

Short Communication

Good or Great: Which One Are You?

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Abstract

Clinicians caring for patients, especially those with chronic diseases or older adults, need to recognize the value of being able to transition away from aggressive care when appropriate and focus on a more palliative approach. Research has shown that patients want to have goals of care discussions and maintain autonomy at the end of life. These goals of care discussions can be challenging, and clinicians must prioritize and develop this skill in order to provide their patients with what they may need most. Being able to treat patients aggressively and prolong life is undoubtedly vital; however, so is the ability to recognize suffering and provide a patient and their family with the opportunity to find peace at the end of life. This skill ensures a more whole person focus and sets the great clinician apart from the good.

Keywords

End of life; palliative; goals of care; whole person; older adults

1. Good or Great: Which One Are You?

One difference between a good clinician and a great clinician is the ability to save lives whenever possible but also be able to recognize when the end of life is approaching and help transition away



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from further aggressive care. Clinicians are trained to treat, and the desire to restore health for patients is a driving force within our training and careers. We want to be the hero for that person in their time of need. It is important to remember, however, that all people are mortal, and, therefore, all patients will one day die. There is a pivotal point during each patient's course when aggressive care becomes futile, and end-of-life care should be discussed. When that time comes, will the patient be fortunate enough to be under the care of someone who recognizes and acts on what they are witnessing, or someone who presses on, missing the opportunity to provide the care the patient and family need most?

2. Case

Mr. F. received a palliative care consultation after being transferred from the oncology unit to the intensive care unit (ICU) for septic shock. He, unfortunately, had been suffering from stage IV cancer and was actively undergoing chemotherapy. Mr. F was now in a critical situation and appeared near the end of his life. The palliative care nurse practitioner proceeded to gather the patient's perspective of his own situation, and he shared that he felt he was dying. As the conversation proceeded, Mr. F explained that his primary wish was to die at home, looking out at his bird feeders and seeing his daughter, who had been living out of state, one last time. The nurse asked Mr. F if he had shared his wishes with his oncologist, to which he replied, "Oh, I would never tell my oncologist. She has worked too hard to keep me alive. I would never disappoint her. She wants to give me more chemotherapy." After the nurse reassured him that she would discuss his wishes with the oncologist, he agreed for the team to attempt to get him home with hospice care before he died. Unfortunately, Mr. F died that night in the ICU. He never returned home, never was able to watch the birds, and never saw his daughter again.

3. Discussion

Conversations surrounding the end of life are certainly challenging. Clinicians may lack the training necessary to initiate these conversations and may have fears regarding stripping the patient of hope or managing the patient's emotional reaction [1, 2]. Additionally, clinicians may question themselves as to the best timing for these conversations and allow the potential unpredictability of a patient's course to sway them from proceeding with what needs to be said [2]. Any clinicians attempting to provide the best care possible would be cognizant of these concerns. However, the goal of upholding shared decision-making and patient autonomy should always override these apprehensions.

Research has shown that most patients do want to know the full truth regarding their illness and have the opportunity to state their own goals, maintaining as much control over their situation as possible [3]. Additionally, patients want to be allowed time to process more than the physical component of their situation and be managed from the viewpoint that physical symptoms may make up only a fraction of their distress. The dying patient wishes to focus on healing relationships, visiting loved ones, finding forgiveness, managing financial concerns, leaving instructions, and finding spiritual peace. If clinicians lack the ability to hold these conversations and transition the focus of care, then the time for these vital tasks slips away.

In today's healthcare culture, "whole person care" is to guide each patient interaction. However, the concept can be neglected as clinicians lack the time and training necessary to manage a patient

beyond their physical needs [4, 5]. Clinicians rightfully seek out opportunities to learn about the newest techniques, interventions, and medications to prolong life, but may not prioritize caring for the dying in the same way. Clinicians should realize that acknowledging personal success in caring for someone well at the end of life is just as important as all other medical accomplishments that have formed their practice.

4. Implication

An excellent place for clinicians to start when learning to hold end-of-life conversations is mastering the technique of “Ask-Tell-Ask.” This communication method can be used to guide virtually any difficult discussion [6]. The first phase of the method “asks” the patient to describe their own perception of their medical situation. This step is followed by the clinician “telling” the patient details regarding their illness and course and informing them of recommendations and care options. The final phase “asks” the patient to share their goals and wishes based on the conversation and information shared.

There are numerous educational programs available for clinicians seeking training. The End of Life Nursing Education Consortium (ELNEC) is a leading international training curriculum for nurses and nurse practitioners wanting to learn palliative and end-of-life care [7].

VitalTalk, Center to Advance Palliative Care (CAPC) CME modules, and the California State University Shiley Haynes Institute for Palliative Care are a few of the interdisciplinary educational programs available in the United States. Additionally, the Education on Palliative and End-of-Life Care (EPEC), Respecting Choices, the European Palliative Care Academy, and the European Certificate in Essential Palliative Care (ECEPC) are examples of international training opportunities.

Health systems should adjust their policy to require clinicians to expand their understanding and prioritize end-of-life care. When selecting a training program, choosing a program with a strong focus on evidence-based communication techniques is vital. Though it is important to know how to care well for the physical needs of the patient nearing the end of life, it is pivotal to be able to communicate prognosis, elicit values and priorities, and hold goals of care conversations with patients and families [8]. These communication skills are often not inherent but can be mastered with the proper training and invested interest.

5. Conclusion

It is a true privilege to serve as a good clinician; the critical thinking and actions taken on any given shift change and improve countless lives. Nevertheless, what separates the good from the great is the ability to recognize that the final phase of a patient’s life is just as important as the ones that came before. A great clinician can empathetically communicate to a patient their steadfast commitment toward working and hoping for the best, all while preparing for the worst. Choose greatness.

Author Contributions

The author did all the research work of this study.

Competing Interests

The author has declared that no competing interests exist.

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