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Advanced communication: A critical component of high quality gynecologic cancer care: A Society of Gynecologic Oncology evidence based review and guide

Ramey D. Littell [a,1], Amanika Kumar [b,1], M. Heather Einstein [c], Amer Karam [d], Kerri Bevis [e,*]

[a] Kaiser Permanente Northern California Gynecologic Cancer Program, San Francisco, CA, United States of America
[b] Mayo Clinic, Rochester, MN, United States of America
[c] University of Connecticut Health Center School of Medicine, Hartford, CT, United States of America
[d] Stanford University, Palo Alto, CA, United States of America
[e] University of Alabama at Birmingham, Birmingham, AL, United States of America

HIGHLIGHTS

- Barriers to serious conversations can be overcome by using evidence-based skills and structured conversation maps.
- Skillfully addressing patient emotions improves knowledge retention, satisfaction, trust in providers, and reduces anxiety.
- Strategies and skills proven to improve provider/patient communication are demonstrated using vignettes.

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ABSTRACT

Effective communication between gynecologic oncology providers and patients is vital to patient-centered care. Skilled communication improves the patient's knowledge retention, builds trust in providers, enhances shared decision-making, and alleviates anxiety of both patients and caregivers. Effective communication is also associated with reduced provider burnout due to improved comfort from possessing the skills to handle emotionally charged situations. Therefore, training in serious illness communication skills is critically important to gynecologic oncology practice and benefits patients, providers, and the healthcare system.

Like surgical skills, communication skills can be learned and improved upon, particularly by making use of communication skills courses and other resources. While the purpose of each conversation will vary based on the medical setting, most communication roadmaps incorporate four basic components: 1) Assess patient knowledge and understanding, 2) inform patient in accordance with her communication preferences, 3) recognize and respond to emotion 4) elicit patient values, and create a plan that aligns with those values. Improved patient outcomes associated with addressing patient emotions underscore a critical need to recognize and address emotional cues during difficult conversations. We present strategies for delivering serious news, and for discussing prognosis and goals of care. In each strategy, we highlight skills for recognizing and responding to patient and family emotional cues.

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* Corresponding author.
E-mail address: ksbevis@uabmc.edu (K. Bevis).
[1] Authors contributed equally.

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1. Introduction

Gynecologic oncologists' daily practice involves situations that require complex communication skills, including disclosing serious news and discussion of prognosis, treatment decisions, and goals of care. Effective communication between health care professionals and patients is vital to patient-centered care: it improves the patient's knowledge of her illness, allows her and her family to actively participate in shared decision-making, and helps alleviate anxiety during the cancer journey [1,2].

A number of communication skills training (CST) programs have been developed to address the challenge of serious conversations in clinical practice. The goal of these programs is to provide a framework to guide tough conversations, develop specific skills to facilitate these dialogues, and ultimately provide clinicians with confidence and expertise to conduct conversations in health care settings. This document provides a practical overview of evidence-based advanced communication techniques, as well as how effective communication can enhance the daily practice of gynecologic oncology. We also provide patient vignettes common to gynecologic oncology practice to illustrate these tools and skills.

2. Why is communication important?

2.1. Advanced communication leads to care consistent with patient goals

Eliciting patient values and discussion of patient preferences in the face of serious illness increases the likelihood of receiving care that is consistent with the patient's documented goals and values, which translates into fewer aggressive interventions at the end of life, improved quality of life, and less caregiver distress [1–6]. Patients whose providers effectively communicated with them regarding end of life issues were less likely to be admitted to the hospital, be transferred to the ICU or to receive chemotherapy within the last 30 days of life [7–9]. This translates into higher patient satisfaction and decreased health related spending, especially as patients approach the end of life.

2.2. Good communication improves patient satisfaction

Large prospective studies have demonstrated significant improvement in patient satisfaction scores when providers have participated in formal CST. Patient experience scores assessed by the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) improved among providers chose to participate in CST relative to physicians who declined participation [10]. Evidence suggests that basic communication strategies reduced the length of the patient encounter by an average of 4 min, increased patient recall of information discussed, and reduced patient anxiety when compared to controls [11]. The simple act of sitting rather than standing during patient encounters has been shown to increase patients' perception of the physician's communication skills, perceived length of time spent, and overall satisfaction [12,13].

2.3. Effective communication reduces provider burnout

With increasing awareness of the detrimental impact and high prevalence of burnout among gynecologic oncologists, all opportunities to improve physician wellbeing should be fully embraced [14,15]. Repeated witnessing of patient suffering is a significant source of physician stress, which can lead to the triad of emotional exhaustion, depersonalization and low sense of accomplishment that define physician burnout [16]. Studies have found that physicians who feel least skilled at communication also report higher levels of stress and decreased job-related satisfaction [17–19]. A survey of gynecologic oncologists found that physician difficulty in discussing death with patients was highly correlated with work-related stress [20]. Lack of effective communication also leads to patient dissatisfaction and increased malpractice claims, which further exacerbate physician stress and burnout [21].

Fortunately, there is evidence that communication skills training can decrease stress and improve wellbeing for both patient and physician [16]. In addition to improving patient experience scores, physician participation in communication skills training has been shown to improve physician burnout. Specifically, CST improved the Maslach Burnout Inventory subscales measuring emotional exhaustion, depersonalization, and personal achievement (i.e. feelings of competence and successful achievement) [9]. The improvement in the burnout inventory stemmed from increased provider self-efficacy and comfort in these emotionally charged encounters, as well as a heightened sense of satisfaction that the provider was able to help the patient, regardless of the outcome of the conversation. Longitudinal tracking of participating providers documented that the positive effect on burnout scores persisted for months following completion of the CST program.

The increasing recognition of the importance of clinician communication skills has led to recommendations that CST be a key component of institutional strategies to reduce physician stress and burnout [22]. Acknowledging the stressful impact of communicating bad news to patients, the Wellness Committee of the Society of Gynecologic Oncology has included a comprehensive training session on “breaking bad news” among its initial four fellowship wellness curriculum modules.

3. What are the barriers to effective communication?

With a significant volume of literature supporting the benefit of skillful communication and its inherent importance to cancer care, it may seem surprising that uptake is not more ubiquitous. In addition to the cultural, language, and family dynamics which heavily influence all aspects of medical care, studies of physicians indicate a number of barriers to consistent high-quality communication regarding serious

news, prognosis, and goals of care. Among the more commonly cited are inadequate preparation, inadequate time, fear of destroying patient's hope, the emotional discomfort of the provider, and the uncertainty inherent in prognostication [23–25].

3.1. Barrier #1: inadequate preparation

Despite the widely recognized importance of communication skills, one survey of practicing oncologists found that half of respondents reported they are ill-equipped to deliver serious news [26]. Contributing to this lack of competency is the paucity of communication skills training in oncology fellowships. Only 44% of gynecologic oncology fellows surveyed reported having ever received feedback about their ability to deliver serious news from attending staff [27,28]. On the other hand, a survey of gynecologic oncology fellowship directors identified advanced communication skills, including delivering serious news, among the most important aspects of palliative care training, rivaling surgical skills in terms of importance [29]. This finding, coupled with the variable quality of communication training reported by both practicing oncologists and fellows in training clearly highlights a gap in training [26–28]. Further, minimal attention is focused on this set of skills during continuing education and improvement activities offered to practicing providers once training is complete.

3.2. Barrier #2: inadequate time

Providers may equate enhanced communication and discussion with longer patient encounters. However, evidence suggests simple communication strategies reduce the length of the patient encounter, as well as increase patient recall and reduce patient anxiety [11]. One study of recorded doctor-patient encounters found that acknowledging emotional cues with empathic statements added on average only 21 seconds of additional discussion [30]. A randomized study of standardized video encounters demonstrated that adding just 40 seconds of empathic language to otherwise identical encounters led to improved rating of the provider on information delivery, even though the information delivered was identical [31]. The initial moments invested in assessing patients' understanding and eliciting their full agendas may actually save time by exposing misinformation early, avoiding last-minute questions, and avoiding subsequent calls due to poorly retained information [32].

3.3. Barrier #3: fear of destroying patient's hope

Physicians may be reluctant to discuss prognosis and discontinuation of chemotherapy due to fear of taking away hope, as evidenced by the fact that many oncology patients are not aware that their chemotherapy is palliative rather than curative [33]. Evidence suggests, however, that prognostic disclosure does not take away hope [2,34]. A study of terminally ill cancer patients and their caregivers demonstrated that having end of life discussions was neither associated with major depression nor increased feelings of worry [1]. Surprisingly, one study demonstrated that more discussion of adverse prognosis leads to increased feeling of hope, even when the chance of cure was low. One possible explanation is that clarity around prognosis may be less anxiety-provoking than uncertainty [35].

In the Gynecologic Cancer Intergroup Symptom Benefit Study, women with platinum resistant ovarian cancer underwent symptom assessment at baseline and at regular intervals. Women with the expectation of higher symptom control with palliative chemotherapy were more likely to experience depression when their expectations were not fulfilled. The authors suggested physicians should strive to offer "realistic hope" for achievable goals which may correlate with fewer depressive symptoms [36]. Patients and their families desire honest information about serious illness, and physician-initiated conversations about prognosis and goals of care are associated with maintenance of trust, without increase in adverse effects like depression and anxiety [37,38].

3.4. Barrier #4: emotional discomfort of the provider

Addressing patient suffering has been identified as being among the leading sources of physician stress [18]. Among the reasons for feeling discomfort, physicians have cited feeling responsible for the news, feelings of failure and powerlessness, and not wanting to take away patient hope. Additionally, clinicians report feeling ill-equipped to handle the emotional reactions inherent to the disclosure of serious news [39–42]. Avoidance of the discomfort associated with patients' expression of emotions can compromise patient care, most commonly leading to medical treatment that is not consistent with patients' goals [42]. The acquisition of communication skills has been shown to improve physician confidence and self-efficacy, which can lessen the discomfort associated with having difficult conversations and can increase the provider's willingness to engage in these vital discussions [23,40,43–46].

3.5. Barrier #5: uncertainty inherent in prognostication

In the face of uncertainty, physicians may choose to avoid discussion of prognosis. However, avoidance of discussion may result in a significant discrepancy between doctors' and patients' expectations of treatment [47]. In a prospective study of 27 patients with recurrent or refractory ovarian cancer, 65% of women receiving palliative chemotherapy expected it to extend their lives and 42% thought it would result in cure [48]. A small qualitative study of ovarian cancer patients reported that 100% of patients wanted detailed prognostic information from their physician and wanted goals of care addressed repeatedly as the goals change across the disease course [49]. When clinicians create opportunities to discuss prognosis, patients are more likely to understand key prognostic factors of their illness, such as potential for cure and expected outcome of each treatment option.

4. Learning advanced communication skills

Learning advanced communication skills bears many similarities to learning surgical procedures. Both involve complex cognitive skills such as recognizing situational cues, anticipating problems, decision-making, and adapting to case variability [50]. Traditionally, both communication and surgical procedures were learned through direct exposure and trial and error, with little training outside the clinical setting. Just as surgical procedure training is moving towards more formalized pre-procedure learning and structured steps to be followed, so can communication techniques be regarded as a structured skill set that can be effectively taught and learned [46,51–54]. For example, following a CST workshop for gynecologic oncologists, 100% of providers reported significant improvement in preparedness to address conflict in family meetings and to respond to patients who deny the seriousness of their illness or request unindicated treatments [55].

Researchers in communication science have published evidence-based, structured communication roadmaps that can be applied to a variety of situations to enhance provider-patient communication (Table 1). All of the communication guides emphasize the need to skillfully address emotion (Table 2). Table 3 outlines non-profit organizations and the educational resources they offer, including in-person CST workshops, online courses, video examples, downloadable resources, mobile device app, communication teacher training (faculty development), and institutional implementation. The techniques offered by these organizations are more notable for their similarities than their differences, and many of the organizations collaborate with one another.

While there are some nuances between the conversation roadmaps that are employed in different settings (e.g. between disclosing serious

Table 1
Talking maps for serious illness conversations.

		Talking map				
		Serious news		Prognosis	Goals of care	
		SPIKES [68]	GUIDE [69]	ADAPT [73]	REMAP [75]	Serious Illness Conversation Guide [74]
Action step	Prepare and assess patient understanding	Set-up Perception Invitation	Get Ready Understand	Ask Discover Anticipate ambivalence		Set up the conversation Assess understanding
	Inform patient	Knowledge	Inform	Provide info	Reframe	Share prognosis
	Expect and address emotion	Emotions	Demonstrate empathy (respond to emotion)	Track emotions	Expect emotion	Explore emotion
	Map values/devise plan	Strategy/summary	Equip		Map goals Align Plan	Explore key topics Close conversation Document conversation Communicate with key clinicians

news and discussing goals of care), most evidence-based communication strategies generally share these basic four components (Table 1):

1. Prepare and gather information, assess patient knowledge/understanding
2. Inform patient in accordance with her communication preferences
3. Expect emotion and address with empathic statements
4. Elicit patient values and create a plan based on those values.

While physicians are accustomed to providing information and making plans (steps 2 and 4), they rarely inquire about patients' understanding of their illness and communication preferences, and often fail to address patients' emotional cues with empathic statements [56].

4.1. Recognizing and responding to emotional cues

Addressing patient and family emotional cues is a critical part of every advanced communication encounter. Addressing emotion decreases anxiety and improves patients' trust in their doctors [53]. Additionally, communicating with empathic language improves patients' knowledge retention, adherence to treatment, satisfaction, and leads to fewer complaints and legal claims [21,57–62]. In contrast, distancing from emotional cues has been shown to decrease patients' ability to recall information [63]. One study demonstrated that giving patients explicit information regarding poor prognosis coupled with empathic language resulted in decreased anxiety and uncertainty compared to giving poor prognostic information without empathic statements, and even resulted in less anxiety and uncertainty compared to avoiding the prognostic information altogether [64].

Feeling empathy for the patient is necessary but not sufficient; in order for patients to experience improved outcomes, it is necessary for the physician to respond to emotional cues with empathic statements. Studies of recorded oncology encounters show that physicians respond to only 25–30% of patients' emotional cues, demonstrating significant opportunity for improvement [65,66]. Emotional cues may be verbal or non-verbal. Verbal cues may be explicit, such as "I'm really worried," or may be implicit, such as "How could this be happening?" or "I feel like I'm going to be in the hospital forever!" Non-verbal cues may be subtle, such as a change in facial expression, looking away, or eyes glossing over while the physician is providing information. The emotion underlying non-verbal cues may be less apparent.

The mnemonic NURSE (Naming, Understanding, Respecting, Supporting, and Exploring) [67] is helpful for addressing of emotions in any patient encounter (Table 2). Several of the statements may be appropriate for responding to emotional cues that may arise when delivering serious news or discussing prognosis or goals of care. The mnemonic does not need to be followed step-wise, but rather provides categories

Table 2
Strategies to respond to patient emotion—NURSE mnemonic empathic statements.

	Technique	Example statements	Statements to avoid
N	Naming When you detect an emotional cue, first try to name what emotion you think is occurring.	"I wonder if you're feeling angry about what happened," or "It sounds like you're worried about having pain when you go home."	*Avoid telling the patient what emotion they are feeling: "I can tell you're angry."*
U	Understanding Normalize that patient's emotions by expressing how you can relate to her perspective.	"Considering what you're going through, I could understand why that would be upsetting."	*Avoid telling the patient "I understand how you feel."*
R	Respecting Showing respect or admiration can help acknowledge the patient's efforts to do the best she can, and can demonstrate alignment of your wishes with hers. It is also useful for praising a family member's efforts.	"I admire how much you've been focused on your recovery." When a patient brings a long list of questions from her internet research: "I can see that you've worked hard to learn as much as possible about treating this cancer"(77).	*Avoid sounding insincere with praising statements that are out of proportion to the patient's expression of emotion.*
S	Supporting Physician can make statements to acknowledge need for emotional support, demonstrate willingness to help, and allay fears of isolation and abandonment.	"No matter what happens, my team is here to help you."	*Avoid giving premature reassurance (e.g. "You're going be OK.") before exploring and understanding a patient's concern*
E	Exploring Patients may give subtle emotional cues that may be difficult to name.	"It seems like some feelings are coming up for you. What's going through your mind?"	*Avoid asking a patient who seems overwhelmed "What questions do you have?" She may not be able articulate a specific question*

Table 3
Communication skills resources.

Resource	Organization	Details	Source
Communication Skills Training workshops with simulation (in-person)	Pallitalk	2-day course in Madison, WI	medicine.wisc.edu/hemonc/pallitalk
	Vitaltalk	1-day course, various locations	vitaltalk.org/courses/
Communication Training modules (online)	CAPC[a]	5 modules on various communication skills topics	capc.org/training/communication-skills/ (requires institutional membership: select your organization to create individual account)
	Vitaltalk	Delivering Serious News	vitaltalk.org/courses/
Communication skill building videos	Univ. of Wisconsin Best case/Worst case	Tool for surgeons to discuss difficult treatment decisions	https://www.youtube.com/watch?v=FnS3K44sbu0 (browser search: Best case worst case video)
	Vitaltalk	Multiple videos on various communication skills topics	vitaltalk.org/resources/
Downloadable tools	Ariadne Labs VA[b]	Serious Illness Conversation Guide Teaching resources (slide decks and handouts)	ariadnelabs.org/areas-of-work/serious-illness-care/ ethics.va.gov/goalsofcaretraining/
	Vitaltalk	Mobile device App Talking maps for various challenging conversations	App store search: Vitaltalk tips vitaltalk.org/resources/quick-guides/
Faculty development (train-the-trainer)	Vitaltalk	4-day teacher training faculty development workshop	vitaltalk.org/courses/
Institutional implementation	Ariadne Labs	Organizational implementation of communication skills program	ariadnelabs.org/resources/articles/news/new-collaborative-aims-to-improve-communication-between-clinicians-and-patients-with-serious-illness/
	Communication Skills Pathfinder[c]	Tools for making case for advanced communication to organization leadership	https://communication-skills-pathfinder.org/find-training/become-a-communication-skills-trainer/

[a] CAPC – Center to Advance Palliative Care.
[b] VA – United States Department of Veterans Affairs.
[c] Collaboration between Ariadne Labs, CAPC and Vitaltalk.

of empathic statements that providers can use to individualize a response to an emotional cue. For the remainder of this review, when examples of empathic statements are provided, the NURSE mnemonic category will be labeled in capital letters.

4.2. Delivery of serious news

Gynecologic oncologists' daily interactions often involve the delivery of serious news. Rather than avoid the discussion or evade patient and family questions, the delivery of serious news in a direct and clear manner is recommended and most desired by patients [23]. Talking maps for discussing serious news, including SPIKES [68] and GUIDE [69] can be used in a variety of settings familiar to gynecologic oncologists, such as concerning imaging findings, progressive disease, unexpected surgical findings, or worsening medical status.

The following case is an example of how one may communicate the serious news of finding more advanced cancer than was anticipated using the SPIKES talking map: Setting, Perception, Invitation, Knowledge, Emotions, Summary.

Case 1. *Ms. Jackson is a 45 year-old with apparent early stage cervical cancer. You just aborted a radical hysterectomy due to positive lymph nodes found during surgery. You have told her partner and family but have not yet spoken with the patient. The patient is now in her hospital room and you go to check on her at the end of your day.*

S - Setting: First ensure the patient is awake and comfortable enough to listen and absorb information. A private, quiet area to talk is important, and the physician should ask the patient if there is anyone else she wants present. Avoid standing at the bedside and starting to talk without the patient's support system present, or without assessing her mental and physical readiness to accept information.

P - Perception: Start by asking what she knows. "What have you heard so far about your surgery?" She may have already been told by house staff, nursing staff, or family about the positive lymph nodes and aborted case. Avoid any assumptions about the patient's knowledge or lack of information. *Avoid the phrase: "What is your understanding of what happened?" – it may be perceived as a challenge or a quiz, whereas when phrased as a patient-centered question ("What have your heard?"), the physician can assess the patient's understanding in a non-threatening way.*

I - Invitation: Use your knowledge the patient's support network to guide when to provide information. "Do you want to talk now about the surgery, or do you want to wait until your family is here tomorrow?" Asking permission serves to focus attention that important information is coming, and also provides patient the opportunity to indicate if she prefers that you speak to a family member or friend on her behalf. Allow her to control the delivery of the information.

K - Knowledge: Begin with a clear headline statement to focus the discussion: "Unfortunately things were not as we hoped." Provide information clearly and concisely in plain language: "We did not do the hysterectomy as planned because we found the cancer had spread to one of the lymph nodes outside the cervix," then pause and allow the patient to absorb the information. Avoid being evasive or using medical jargon.

E - Emotions: Use the NURSE mnemonic (Table 2) to address the emotional reaction to this information. Remember that while physicians may be inclined to launch into data or a plan of action, emotional reactions will block any ability for our patients to process or retain information. Respond to emotion and align with the patient. If she appears upset: "I think anyone would be upset hearing this"

(NAMING). Or, "This is not the news we were wanting to hear" (UNDERSTANDING, as well as shows alignment of your wishes with hers). When expressing understanding, a*void suggesting that you know what the patient is feeling, i.e. avoid saying "I know how you must feel."* If the patient asks "What does this mean?", balance honesty with hope: "The cancer is still treatable. In the coming days we can talk more about next steps. My team and I will be with you every step of the way" (SUPPORTING).

S - Summary: Summarize with an assessment of the patient's understanding and outlining the next steps. For example, one may ask, "I always like to check if I've done a good job explaining things. Can you tell me the main things you'll take away from our conversation?" (This assesses understanding as well as normalizes the teach-back process as your routine practice). Other ways to a patient to summarize include, "What will you tell your family members when they ask about our discussion today?" Following a complex explanation: "I've done quite a bit of talking. What are the main things you're hearing?" Finally, check that the patient is aware of the next steps, such as a follow-up visit to discuss a plan of treatment.

4.3. Discussion of prognosis

Discussing prognosis is similar in some ways to a discussion of serious news: it may be difficult to discuss for both physician and patient, and may trigger emotional reactions. However there are key differences between serious news and prognosis: 1) discussion of prognosis is often not urgent, and might be postponed as long as the discussion is not triggered by a serious event; 2) patients may feel ambivalent regarding desire for prognostic information; and 3) prognosis carries uncertainty around the likelihood of the event (such as recurrence, death, or risk of complication). Earlier discussion of prognosis leads to earlier identification of goals of care to decrease suffering, increased likelihood of discussing hospice, and less cancer-directed therapy during the last month of life [58]. Therefore, possessing skillful techniques for communicating prognosis is especially useful for the gynecologic oncology provider.

Patients consistently express that they desire communication that balances honesty and hope [70]. Therefore disclosure of poor prognosis should be coupled with empathic statements, taking care not to be overly optimistic [71,72]. Balancing optimistic statements and pessimistic statements has been shown to achieve the highest rates of accuracy in patient estimates of their prognosis [47]. The framework we present below for discussing prognosis is ADAPT: Ask, Discover, Anticipate ambivalence, Provide information, Track emotion [73].

Case 2. *Ms. Delago is 55-year old woman with history of advanced ovarian cancer underwent aggressive surgery and completed front-line chemotherapy less than six months ago. A rising CA125 prompted abdominal imaging, which reveals diffuse peritoneal masses consistent with recurrent disease. You have delivered the serious news regarding the recurrence. The patient is anxious about what this means for her and what to expect next. Her spouse and a friend are present for the discussion.*

A - Ask what patient knows: Start by assessing the patient's current knowledge of recurrent ovarian cancer. She may have discussed her diagnosis with other physicians, patients from a support group, or may have done her own research. You may ask, "What have you heard from other doctors?" or, "Have you heard or read anything about what to expect when ovarian cancer comes back?" These questions are useful because they can eliminate re-explanation of information that a patient already understands. You may also discover that the patient's understanding of the information is lacking or inaccurate, which will allow you to address her misconceptions.

D - Discover what information the patient wants to know about the future: It is important to understand what the patient wants to know. Because not all patients want the same level of detail, the most effective way to understand a patient's preference is to ask directly [68,70]. For example: "What information about the future would be helpful to you? Some people like specific numbers, and others like to speak more generally. What do you prefer?" Some patients may want to know prognosis in context of a specific event. For example, this patient may ask if she will be able to attend a child's graduation next year. Discussing prognosis within the context of the patient's wishes will make the conversation more relevant and meaningful to her.

A - Anticipate ambivalence: Patients may have ambivalence about wanting prognostic information, particularly as it may affect treatment decisions. Here addressing emotions becomes important. Listen and watch for emotional cues, and address them by NAMING the emotion, for example, "It seems like part of you is interested in talking about prognosis and part of you isn't." Or, "Talking about the future can be scary for a lot of people."

P - Provide information: If the patient indicates that she wants information about prognosis, summarize your understanding of her wishes for information: "So I heard you don't want to hear lots of statistics, but you would like to talk about what to expect from more chemotherapy treatment. Shall we go ahead and talk about that now?" Asking permission to proceed confirms her readiness and serves as a signpost to the patient that important information is coming. Then state a clear headline by providing information according to the patient's expressed wishes (for example, if she wants to know survival statistics, versus a general likelihood that she'll be able to attend a specific event). In this case, it would be important to state that the disease is no longer curable: "When ovarian cancer comes back after chemotherapy, it is no longer curable. It will eventually continue to grow regardless of treatments we provide." Another technique, particularly in light of prognostic uncertainty, is to describe the best case/worst case/most likely scenario. For example, "With another line of chemotherapy, in the best case, we see some temporary shrinkage of the cancer, lasting maybe 6 months. In the worst case, we see signs of cancer growing even with the new chemotherapy. The most likely situation is that the chemotherapy will suppress the cancer growth for 3 or 4 months before it starts to grow again.".

T – Track emotion: If the information has sunk in, it will likely trigger emotions. If unaddressed, the emotions will likely prevent any further absorbing of information or ability to make plans. Address any emotional cues using empathic statements as described (NURSE—Table 2): "This kind of information is hard for most people to hear" (UNDERSTANDING). If it is not clear what the patient is feeling: "It seems like you're having some feelings. What's going through your mind?" Or, "Are any worries coming up for you?" (EXPLORING). This will help uncover specific concerns such as fear of pain, isolation, or hope to live long enough to see a specific event, that can help frame discussion around goals of care.

4.4. Goals of care

A "goals of care" conversation is appropriate in any situation when a decision needs to be made, especially when more than one reasonable path exists. Examples include decisions about treatments such as surgery, chemotherapy, radiation, or other interventions. Discussions of patient goals are especially important at times of transition, such as

disease progression or medical complications affecting vital organ function. Two frameworks for guiding these conversations are the Serious Illness Conversation Guide by Ariadne Labs [74], and REMAP [75]. In the following example of a non-resolving malignant small bowel obstruction, we use REMAP (Reframe, Expect emotion, Map values, Align, Plan) to guide a conversation regarding a critical transition in disease status.

Case 3. *Ms. Lim is a 72 year-old with recurrent endometrial cancer that has not responded to the last two lines of treatment. She is admitted with a malignant bowel obstruction and ascites. You have already determined that surgical intervention is not possible. Despite medical management for several days, the obstruction is unresolved. Ms. Lim and her family are wondering what to do next. You think the best next step is to transition to hospice. You have arranged a family meeting. You have made introductions and provided a brief summary of the hospital course.*

R - Reframe: Transition the conversation with a warning that there has been a significant change in the trajectory of her disease. Frame the conversation with a clear headline: "We're in a different place." This headline signals a disruption in the routine, and highlights a need for discussion around the new situation [76]. Summarize the situation clearly and concisely: "Despite the tube in the stomach and letting the bowel rest for an extended period of time, the bowel blockage has not resolved, and at this point I worry that it's not going to. Surgery is not possible in this situation."

E - Expect emotion: The news presented in the Reframe is likely to be upsetting. As with all talking maps, watch for emotional cues, and address them with empathic statements (NURSE—Table 2). Witness her reaction and her family members' reactions and start by NAMING the emotion: "I can't imagine how upsetting this is to hear." Or, "It looks like this is quite a shock." She may be angry, sad, frustrated, disappointed, fearful, or all of the above. It may be helpful to honor the patient's efforts with a RESPECTING statement: "You've been working so hard to fight this cancer for so long." *Resist the urge to answer emotionally laden questions directly, such as "Will I ever eat again?!"* Address emotions with empathic statements first, before asking permission to move on.

M - Map goals: Understanding a patient's values and discovering what is important to her and her family will allow you to design a treatment plan that is acceptable to her. Do this before discussing any treatment options. Consider asking, "Is it OK if we take a few minutes to talk about what is most important to you?" Be careful not to make assumptions. Follow up patient statements to understand their meaning: "I hear you say that quality of life is important. What does that mean to you?" Involving friends and family in this discussion is important, and leaving the conversation open ended allows her to values to be revealed over time.

A - Align yourself with the patient's values: Summarize your understanding of what is important to the patient. "What I'm hearing is that you are most worried about having pain at the end of life and being a burden on your family." Or, "It seems like you are worried about giving up too soon." Using the statements "I worry" or "I'm concerned" and the words "I hope" and "I wish," can allow you to demonstrate that your concerns are aligned with your interest in the patient. For example: "I wish there were another chemotherapy that had a significant chance of helping you, AND I worry that trying another chemotherapy will make you feel sicker without making the cancer any smaller." Or, "I hope that you can live until that event, AND I also worry that you may not have much time." Avoid using the conjunction "but," because it negates the statement just before it. Strive to use "and" in place of "but."

P - Plan: After gaining a clear sense of her goals, make a plan with the patient. "Based on what I'm hearing, it sounds like your goals are to avoid pain and to be back in your home. We can help you with that. I think the best next step is to place that tube in the stomach which you will be able to manage at home." Or depending on the patient's values and wishes, "It sounds like you would like to give your obstruction more time and still want to consider more chemotherapy. We can re-address this in 24-48 hours to see where we are. Does that sound OK?" This second plan allows the patient to have more time but also makes a plan to revisit the next transition in her care.

5. Conclusion

Effective communication regarding serious illness is critically important to gynecologic oncology practice and benefits patients, providers, and the healthcare system. The improvement in patient satisfaction, provider wellbeing, and high quality care associated with skillfully led conversations warrants a commitment to these dialogues in gynecologic oncology practice. This necessarily justifies prioritizing advanced communication education during fellowship as well as nationally sponsored and organized continuing education programs for practicing providers. Much like surgical skills are best taught through hands-on experience and deliberate practice, the skills necessary to effectively navigate challenging conversations are best learned through combined techniques of brief didactic encounters followed by simulated practice with focused feedback. In order to make the gynecologic oncology providers of both today and tomorrow optimally prepared to provide state of the art cancer care, access to programs that teach these skills must be made available to trainees and providers. Efforts to adapt CST to gynecologic oncology fellowship training as well as to provide these training opportunities in conjunction with regional and national meetings are ongoing. For providers interested in learning more about communication skills, Table 3 outlines multiple resources that offer immediate guidance and further reading on the benefits of communication skills in practice.

Author contributions

Paper conception: RL, AKumar, KB.

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