Patient-Clinician Communication Is a Joint Creation: Working Together Toward Well-Being

Timothy Gilligan, MD, Liz Salmi, and Andrea Enzinger, MD

OVERVIEW

Oncology clinicians face a monumentally difficult task: to guide patients on what may be the scariest and most unpleasant journey of their lives. They must preserve their patients' hope while at the same time giving them accurate information. And patients with cancer face a monumentally difficult task: navigating a path while confronting an often-terrifying disease. Communication between patients with cancer, their loved ones, and the treating clinicians presents many challenges. We must become better at communicating with each other; patients need easier access to information about their medical condition and their health care; and we must establish relationships that are stronger and more respectful, trusting, and empathic. If we are to deliver patient-centered or whole-person care, we must know who our patients are, what is important to them, and how they derive meaning in their lives. In this review, we discuss ASCO's first Patient-Clinician Communication guideline, the importance and value of patients having direct access to their medical record, and how to address spirituality and/or religion with patients with cancer.

Oncology clinicians face a monumentally difficult task: to guide patients on what may be the scariest and most unpleasant journey of their lives. They must preserve their patients' hope while at the same time giving them accurate information. And patients with cancer face a monumentally difficult task: navigating a path while confronting an often-terrifying disease, and having to work with a health care system that often seems bureaucratic and uncaring.

Communication between patients with cancer, their loved ones, and the treating clinicians presents many challenges. The medical and emotional stakes are high, and there is generally a large disparity in expertise—the patients know more about themselves, their life, and their values, and the clinicians know more about medicine. In addition, most patients have not faced a cancer diagnosis before, and many clinicians have received little if any high-quality training in how to talk to patients and colleagues in a manner that fosters strong, trusting relationships.

A further challenge is the strong move away from a paternalistic model of medicine. Under this model, the physician was assumed to know best and patients were often assumed to be too fragile or too lacking in medical expertise to be able to handle hearing the truth about their condition. Fast forward to the present, and we find ourselves in a world where patients are increasingly recognized as members of the care team who have an essential role to play as experts in their own experience, history, and values.

To adapt to this new world, several things are needed. We must become better at communicating with each other; patients need easier access to information about their medical condition and their health care; and we must establish relationships that are stronger and more respectful, trusting and empathic. If we are to deliver patient-centered or whole-person care, we must know who our patients are, what is important to them, and how they derive meaning in their lives. With regard to the first challenge above, ASCO issued its first Patient-Clinician Communication guideline in 2017; it is discussed below. Second, Liz Salmi, a patient with cancer, writes about the importance and value to patients of having direct access to their medical record, including clinician notes. Finally, the article discusses how to address spirituality and/or religion with patients with cancer.

ASCO PATIENT-CLINICIAN COMMUNICATION GUIDELINE

The ASCO patient-clinician communication guideline was developed by a multidisciplinary, multiprofessional panel that included representation from medical oncology, psychiatry, nursing, hospice, and palliative medicine, as well as a patient representative and experts in health care communication and health disparities. The guideline was based on a systematic review of the literature and was developed using a formal consensus process. It is structured around nine key areas and makes specific recommendations within each of

From the Taussig Cancer Institute and the Center for Excellence in Healthcare Communication, Cleveland Clinic, Cleveland, OH; OpenNotes, Boston, MA; Dept of Medical Oncology, Dana-Farber Cancer Institute, Boston, MA.

Disclosures of potential conflicts of interest provided by the authors are available with the online article at asco.org/edbook.

Corresponding author: Timothy Gilligan, MD, Taussig Cancer Institute and the Center for Excellence in Healthcare Communication, Cleveland Clinic, 9500 Euclid Ave., CA-60, Cleveland, OH 44195; email: gilligt@ccf.org.

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these categories. The nine key areas are core communication skills, discussing goals of care and prognosis, discussing treatment options and clinical trials, discussing end-of-life care, using communication to facilitate family involvement in care, meeting the needs of underserved populations, communicating effectively when there are barriers to communication, discussing cost of care, and clinician training in communication skills.

A common theme linking most of these topics is relationship-centered communication (RCC) skills.[1,2] RCC aims to facilitate patient-clinician interactions by developing a strong therapeutic relationship based on trust, caring, and mutual respect. Key RCC skills include rapport-building, listening, conveying empathy, and partnering with the patient with regard to setting the agenda for the visit and developing the treatment or management plan. The specific recommendations for each of the key areas are described below.

Core Communication Skills

These skills apply to almost every conversation. They include prework: reviewing the patient's medical information, clarifying one's own goals for the conversation, and anticipating the needs and responses of the patient and family. Core skills also include behaviors that actively foster trust and collaboration, such as sitting down, listening, and getting to know the patient as a person beyond their illness. The guideline recommends taking time at the beginning of encounters to inquire what the patient wants to address during the visit so that an agenda can be set collaboratively. Exploring patients' understanding of their condition is also recommended so that the discussion can start from a place of shared understanding and misunderstandings can be addressed. When providing information, it should be timely and oriented to the patient's concerns and preferences for information. Patients often complain that they have difficulty obtaining clinical information when they want it and are sometimes subjected to data-dumps whereby they receive more information than they can understand and retain. Retention can be improved by using "teach-back," which is the practice of asking patients to tell the clinician how they would explain their condition and/or treatment plan to someone else. The final core skill is to respond empathically when patients display emotion.

PRACTICAL APPLICATIONS

- **Expectations regarding patient-clinician communication are changing: patients and our health care system are paying more attention to the quality of communication between patients and clinicians, and ASCO recently published a consensus guideline on the subject to help health care professionals caring for patients with cancer and their loved ones.**
- **Communicating is a skill that can be improved with practice and high-quality feedback. When we communicate better, we build stronger and more trusting relationships with others.**
- **Patients can become more actively involved in their care and in partnering with the clinicians caring for them if they have direct access to their medical records, including progress notes. Institutions giving patients direct access to progress notes have reported positive experiences.**
- **Cancer can be a threat to a person's identity and raise profound questions about mortality and the meaning of life. For many patients, spirituality and religion are important and help them cope with the trauma of cancer; this article provides tools for taking a spiritual history.**

Discussing Goals of Care and Prognosis

Oncology clinicians have a responsibility to develop treatment plans that align with the patient's values and priorities. Patients cannot participate meaningfully in clinical decision making unless their goals are clearly defined and they understand the likely outcome of each of the options available to them. We must find out who our patients are as individuals, what is most important to them, and what they want from their health care team. Complicating matters, surveys of patients have made it clear that patients generally want accurate and candid information about their prognosis and also want information communicated in a way that sustains hope. Sustaining hope while providing candid information about a cancer's prognosis can be challenging.[3-5]

It is appropriate to have a goals-of-care conversation whenever there is a substantial change in the condition or when considering a substantial change in treatment. The guideline has several recommendations for these conversations:

1. The core skill of asking patients about their current understanding of their condition and their prognosis can help clinicians frame medical information in a way that is more individualized to the specific patient. When the news is bad, this skill can alert the clinician as to how much of a surprise the news will be.
2. Asking what patients want to know and how much information they desire helps the clinician tailor the information delivered to fit the specific patient's needs.
3. Clinicians can support hope by articulating their commitment to help and care for the patient throughout the course of the illness and to strive to obtain as good an outcome as possible.
4. When discussing prognosis, mixed framing and providing the information in small, discrete doses can improve patient understanding and recall. One example of mixed framing is to tell the patient the best, worst, and most likely outcome.
5. Clinicians should be prepared to respond empathically to patients' emotional responses during or after these weighty conversations. When providing bad news, there are specific steps specified in the guideline that can improve the patient's understanding and experience.

Discussing Treatment Options and Clinical Trials

Understanding their treatment options can be challenging for patients and studies have reported that patients accurately

remember well under half of the information they are given at health care visits.[6] Several steps can help increase patient understanding and retention of information:

1. Clarifying the goal(s) of care and the expected outcome of each option (e.g., cure vs. prolongation of survival vs. improved quality of life).
2. Presenting benefits (e.g., longer life, delay of progression, symptom improvement) and burdens of treatment (e.g., side effects, cost, invasive procedures, time spent away from home in medical institutions and traveling to and from appointments) so that patients can balance them in light of their goals and priorities.
3. Delivering information about treatment options in small chunks and checking frequently for understanding.
4. Presenting standard treatment options, including palliative care, prior to investigational options so that patient understands what the clinical trial is an alternative to.

Discussing End-of-Life Care

Discussions of end-of-life care can be emotionally fraught for patients and loved ones and clinicians alike. The guideline makes several recommendations to facilitate these critical conversations. Using an organized framework can provide a structure that promotes higher-quality conversations and greater participation from patients and their loved ones. Just as when placing a central venous catheter or removing a gallbladder, clinicians will generally feel more confident if they have a clear understanding of what the key steps are and the order in which they should be undertaken. The guideline recommends initiating conversations about end-of-life preferences early in the course of a terminal disease and exploring how each patient's culture and religion or spirituality affect their preferences regarding care near the end of life. Anticipating grief and distress among patients and their loved ones is appropriate, and an empathic response is important. Clinicians can be more effective in helping terminally ill patients if they are familiar with and inform patients about local resources available to provide support for terminally ill patients and their loved ones.

Using Communication to Facilitate Family Involvement in Care

Cancer affects not only the patient but the patient's families and loved ones. Key decisions about treating and caring for the patient often have strong input from all of these parties. And families and loved ones often play a critical role in cancer care by providing care and support to the patient in many different ways. They also help by being another set of ears to hear medical information and thus help the patient remember and adhere to the treatment plan. And they are often a key source of important information about how the patient is doing at home. The guideline recommends encouraging involvement by family and loved one in discussions about goals of care and treatment early in the course of the disease if the patient consents. Formal family meetings are also recommended to help build a shared understanding of the patient's condition, prognosis and goals of care, and end-of-life care preferences.

Meeting the Needs of Underserved Populations

There is abundant documentation of substantial racial and socioeconomic disparities in cancer care and cancer outcomes. The guideline includes three recommendations to improve communication with underserved populations. First, clinicians should maintain awareness that patients may have beliefs, experiences, understandings, and expectations that are different from the clinicians'. Curiosity about the patient and a sincere desire to understand them help build trusting relationships. Second, avoiding assumptions about sexual orientation and gender identity can help make all patients feel welcome and cared for. Similarly, clinicians should use nonjudgmental language when discussing sexuality and sexual behavior. Third, clinicians can build a more empathic relationship with members of underserved or marginalized populations by remembering that such patients are more likely to have had negative experiences with health care in the past, including experiences of feeling disrespected or unsafe. When patients have had such experiences in the past, it can take longer to build a trusting relationship.

Communicating Effectively When There Are Barriers to Communication; Discussing Cost of Care

When patients don't share a common language with the clinician or have low health literacy or numeracy, communication about health care is more challenging. Attending to these issues by being rigorous in using trained medical interpreters, visual aids, and terminology the patient understands can all help. For a substantial proportion of patients, medical costs are a substantial burden. However, there are very limited data to guide best practices regarding talking to patients about cost of care, and some patients do not wish to discuss such matters with their oncologist.[7] The guideline recommends exploring with patients whether cost of care is a concern and whether they want help learning more about the costs of their treatment and exploring options for covering those costs.

Clinician Training in Communication Skills

Health care communication is highly complex, and high-quality training can help clinicians improve. Such training should be based on sound educational principles and should include abundant opportunities to practice skills in simulated-patient scenarios, observed patient encounters, and other experiential learning opportunities. In teaching communication skills, the goal is not so much for the clinician to understand key principles of communication but rather to be able to use effective communication skills in practice. Learning to communicate is thus similar to learning to play a musical instrument or a sport. Lectures have not been demonstrated to be of any benefit; skills practice enables clinicians to improve.[8,9]

When communicating with patients, clinicians bring their own history of experiences and their own biases and

sensitivities. Communication skills training is most effective if it fosters self-awareness and situational awareness related to emotions, attitudes, and underlying beliefs that may affect communication and decision-making. Teaching communication skills is complex and demanding work, and faculty of such educational sessions should be appropriately trained and experienced to be able to model and teach the desired skills and facilitate experiential learning.

ANCHORING PATIENT CONVERSATIONS THROUGH TRANSPARENCY

There's no such thing as a "good time" to get sick or have a health emergency.

One week after my 29th birthday, I suffered a massive seizure and was rushed to the emergency department. Scans showed I had a mass in my brain. After a 9-hour brain surgery, it was discovered I had a grade II astrocytoma, a slow-growing but malignant brain tumor. A few months after the first surgery my tumor grew back, sending me into a whirlwind of treatments over the following years, including a second brain surgery and 24 months of chemotherapy. To say I "had a few questions" about my new health status is an understatement.

Having been born on the cusp between Generation X and the Millennials, my instinctual response as a patient is to Google every new medical term I encounter. For the most part I find what I am looking for, and if I get confused I email my doctor to ask questions. But this makes me wonder, how do people with no formal training in medicine seek answers when we aren't with our doctors 24/7? Are we all relying on Dr. Google? Are we finding the right answers in our internet search? Or perhaps, more importantly, are we even asking the right questions?

I have friends dealing with sick kids, caring for aging parents, or wondering if and when their family history of breast cancer is going to catch up with them. The modern patient living with chronic illness spends only a few hours each year in health care but over 5,000 waking hours in self-care.[10] It's no wonder that of the 40,000 Google searches happening every second, 2,000 are health-related.[11]

In early 2017, a change in my health insurance plan forced me to obtain my medical record and transfer it to new doctors. I was given a DVD with my record on it. When I popped the disc into my computer I had no idea this simple action would forever change the way I view access to my health information. There I found a 4,836-page file detailing my previous 8 years of living with brain cancer, including my doctors' notes.

Like most people, I didn't know clinical notes were *a thing*, let alone imagine I could have access to this information. For the previous 8 years, I could Google my condition, but I was never able to read what my own doctors wrote about me. Seeing my doctors' notes was eye opening and helped fill in details I missed when I was unconscious from seizures and surgeries—moments I thought would forever remain a mystery to me.

Yes, my notes contained a few typos and a lot of medical jargon. Yes, I could tell physicians had copied and pasted from note to note. But I didn't care about all that because what I also saw was detailed information about my diagnosis and *me*, and I saw that my doctors cared. To a patient, notes are a behind-the-scenes look at our health. Beyond gaining a greater understanding of my care and my condition, I could tell my doctors and nurses were paying attention and noticing the smallest details about me. This is not something I could ever learn from a Google search.

I got great care from my previous health system—the fact I am here proves that. But it makes me wonder even more: Why hide my notes?

Be There for When Your Patients Are Ready to Engage

Most discussions about health care transformation include strategies to improve patient engagement. I believe two things are fundamental to achieving successful engagement: (1) truly inviting patients to the table and (2) giving us access to information.

I don't need to tell you that a cancer diagnosis is scary. Access to the medical record isn't going to change that, but it can help us gain a solid understanding of our condition, a better understanding of our treatment plans, and greater trust in our care teams.[12] Research shows that patients forget much of what doctors tell them, up to 80% when the news is bad. Why keep notes from any patient?

Today there is a growing movement toward transparency in health care, a movement in which clinicians and patients are working together to make it easier for regular people like me to have complete access to our full medical records, including our notes. Researchers at OpenNotes and other institutions are studying the effects of sharing clinical notes with patients. The findings are positive and consistent.

When patients read notes, they become more actively involved with their health, ask better questions, and are able to make more informed decisions. And when patients have an opportunity to review their medical information they're more likely to confirm and remember next steps (e.g., booking necessary follow-up appointments and tests), and can partner in the safety of their own care by identifying errors and inaccuracies in the record.[13]

Patients care about their own notes more than anyone else, or, as Podge Reed, a double-lung recipient at Johns Hopkins, said, "OpenNotes is a very critical part of my care so that I can ensure that I'm staying on line with my treatment plan and can continue to live a productive life."

Today, more than 100 health systems across the country are sharing notes through online patient portals. That means over 20 million people can review their notes, online, whenever they choose … except for me and about 94% of the rest of America. We're moving in the right direction, but there's still a long way to go.

Open Notes in Cancer Care

MD Anderson was one of the first health systems to start sharing notes with patients, in 2009, and they have the most experience sharing oncology notes. Not only does MD

Anderson report nothing bad ever happening as a result, the feedback from patients and clinicians about sharing notes has been good.[14] As a result, patients who read oncology notes report benefits similar to those of primary care.[15]

Continued observation of open notes at cancer centers shows that patients who access their electronic records are more informed about their care plan and ask more focused questions. Other cancer centers noted for their implementation of open notes include Cleveland Clinic, Mayo Clinic, Stanford Health Care, and UW Medicine.

But What About Imaging?

The most consistent concern I've heard from oncologists about open notes is related to imaging.[16] Some oncologists have had the unfortunate experience of hearing from patients who have seen the results of an unfavorable report before the oncologist was able to talk with the patient. Understandably, a report identifying every possible diagnosis, or a scan showing a growth or return of cancer, can induce anxiety, but it is even worse when presented without the context and empathy a good cancer doctor and good notes can provide.

As a patient and proponent for open notes, I share the same concerns. But open notes, laboratory reports, and/or imaging findings are not an "all or nothing" concept. I have had the opportunity to talk with some of the nation's top health information technology specialists about open notes, and nearly every feature that makes notes-sharing a possibility can be tweaked on the backend of the electronic health record. It is possible to customize the timing of how and when laboratory and imaging reports are delivered to patients. Some health systems choose to delay the delivery of imaging reports by 3 to 7 days after the report is signed by a radiologist.

Everything can be customized—so don't let technology be the barrier.

Notes Are Forever

A visit with my oncologist might last 45 minutes, but my note lasts forever. If I had had access to my notes during active treatment, I know I would have read each one with care. A cancer diagnosis fills our lives with uncertainty, but a physician's assessment and plan provides a roadmap to what's next. Remove the barriers. Let patients know the notes exist, and invite us in. Make it easy to find the notes and easier for us to be engaged.

I can't believe it took a massive medical records request for me to have stumbled across my notes, and there isn't a single thing in my notes I don't understand. I wish I could have seen them sooner. Your patients are hungry for information, and we can handle it. Although you cannot make patients engage, you can be there when we are ready.

SPIRITUALITY IN ONCOLOGY

Spirituality and religion are important to patients facing cancer, particularly those with advanced disease.[17-19] Spirituality and religion can be a tremendous source of comfort, strength, and support; however, cancer can also raise or magnify spiritual concerns related to mortality, suffering, meaning, and purpose in life. Although oncologists are seldom trained in spiritual matters, few professionals interact more frequently or intimately with patients as they grapple with these issues. Many clinicians feel uncomfortable when spiritual concerns arise; however, appreciating the deeper dimensions of our patients' cancer experience, and addressing these issues on a basic level, can benefit both patients and our relationships.[20]

Spirituality and the Religious Landscape of the United States

Spirituality is often thought of as a religious process concerned with promoting connection to God or the sacred; however, it is increasingly recognized that the construct of spirituality is not necessarily rooted in religious faith. The European Association for Palliative Care defines spirituality as "the dynamic aspect of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose, transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred. Spirituality is expressed through beliefs, values, traditions and practices." Through this lens, it becomes clear that many familiar patient concerns are by nature spiritual, including questions of meaning ("Why is this happening to me?"), value ("I don't want to become a burden"), and relationship ("I regret things I've said and done").[21]

This broad understanding of spirituality is particularly important as U.S. religious landscapes shift. According to a 2013 Pew Center survey, more than 20% of the US population identifies with no specific religious tradition, with rates approaching 40% among younger adults. Most patients, even those who are not religious, have systems of belief that bring meaning and purpose to their lives. These formal or informal belief systems can be an important source of support or can be substantively shaken by a cancer diagnosis.

Relevance of Religion and Spirituality to Cancer Care

Cancer is a major threat to people's sense of identity. Cancer interrupts the trajectory of patients' lives; it upends a sense of security, raises questions about meaning and purpose, and challenges relationships. For many, religion and/or spirituality can help confront and make sense of this upheaval. Indeed, faith is one of the most important and frequent coping strategies cited by patients. But just as often, the upheavals caused by cancer can challenge the core of patients' spiritual and religious beliefs. Most patients with cancer experience spiritual needs or struggles, ranging from existential to highly religious in nature.[17,22] Upward of 75% of patients with cancer, whether religious or not, endorse spiritual struggles, including loss of hope or meaning, the need for forgiveness, and even feeling abandoned, punished, or unloved by God.[17,22-24]

Although these struggles do not always present themselves on the surface of clinical encounters, they can be a

powerful undercurrent eroding patients' well-being and quality of life. Spiritual/existential well-being has been shown to be a powerful predictor of quality of life, over and above physical, emotional, functional, and social well-being.[25,26] Given the incontrovertible importance of quality of life, it could be argued that care teams should pay much more attention to spiritual well-being.

Religious and spiritual factors can also affect highly personal care decisions,[27] such as the decision to pursue experimental treatment[28] or to choose comfort-oriented or intensive care at the end of life. One study found that patients with cancer who relied highly on religion to cope were more likely to receive intensive medical care at the end of life,[29] potentially reflecting hope for miraculous healing or beliefs about the sanctity of life. It should be emphasized, however, that religion and spirituality operate in highly individualized ways in patients' medical decisions. In a secular medical environment, patients are often ill equipped to bring deeply held religious convictions to medical decision-making. In these cases, board-certified chaplains or patients' own clergy can be useful partners in challenging treatment discussions.[30]

One could argue that religion and spirituality are relevant to cancer care simply because of their importance to patients. Particularly near the end of life, spiritual issues are at the forefront of patients' and families' priorities. In one survey of nearly 2,000 terminally ill patients and family members, freedom from pain and peace with God were equally ranked as the most important factors in determining a "good death."[31] In fact, spiritual care has long been considered a core domain of quality palliative care and was engrained within the ethos of the modern hospice movement.[21]

Patient Perspectives on Addressing Religious/Spiritual Issues Within Cancer Care

Patients' attitudes toward addressing spiritual issues within clinical care vary according to the patient, the situation, and

TABLE 1. Spiritual Screening Tools

Tool	Domain	Sample Questions
Spiritual History Tools		
FICA		
F	**F**aith	Do you consider yourself spiritual or religious? Do you have spiritual beliefs that help you cope with [contextualize to situation]?
I	**I**mportance	What importance does spirituality have in your life? Does it influence your medical decisions?
C	**C**ommunity	Are you part of a spiritual community? Is this a support to you?
A	**A**ddress within care	How would you like me to address these issue in your care?
HOPE		
H	Source of **h**ope, meaning, comfort, strength, peace	What are our sources of hope, strength, comfort and peace? What do you hold onto during difficult times? For some, spiritual beliefs are a source of comfort. Is this true for you?
O	**O**rganized religion	Are you part of an organized religious or spiritual community? What aspects of your religion are helpful or not-so helpful to you?
P	**P**ersonal spirituality and **P**ractices	Do you have personal spiritual beliefs? What aspects of spirituality or spiritual practices do you find most helpful?
E	**E**ffects on care	Has being sick affected your ability to do things that usually help you spiritually? How do your beliefs affect the kind of care you would like me to provide?
FACT		
F	**F**aith and/or beliefs	Do you consider yourself spiritual or religious? What things do you believe that give your life meaning and purpose?
A	**A**ctive	Are you active in your faith community?
C	**C**oping, **C**omfort, **C**onflict, **C**oncern	Do your beliefs (faith) help you cope? How has your faith provided comfort in light of your cancer?
T	**T**reatment Plan	Based on responses, make a plan to support/encourage, reassess, or refer to a spiritual care provider such as a chaplain or clergy.
Sample One- or Two-Item Spiritual Screening Questions		You're dealing with a lot. What helps you cope in difficult times? Is spirituality or religion a part of that?
		Where do you find strength during difficult times? Do your personal beliefs help you make sense of your illness
		How often are you at peace at the end of the day?

the type of spiritual interaction.[32,33] Given the life-threatening nature of cancer and the close relationships between patients and providers, it is not surprising that patients with cancer are particularly welcoming of spiritual conversations with their doctors and nurses.[26,34,35] Even among secular urban populations, most patients with cancer believe it is appropriate for oncologists to inquire about their spiritual needs.[23,34] Another study found that large majorities of patients with cancer approved of oncology doctors and nurses routinely addressing spiritual issues, including asking about spiritual/religious background, referring to chaplaincy, and even offering prayer in appropriate circumstances.[34] Nearly 80% of patients thought that routine spiritual care would have a positive impact on patients. In open-ended responses, patients noted that they thought spiritual care would provide emotional support, help providers see them as "whole persons," and deepen relationships.[35] Unfortunately, patients seldom experience spiritual care from their cancer care team.[23,34,35]

Practical Suggestions

Addressing spiritual or religious issues within clinical care must begin with humility and self-awareness. Clinicians must be conscious of their own belief systems, biases, competence, and boundaries. Discussions must be predicated on respect for patient autonomy, recognizing that our role as clinicians is to listen and support patients within their own belief system, not persuade them toward our own. This aligns with qualitative data showing that patients' interest in spiritual care arises mainly from a desire to be more deeply heard, understood, and supported by their providers. In contrast, patients generally do not expect or want spiritual counsel from clinicians.[35]

Many patients do not spontaneously bring up spiritual issues with their care team, as culture or past experiences may suggest that doctors and nurses are not interested. To reset these expectations, it is important to create an environment in which patients feel comfortable bringing up spiritual issues, if and when they choose. An easy starting point is to pay attention and respond to patients' own cues, including statements like "So many people are praying for us," "We are trusting God for…," and the presence of scriptures or religious cards in a hospital room. Research shows that clinicians rarely acknowledge or respond to types of spiritual statements,[36] effectively telling patients we are uninterested. Although there are no simple formulas on how to respond to spiritual cues, it can be helpful to approach these observations with a respectful curiosity. We suggest using open-ended questions, such as "It sounds like your faith community is very important to you, tell me more about that" or "I'm really interested in what you mean by that. Would you mind sharing more?" These conversations can be very short, but they send a signal to patients and grant permission for future open conversations about the spiritual dimensions of their experience.

Another important practice is taking a "spiritual history," which refers to asking patients about their spiritual background, beliefs, and support system. This need not be at the first clinical encounter and is likely most appropriate after several visits when a relationship exists. A variety of spiritual history tools have been developed, including FICA,[37] HOPE[38] and FACT,[39] which are detailed in (Table 1). Rather than use a formal spiritual history tool, it may feel more natural to ask one or two open-ended questions. Examples include "You've been dealing with a lot lately. What helps you cope in difficult times? Is spirituality or religion a part of that?" or "Where do you find strength during difficult times?" or "How often are you at peace at the end of the day?"[40] Regardless of the tool, it is probably most important to try out different words and phrases and use what works for your own communication style.

If patients bring up specific spiritual struggles, be mindful that our job is not to "fix" the problem. Most important is to listen well, to empathize, and to offer a caring and nonjudgmental presence. Detailed discussion of responding to spiritual needs is beyond the scope of this review, but it can be helpful to follow communication principles, such as the NURSE framework for responding to emotion: Naming, Understanding, Respecting, Supporting, and Exploring. When patients get stuck in unanswerable questions (e.g., "Why is this happening to me?") or if they express spiritual pain ("God is punishing me"), acknowledge and listen to patients' concerns. Then, validate the importance of their struggle and ask permission to involve spiritual professionals, such as a board-certified chaplain or patients' own clergy. Debriefing with professional spiritual care providers can be an important way to build comfort and skills in integrating spiritual care within the clinical care of patients.

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