with high death anxiety have longer hospital lengths of stay.¹³

We, therefore, propose that interventions to improve prognostic understanding should also address these psychological factors, which may be outside everyday awareness but are accessible with guidance, self-awareness, and reflection as described by Meier et al,⁹ with steps including the following: 1) recognizing and naming the feeling, 2) accepting the normalcy of the feeling, 3) reflecting on the emotion and its possible consequences, and 4) consulting a trusted colleague. There have been several studies evaluating psychotherapeutic interventions for reducing death anxiety in patients,¹² and mindfulness-based approaches may mitigate human tendencies to avoid or become defensive when death is more proximal.^{14,15} Components of these approaches might be adapted for physicians.

To promote prognostic disclosure, we propose that 2 physician qualities should be cultivated. First, physicians can be self-aware, honest, and kind with themselves (*eg, I want to fix this, but I cannot. Yes, it hurts me, too. I can reframe failure as an opportunity to do good. I can tolerate the uncertainty of not knowing how long this person will live.*). Second, physicians can be honest and kind with patients (*eg, I can disclose the prognosis without falling apart and worrying that others may hate me. I must be honest because it will lead to better patient outcomes. I can provide information that patients want and need but just enough to make informed decisions and not bludgeon them with the inevitable.*). We believe that self-awareness can be better incorporated into clinical training and institutional cultures, just as it has been developed in the corporate world¹⁶ and in sports and the performing arts. Of course, no person is an island. Physicians who work in environments that genuinely support the cultivation of these qualities will provide better care (and be happier) than physicians who cultivate these qualities but work in less supportive environments.¹⁷

It is important to acknowledge that many factors are associated with prognostic understanding, including patients' underlying beliefs¹⁸ and their social networks. In particular, older adults, who represent the majority of patients with cancer, have unique aging-related conditions such as functional and cognitive impairments¹⁹ for which they rely on caregivers to provide input and help^{20,21} and which can influence understanding. What happens between the clinical encounter and a decision being made is often a black box. Some patients may consult their families and friends, whereas others may more heavily weight the information that they obtain from the internet, and still others make decisions without drawing on external input. We know that caregivers and social support systems affect prognostic awareness, but these are rarely addressed in research.^{3,22,23}

We would also like to raise one methodological challenge associated with assessments of prognostic awareness. These assessments presume reasonable levels of numeracy and health literacy and ignore the fact that most high-stakes treatment decisions are influenced by psychological processes outside of conscious awareness. The use of stimuli that tap into nonconscious processes has gained remarkable traction in health research over the last few

decades, and this could potentially be used in research on prognostic understanding in advanced cancer.^{24,25}

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