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As a primary care physician about to begin your medical career or in the early years of practice, you may be assessing your future direction. Did you know that the *New England Journal of Medicine* (NEJM) offers a free service to assist physicians with career decisions? NEJMCareerCenter.org is the leading source of information for physician job openings in the United States and provides a full suite of career resources.

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A career in medicine is challenging, and current practice leaves little time for keeping up with new information. The *New England Journal of Medicine* is committed to delivering the highest quality research and clinical content. If you are not currently an NEJM subscriber, I invite you to become one by subscribing at NEJM.org. We are continually developing new features and enhancements to bring the best, most relevant information each week in a practical and clinically useful format.

One such example is our popular Clinical Practice articles offering evidence-based reviews of topics relevant to practicing physicians. This edition includes the January 4, 2024, Clinical Practice article, "Navigating and Communicating about Serious Illness and End of Life." You also might want to listen to *Intention to Treat*, a free podcast from NEJM that draws on the world-class expertise of NEJM editors and specialists to offer patients and clinicians critical context and insights into complex research, medical interventions, and urgent health policy debates.

On behalf of the entire *New England Journal of Medicine* staff, please accept my wishes for a rewarding career.

Sincerely,

Eric J. Rubin, MD, PhD

860 WINTER STREET, WALTHAM, MA 02451-1413 USA

How to Prepare for Your Physician Job Interview

By Nisha Mehta, MD, *a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine*

Finally! You've done countless interviews at this point, but for many of you, this is the first one where you are interviewing for a "real job." Some of the same rules apply, but others are very different.

To start, the dynamic in this interview is much different than others. You are likely interviewing with people who will be your colleagues, and your impression of them counts just as much as their impression of you. Depending on the job market in your field, there's a distinct possibility that they may even need you more than you need them.

Additionally, in an ideal scenario, you are picking a job that will last longer than a set time period of training. You are designing what potentially decades of life could look like for you and your family. Since this isn't just a stepping stone to the next thing, your approach will need to be more all-inclusive. Also, unlike residencies and fellowships, where a similar core set of responsibilities and expectations are already outlined, there is a lot of variability between jobs, even within the same city and specialty. It's important you are able to leave the interview with a 360-degree view of the position and the life you will build around it.

Keeping all of that in mind, here are some of my core tips for preparing for an interview:

1. **Do your research about a job ahead of time.** Not doing this is one of the biggest mistakes I see applicants making. Showing up to a job and asking basic questions whose answers can easily be found online will cause interviewers to question why you're at the interview and how serious you are about the job. You want to come in knowing how the group is structured from a management perspective, what its patient population looks like, who the referral base may be, and what areas within your field the group specializes in, as well as some areas or topics where you may be able to add value. Look at the group's website and the members and see if there are any connections that you might have where you might be able to find common ground. Call the people you know who may be familiar with the group and ask them for insights. Find out if people have left the group recently, as it may raise some red flags. This will all lead to more sophisticated questions that you can ask and more valuable information to consider when you are making your decision. It will also tell group members you are serious about the opportunity, which will help your chances as they decide whether to extend a job offer. Time and resources are precious in this process, and many won't want to waste their time if they feel they are 1 of 100 possibilities.

2. **Try and allot time to get to know the city you are interviewing in.** For those of you who are trying to return to a known place, this may be less of an issue, but nonetheless, training somewhere or growing up somewhere is different from living there as an adult and potentially raising a family in that location. Make sure the place offers outlets to foster your interests outside of work, as it will play into your happiness and burnout. Tour neighborhoods you may want to live in, and if you have educational preferences for your children, take some time to explore your options. If applicable, bring your significant other with you so that you're on the same page about pros and cons of living there.

3. **When interviewing with potential future colleagues, don't be afraid to be yourself.** It's important that the fit feels natural and that there is a mutual desire to work together. As the saying goes, you can't choose your family, but you can choose your friends. Similarly, you can choose colleagues that you are confident will contribute to your happiness at the job, whether it be via friendships, accommodating emergencies when they arise, splitting work in a way that feels equitable, or being respected. You should see yourself fitting into the culture of the group's members and in line with the standards, ethics, and practice patterns that they embrace.

4. **In a similar vein, take note of how colleagues are interacting with each other.** As the landscape of health care delivery gets more challenging and complicated, it's important that you feel that the group is cohesive and supports each other. If there are obvious tensions within the group, it may be a sign that there is more beneath the surface that's resulting in conflict, whether it's RVU (relative value unit) structures, partnership issues, different beliefs about the direction the company is taking, etc.

5. **Talk about money and opportunities for growth.** After all, this is a job. Put some effort into figuring out how revenue is generated, when you get to share in those profits, and what the plans of the group are in terms of expansion. If the compensation structure is complicated, ask for details. You don't have to take up your entire interview time talking about it, but get a basic sense and then ask the interviewer to send you a summary with details later. Understand the benefits. If the group's members do something a lot different from other groups you've interviewed with or your colleagues are interviewing with, ask them why they chose to structure things in that way.

6. **If possible, spend some time shadowing someone whose job is similar to the one you're interviewing for.** Make sure you can see yourself happy in his or her shoes, and if there are obvious pain points or dealbreakers, take note of them. You may not be able to do this on the day of the interview, but if you have doubts about whether you'd enjoy the particular setting ahead of time, see if an interviewer can incorporate this on a later date. Again, it's in everybody's best interest to ensure a job is a good fit for you.

I could go on, but your goal on your interview day is to confirm the job is one you can see yourself enjoying for years to come. You're really picking more than a job — you're picking a lifestyle and a vision for your future, and you want to make sure you are keeping a keen eye out for pros, cons, and red flags.

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Hospitalist Update: For Hospital Medicine Physicians, Emerging Opportunities Plentiful in Clinical and Operational Realms

By Bonnie Darves

Hospital medicine has made a lot of headway for a relatively new physician specialty. In just over 25 years, hospitalists have integrated themselves into virtually every aspect of care delivery in hospitals and health systems. From their beginnings as in-hospital internists and family medicine physicians managing the inpatient care of community primary care physicians' patients, a vital role that persists today, hospitalists are now serving in top leadership positions, commandeering quality improvement initiatives, and developing facility-wide protocols. They're also comanaging specialists' patients and delving deep into hospital operations and IT infrastructures to help facilitate systems improvements.

For young physicians contemplating where they'll hang their stethoscopes, that broad swath of practice possibilities is a large part of the specialty's appeal, according to Rohit Uppal, MD, MBA, chief clinical officer for TeamHealth Hospitalist Services in Orlando, Florida. "The lure of hospitalist practice is that physicians are exposed to aspects of medicine that they might not encounter elsewhere and also have the opportunity to learn leadership skills on the job," Dr. Rohal said. "There's really no other specialty that exposes you to the breadth of medicine."

For example, hospitalists may work with colleagues in the ER and critical care, cardiology, neurology, orthopedics, and, in limited cases, trauma specialists, Dr. Rohal said. In a newer role, serve as physician advisers assessing the status of and optimal care setting for an even broader range of patients.

Increasingly, Dr. Rohal said, hospitalists are also integrally involved in managing transitions of care and the systems issues that challenge hospitals. Hospitalists are moving into informatics, quality improvement (QI), care management, telehealth, and services utilization. "The possibilities, in terms of career paths for hospitalists, are robust — and growing. Hospitalists were already being viewed as leaders in the hospital before the pandemic hit. Their impressive performance during COVID-19 cemented that," said Dr. Rohal, whose company employs approximately 3,000 hospitalists at 200 U.S. sites.

Jerome C. Siy, MD, a past president of the Society of Hospital Medicine and division medical director of hospital-based specialties for HealthPartners in Minneapolis, Minnesota, agrees that hospitalists' role in helping hospitals navigate the pandemic has revealed even more ways, particularly in telehealth, that hospital medicine physicians' expertise might bring value.

Today, Dr. Siy said, hospitalists are being tapped for key roles in operations — improving electronic health records (EHRs) and consulting on informatics innovations. "We're even seeing hospitalists getting involved in emerging areas such as predictive analytics, patient risk scoring, population health, and nascent hospital-at-home programs," he said.

> "As an early-career hospitalist, you have to invest in growing your knowledge base and carving out time to do committee work if you want to pursue a leadership role. There are new skill sets to learn, and that takes time."
>
> — Jerome C. Siy, MD, HealthPartners

Per Danielsson, MD, a hospitalist who has helped hospitals pilot hospital-at-home (HAH) programs, which seek to provide hospital-level care for older patients who may be at risk for functional decline or other problems associated with long inpatient stays if they remain in the hospital. He views the model as a win-win for hospitals and the hospitalists who clinically

manage such patients. Hospitalists bring valuable experience to HAH programs because of their extensive expertise in triaging acutely ill patients, working in multidisciplinary teams, and, recently, delivering telemedicine. In a June 2019 article in the *Journal of Hospital Medicine*, Dr. Danielsson predicted that HAH hospitalists might one day become a subspecialty of their own.

In a field that continues to grow steadily, and at a time when hospitals are amenable to placing talented hospitalists in just about any administrative role they're interested in, there's no shortage of both traditional practice opportunities and jobs that combine clinical and administrative work. Today, an estimated 50,000 hospitalists practice in the United States, and the specialty experienced a 50 percent growth rate between 2012 and 2019, according to a study published in *Journal of Hospital Medicine* in August 2022.

What early-career hospitalists are seeking

Even if the sky is the limit in terms of the myriad ways that hospitalists might configure their clinical careers or combine clinical and administrative work, young physicians considering — or newly entering — the field choose the specialty for its schedule flexibility and its perceived ability to deliver acceptable work/life balance. Ijeoma Carol Nwelue, MD, hospitalist medical director for Baylor Scott & White Health in Fort Worth, Texas, said that even early-career hospitalists aren't shy about articulating their wish lists.

"Young physicians really want that work/life balance, so schedules are a big issue for them," she said. "Hospitalists really want their work planned around their life, and they're expecting not to have to grind it out every day. They want specific fixed hours, but they also want some schedule flexibility when they need it."

Most hospitalist organizations are attempting to deliver on both fronts. Still, the predominate schedule in the specialty is seven on/seven off (often called a "7/7") — hospitalists work seven days or nights in a row, followed by seven off — can be a bit of a grind when hospitalists are in the "on" mode, several sources acknowledged. As such, some groups are exploring ways to shorten shifts or otherwise reconfigure schedules. So far, no new standard has emerged.

Young physicians are also looking for ways to serve the community at large. They're increasingly articulating that desire when they interview for positions, observed Dr. Nwelue, now a veteran of the field. "That's something we've been seeing a lot in recent years — young physicians wanting dedicated time for community outreach, for opportunities to care for or teach patients outside of the hospital setting," she said. "It's a common request of this new generation."

Hospitalists want to teach, too

Also high on the wish list for many young hospitalists are formal or informal teaching opportunities. Although hospitalists in academic medicine have such opportunities as a matter of course, many of those practicing in other settings such as community hospitals also want to spend some time teaching students, residents, or even other colleagues, several sources mentioned. Fortunately, some of the hybrid community hospital/academic institution partnerships that have emerged in the past decade are giving hospitalists a chance to do some teaching and research work in addition to their clinical duties.

In the academic realm, some programs are seeking more expedient pathways for early-career hospitalists move into medical education more quickly — with the objective of providing that career satisfier sooner that it might occur traditionally in competitive academic environments. The University of Chicago, for instance, has pioneered an innovative Passport to Clinical Teaching program, which offers early-career hospitalists access to medical-education opportunities that they can pursue on their own time and can coordinate with their clinical responsibilities.

"A lot of young hospitalists really want to teach and to learn how to become mentors, but it's challenging because their schedules are heavy clinically. And there is substantial competition for available teaching time in academic environments," said Elizabeth A. Murphy, MD, assistant professor and director of clinical service development in the University of Chicago's Section of Hospital Medicine. "What we've done is create structured content on becoming a better teacher that hospitalists can access on their own time."

More limited teaching opportunities are available as a series of Passport rotations in various domains, that cohort members complete within about a year, Dr. Murphy noted. Participants typically spend time at external community hospitals that operate smaller residency programs or host

medical students and can use extra hands. Cohort members also learn how to develop continuing medical education (CME) offerings, work in community health clinics, and engage in scholarly activities, among other offerings.

J.P. "John" Murray, MD, a young University of Chicago hospitalist who now directs the hospitalist consult service, maintains that his Passport program participation effectively jumpstarted his career. "I really appreciated the fact that the Passport program is geared toward young hospitalists. It provides lots of opportunities to get involved with residents and medical students, that you might not have otherwise," Dr. Murray said. "It provides a framework and exposure. It keeps you sharp, and it provides a way to show leadership that you're very interested in teaching."

The program started in 2020 and has been well received, Dr. Murphy said. Some of the learners in the initial cohort have received teaching awards or moved into formal teaching roles. "Many hospitalists come into academic medicine because of their favorable training experiences and because they want to be part of what academic medicine does," Dr. Murphy said. "This offers early-career hospitalists a way to do that, and it gives us a way to harness the mentoring talent we have."

Telehealth and other practice options

Not surprisingly, because of their varied exposure to many aspects of care delivery and the skills they gained navigating the pandemic, hospitalists have been pivotal in helping hospitals develop and expand telehealth services, to reach both home-bound patients and those in underserved areas. Dr. Siy noted that hospitalists at his organization provide telehealth services at night to outlying hospitals and some reserve a portion of their clinical time to work in rural hospitals.

Dr. Nwelue reported that her organization is piloting a hospitalist-managed telehealth service aimed at managing lower-acuity patients — such as those with infections that require IV antibiotics — who can be safely cared for at home with nursing intervention and hospitalist management. Likewise, in pediatrics, a field that has struggled with capacity as dedicated pediatrics units have shrunk or disappeared, pediatric hospitalists are using telemedicine to expand their reach into rural and smaller hospitals. In particular, pediatric hospitalists are helping such facilities care for lower-acuity young patients that present to their emergency departments.

In recent years, another brand of hospitalist has emerged — transitionalists. These hospitalists focus on the intersection of inpatient care and so-called step-down units. Transitionalists practice either part-time or full-time in post-acute settings such as inpatient rehabilitation facilities, long-term acute-care hospitals, or skilled nursing facilities. In such roles, hospitalists often serve as medical directors.

In another recent development, hospitalists are being tapped as in-house consultants. They're helping hospitals reduce unnecessary services utilization, assess medical-necessity issues, and streamline post-discharge care continuity. Because hospitalists develop in-depth familiarity with specialists' practice patterns, test ordering, and patient lengths of stay, hospitals are discovering that hospitalist input pays dividends in both reducing costs and improving care.

Inside hospitals and health systems, organizations are realizing that young tech-savvy hospitalists can also be instrumental in helping them vexing issues. Hospitalists are being tapped to help resolve workflow, IT, and EHR issues that cause inefficiencies — or clinician frustration. "This is an ideal role for early-career hospitalists who have an interest and some expertise in healthcare technology," said Dr. Siy. "There's a real demand for such skills."

One of the big draws in the early years of hospital medicine was that hospitalists working "7/7" schedules could use some of the off-week time to moonlight at local hospitals, perhaps to pay off education debt more rapidly. Although moonlighting isn't as common as it once was in the field, some hospitalists recognize that they can use their off time to learn new clinical or business skills or even start new ventures.

Mitchell Durante, DO, and Anthony King, DO, hospitalists at BJC Healthcare Christian Hospital in St. Louis, Missouri, recently decided to take advantage of their "7/7" schedule flexibility to start a manipulative medicine clinic that's open during their off weeks. "It took us a few years to get this up and running, but we're excited about starting our own business," Dr. Durante said. "That's one of the good things about hospital medicine — it gives you the flexibility to do something like this."

Some hospitalists are also utilizing their newly developed telemedicine skills with their flexibility to carve out opportunities to provide remote care and consultations from home. Others are developing new products or apps, launching podcasts, or serving an independent medical reviewers.

The other 'ists' — growth of specialty hospitalists is slow, but steady

In the past 15 years, several specialties have made strides in developing inpatient-only services based on the hospitalist model as specialists wrestle with the growing challenges of simultaneously managing a combined outpatient/inpatient practice.

The mainstays of the specialty hospitalist movement remain orthopedics, trauma, anesthesiology, OB/GYN, general surgery, and gastroenterology. But psychiatry and neurology are both increasingly embracing the hospitalist model. In a pioneering venture, the University of California, San Francisco has started a Neurohospitalist Division that utilizes a structure similar to the traditional medicine hospitalist model.

Leadership roles

Although it's not uncommon now to see hospitalists as medical directors, chief medical officers, and health-system committee chairs, young hospitalists should understand that both a learning curve and a willingness to devote extra time to small-scale initiatives are prerequisites for obtaining leadership roles, Dr. Siy noted. "As an early-career hospitalist, you have to invest in growing your knowledge base and carving out time to do committee work if you want to pursue a leadership role. There are new skill sets to learn, and that takes time," he said.

Organizations are trying to accommodate hospitalists' desires to move into leadership roles without waiting a decade or longer. TeamHealth, for example, operates a designated leadership track for interested hospitalists. And it's a popular option, according to Dr. Uppal. In addition, the Society of Hospital Medicine's Leadership Academy offers a wide range of courses that enable hospitalists to obtain leadership and management skills.

> "The possibilities, in terms of career paths for hospitalists, are robust — and growing. Hospitalists were already being viewed as leaders in the hospital before the pandemic hit. Their impressive performance during COVID-19 cemented that."
>
> — Rohit Uppal, MD, TeamHealth Hospital Medicine

For Jessica Porter, MD, a TeamHealth hospitalist medical director at Memorial Hospital Miramar in Hollywood, Florida, the opportunity to lead came early — soon after she completed residency in 2016. She jumped at the chance. "I'd always been interested in leadership, and in contributing, because, well, someone did the same for me. It was a steep learning curve, but I managed it and found I really enjoyed the administrative work," said Dr. Porter.

Today, although Dr. Porter maintains a full clinical schedule, she manages to fit in most of her administrative duties during her "on" weeks, and receives a stipend for her leadership work. Those duties include managing operations and coaching physicians, representing hospitalists' interests at hospital management meetings and, as needed, boosting morale. "It's very gratifying work, and I think it's important to have a seat at the table when [organizational] decisions are being made," she said.

Dr. Porter advises young hospitalists who are interested in leadership to look for committee and task force openings, engage in quality improvement initiatives and, above all, express their interest in leadership roles. "If you don't ask, you don't get it — whether it's a raise or a leadership opportunity," she said.

CLINICAL PRACTICE

Patrick G. O'Malley, M.D., M.P.H., *Editor*

Navigating and Communicating about Serious Illness and End of Life

Vicki A. Jackson, M.D., M.P.H., and Linda Emanuel, M.D., Ph.D.

This Journal *feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the authors' clinical recommendations.*

From the Department of Medicine, Division of Palliative Care and Geriatric Medicine (V.A.J.), and the Center for Aging and Serious Illness Research (V.A.J., L.E.) and Cancer Outcomes Research and Education Program (V.A.J.), the Mongan Institute, Massachusetts General Hospital, and the Harvard Medical School Center for Palliative Care (V.A.J.) — both in Boston; and the Department of Supportive Oncology, Robert H. Lurie Comprehensive Cancer Center, Northwestern Medical Group, Feinberg School of Medicine, Chicago (L.E.). Dr. Jackson can be contacted at vjackson@mgh.harvard.edu or at Massachusetts General Hospital, 55 Fruit St., Austen 600, Boston, MA 02114.

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A 71-year-old man had previously received a diagnosis of stage IV non–small-cell lung cancer that was positive for epidermal growth factor receptor (EGFR) and metastatic to the spine. The cancer responded to treatment with an EGFR tyrosine kinase inhibitor, providing the patient with an excellent quality of life for 3 years. During that time, his main priority was caring for his wife, who has dementia. The patient now has leptomeningeal disease and worsening back pain. His oncologist reports the news of the disease progression and discloses the prognosis that the patient's remaining life may be as short as a few months. Despite multiple conversations with his clinician, the patient continues to state that he hopes to live several more years and that he feels his oncologist is giving up on him. In addition to starting chemotherapy and radiation therapy and referring the patient to outpatient palliative care, how can his clinicians support him in integrating information regarding his prognosis and help him with end-of-life planning?

THE CLINICAL PROBLEM

Conversations about prognosis can be difficult and confusing for both patients and clinicians. It is not uncommon that patients who have a serious illness, such as cancer or heart failure, continue to express seemingly unrealistic hopefulness despite conversations in which accurate prognostic information has been well communicated and tailored to the patient's preferences. This reaction is disconcerting for clinicians who want to understand what is most important to the patient and are rightly concerned that a patient may not be prepared for the end of life.[1] Such concerns that lack of preparation can lead to poor-quality end-of-life care are supported by evidence of late referrals to hospice and unwanted in-hospital deaths.[2]

Several factors contribute to the difficulty of conversations about prognosis. Consideration of matters related to death is difficult for patients and clinicians across most cultures, and therefore, patients may have a poor understanding of their illnesses and clinicians may not know how to help patients cope. The task of the clinician is to assess and guide the patient's awareness and adaptive coping process, including discerning the patient's priorities for this last part of life. Such considerations include the patient's relationships; their feelings regarding disability, pain, and treatment invasiveness; and the evolving nature of all these issues. As the prognosis translates into medical decisions, the process must be coordinated across medical teams. These tasks are as yet imperfectly practiced.[2]

KEY CLINICAL POINTS

NAVIGATING AND COMMUNICATING ABOUT SERIOUS ILLNESS AND END OF LIFE

- Partnering with patients as they navigate serious illness requires effectively communicating prognostic information while responding to the emotions generated by the conversation.
- Clinicians should expect, and have the skill, to engage in a continuum of conversations that allow patients to integrate prognostic information cognitively and emotionally.
- Patients oscillate between expressions of intense hopefulness and more realistic aspirations; this a normal and expected part of the process.
- Facilitating patient exploration of their hopes and worries allows them to grieve, understand their priorities, and build coping skills for living with a serious illness.
- As patients integrate prognostic information, clinicians should discuss what is most important to the patient given the likely illness trajectory and incorporate these goals and values into a recommendation about medical care, including care at the end of life.

Many clinicians have not had the opportunity to master the communication skills necessary to help seriously ill patients cope with their illnesses. These skills include recognizing that a patient's continued extreme hopefulness is a normal part of coming to terms with an uncertain or poor prognosis. To help patients with serious illness develop their capacity to cope with the enormity of their illness, clinicians need skills that go beyond selecting the most appropriate scripts for communicating bad news. These skills should include recognition of the patients' current understanding of their illness and their capacity to adaptively cope with prognostic information, and clinicians should be able to help cultivate prognostic awareness and existential maturation.[3-9]

Prognostic awareness is a patient's ability to integrate the likely illness trajectory both cognitively and emotionally.[5] Partnering with patients to deepen their understanding of their illness is an iterative process that requires several conversations over a period of months to years before the end of life. Intervention studies that have been aimed at increasing prognostic awareness have had mixed results. Some studies have shown that increased prognostic awareness was associated with lower quality of life and higher levels of psychological distress.[10,11] We hypothesize that these poorer outcomes may occur when patients do not have enough time and support to develop adaptive coping strategies.[8,12] Cultivating prognostic awareness entails the development of coping strategies to manage a more integrated awareness of an uncertain future.[4,8] This process is a part of existential maturation, which is the development of integrated ways of living fully that are informed by an awareness of mortality and that allow death to be viewed as a nontraumatic outcome.[7,13] A patient's ability to cultivate prognostic awareness as part of the existential maturation process is critical when it comes to advance care planning, when what is most important to the patient is translated into a treatment plan, especially as it relates to end-of-life care.[14]

STRATEGIES AND EVIDENCE

Advance care planning, serious illness conversations (with the use of a scripted communication guide to discussing serious illness), and palliative care interventions share the common goals of aligning medical care with patients' goals and values and improving clinical outcomes. These strategies, however, have shown varying effectiveness in achieving the intended goals. Trials that have analyzed advance care planning have shown that patient preferences regarding factors such as code status can change and that it is hard for most patients to determine an appropriate medical decision far in advance of the need for that particular decision.[15-17] In addition, rigorous trials of advance care planning interventions have shown that simply having an advance care planning document does not result in improved patient outcomes. For instance, a large multicenter, randomized trial of advance care planning involving patients with cancer resulted in an increased number of advance directives that were completed, but investigators found no improvement in quality of life or coping strategies.[18] These findings may reflect that current advance care planning models do not focus on the actual process by which patients come to understand their prognosis, share what matters most to them, and then iteratively express their preferences for medical care.[19]

Serious illness conversations that are con-

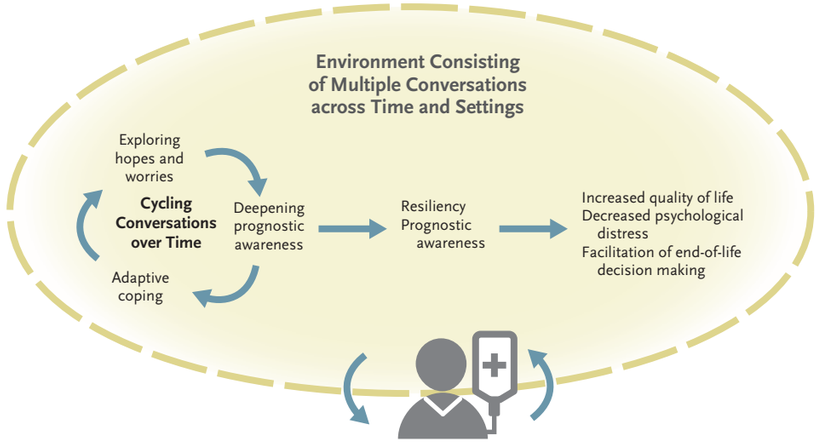

Figure 1. Prognostic Awareness and Patient Outcomes.

A conceptual model shows the association of prognostic awareness with outcomes in patients with serious illness. The oval represents the environment of early palliative care, which supports patients as they cognitively and emotionally integrate prognostic information and develop adaptive coping strategies.

ducted repeatedly over a span of time expand the framework of advance care planning, and there is a growing evidence base for their effectiveness.[20-22] This approach more fully incorporates the complex, longitudinal process of planning for a patient's future health. We suggest that in order for serious illness conversations to be effective, the focus should be on the patient's ability to cognitively and emotionally integrate the likely trajectory of a known illness and the psychological processes necessary to cope with this information. Continuing, attuned conversations of this nature require more time and openness to psychological adjustment than the current norm of advance care planning, which aims for durable treatment preferences that are stated once.[23]

In contrast to advance care planning trials, multiple randomized clinical trials of palliative care have shown improvements in patient-reported outcomes. Early integration of palliative care for patients with cancer improves mood, quality of life, and quality of care at the end of life.[24-26] Another trial showed changes in prognostic awareness among patients who had been randomly assigned to receive early palliative care.[27] The improvements in quality of life and mood that were shown in trials involving palliative care are likely to be mediated by patients' increased use of adaptive coping strategies.[12] Patients who see palliative care clinicians regularly and earlier are more likely to use adaptive coping strategies such as positive reframing (focusing on ways the stressor might be positive or beneficial) or gratitude (expressing appreciation for positive things in their lives) rather than avoidance or denial (refusing to acknowledge or discuss the stressor). Figure 1 shows a conceptual framework based on findings related to how the cultivation of prognostic awareness may influence patient quality of life, mood, and end-of-life decision making.

All clinicians caring for patients with serious illnesses, not only those practicing palliative care, can integrate these results into clinical practice. Here, we consider some of the factors that clinicians should understand with regard to how patients cognitively and emotionally process and integrate prognostic information. This understanding is the key to initiating end-of-life care neither too soon nor too late.

COGNITIVE INTEGRATION OF PROGNOSTIC INFORMATION

The promotion of cognitive integration of prognostic information is a complicated process. Patients report that they want honest prognostic information from their doctors and, at the same time, want their doctors to be optimistic.[28,29] Best practices suggest that a clinician tailor population-level data to the individual patient, acknowledging uncertainty (including uncertainty resulting from a lack of data), providing times in ranges, and respecting the patient's information preferences.[30]

However, even when effective communication methods are used, patients often have misconceptions about their illness that affect treatment decision making. One study showed that 69% of patients with metastatic lung cancer and 81% of patients with colorectal cancer did not understand that chemotherapy was unlikely to cure their cancer,[31] and data have confirmed misperceptions across numerous populations, including patients with hematologic cancer, congestive heart failure, and end-stage liver disease.[32-34] Patients who overestimate the likelihood of survival are more likely to choose intensive care measures at the end of life and are less likely to discuss their end-of-life care preferences with their clinicians.[35] These data show that there is an opportunity for clinicians to help patients develop a more accurate understanding of the likely course of their illness. Rather than insisting that a patient immediately accept a harsh new reality, the clinician can offer support as the patient builds the capacity to come to terms with the likelihood of dying.[36]

EMOTIONAL INTEGRATION OF PROGNOSTIC INFORMATION

The process of emotional integration of difficult prognostic information necessitates that the patient grieve losses, reimagine hopes, and manage fears and worries in order to tolerate and effectively cope with the distress related to their prognosis. It is often a bumpy, oscillating developmental process that involves conflicting, intense emotions. Patients oscillate between expressions of extreme hopefulness ("I know I will beat this. I don't believe the oncologist.") and realism ("I don't know what the future holds. I hope I feel well enough to take a trip with my family this summer.") Oscillation between conflicting states of mind is a fundamental part of normal emotional processing and development and is well-established in psychological theories that have been applied to processing the realities of serious illness.[37-39] With the benefit of time and the opportunity to explore hopes and worries in a trusted environment, patients tend to progress toward prognostic awareness and existential maturation.[3,5,7,13]

EVOLUTION OF INTEGRATED AWARENESS

Studies have shown that deeper prognostic awareness happens over time, often across a continuum of conversations.[40,41] Patients and clinicians often "cycle" through short portions of this ongoing conversation over periods of weeks, months, or years, depending on the patient and the cadence of the illness.

Clinicians can align with patients in these vacillations, not only accepting patients' hopes but exploring them in order to better understand what is most important to the patient. Additional factors that may facilitate this interaction include showing empathy; normalizing patient reactions; slowly exploring the sadness, grief, and loss; and maintaining a reliable and accessible partnership to help the patient cope and live as fully as possible in this final phase of life, however long it may be.[42]

The cycling of these conversations over time and in different settings (e.g., palliative care, oncology, and primary care) and with different disciplines (e.g., social work, psychology, and chaplaincy) allows the patient to develop a language for discussions about the possibility of dying and the adaptive coping skills to participate in those discussions. Crucial conversations about these matters also involve families and loved ones. Some conversations with family and loved ones entail divergent hopes and worries that affect the patient's process of integrating the prognostic information and may need to be discussed with the clinician. Throughout the course of all these conversations, patients increasingly link a cognitive and emotionally integrated understanding of the illness to their expression of what is most important, and they are able to make more fully informed decisions (Fig. 1).

Despite effective communication and partnership with their clinicians, some patients may continue to struggle to cognitively and emotionally integrate prognostic information. This lack of integration may result in the clinician facing a situation in which a patient is requesting a treatment that is unlikely to be of benefit. The competing precepts of autonomy and nonmaleficence can be difficult to balance. Continued attuned conversations and, perhaps, a time-limited trial of treatment may be helpful.[43]

Table 1. Key Concepts and Examples of Communication Strategies.

Concept	Communication
Assess the patient's prognostic awareness while eliciting and exploring hopes and worries.	"What is your understanding of your illness? When you think about what lies ahead, what are you hoping for? What are you most worried about?"
Respond to prognostic questions with your best understanding, even if there is uncertainty.	"I hope your health will steadily improve, and I am worried that you may have a continued decline in your health."
Respond to emotions.	"This is so sad." "I can only imagine how hard this is."
Include loved ones in conversations exploring illness understanding.	"Who else might be helpful to include in our conversation?"
Help patients discern what matters most to them.	"If your health does worsen, what is most important to you?"
Recommend clinical care that is based on what matters most to the patient.	"It sounds like _____ is most important to you. Given this priority, I'd recommend _____."

AREAS OF UNCERTAINTY

Clinicians and researchers need to be able to measure the degree to which patients have cognitively and emotionally integrated key prognostic information and how well they are adaptively coping.[44] We need a better understanding of which domains of patient concern are germane to medical decisions — such as relationships and thresholds regarding disability, physical suffering, and invasiveness of treatment — and how these factors relate to the oscillations of hopes and worries.[45,46] More research is needed to better understand the ideal timing, content, and structure of these conversations and how these elements might vary with factors such as a patient's baseline coping strategies, cultural preferences, lack of trust in the medical system (including concerns about systemic racism), physical or spiritual suffering, and the patient's ability to develop trusting relationships.[45,47] We also know very little about how factors that affect clinicians, such as self-awareness, burnout, existential maturity, and capacity to tolerate uncertainty, influence their abilities in this area.

In addition, research needs to produce a better understanding of the ways in which well-studied psychotherapy interventions could be helpful to patients with serious illness, not only in mitigating psychological symptoms such as anxiety and depression but also in cultivating prognostic awareness, coping, and the quality of decisions.[6,48] Reconsideration of how best to conduct the research and the clinical process of advance care planning is under way.[17,23,45,46,49,50] Because palliative care specialists cannot be the sole orchestrators of these conversations, more research is needed to guide not only clinicians' acquisition of primary palliative-care skills but also the way serious illness conversations — and the documentation of those conversations — are integrated into their workflow. Finally, clinicians need methods to easily and visibly document in the medical record an assessment of patients' illness understanding, coping abilities, and the elements of what matters most to them.[45,46]

GUIDELINES

Professional societies have not promulgated guidelines regarding the ways clinicians can help patients integrate prognostic information.

CONCLUSIONS AND RECOMMENDATIONS

To guide patients such as the 71-year-old man described in the vignette, clinicians first must effectively communicate prognostic information.[30] Next, clinicians need to partner with patients as they integrate prognostic information while their states of mind oscillate normally between intense hopefulness and more realistic aspirations. By exploring their hopes and worries, patients may begin to grieve the life they had expected and to integrate and cope with the likely course of the illness. As a patient gains an integrated awareness that life may be short, clinicians should be ready to discuss what is possible, with regard both to decisions about medical treatments and to decisions about how the patient may choose to live this last phase of life, given the illness trajectory. By means of these discussions, clinicians must be able to help their patients to discern what now matters most to them. With that knowledge, clinicians can incorporate the patient's informed goals and values into a recommendation about care at the end of life, such as hospice or life-sustaining treatment and the limitations of such therapy (Table 1).

For the patient described in the vignette, we would initiate a plan to treat his pain, build a strong therapeutic relationship, and then assess his prognostic awareness. If he continued to express a belief that he could live several more years, we would explore his hopes and worries regarding that next period of time. In this exploration, clinicians and patients often find common ground and goals for their work together. If the patient's hopes and worries were centered on the care of his wife, we would acknowledge the patient's loving support, normalize his desire to care for her and attend to his emotions related to the thought of leaving her, and engage in practical planning for her care.

Over the course of several visits, we typically find that a patient gradually oscillates less widely and becomes more open to discussions of prognosis. As the patient's prognostic awareness deepens, the patient is better able to understand the implications of changes in physical function, such as intense fatigue or anorexia. If the patient described in the vignette states that he would like to be at home surrounded by his family at the end of his life, we would recognize his possible readiness for a recommendation for hospice care. Finally, we would document the serious illness conversation in the medical record, including the patient's prognostic awareness, coping, and what is most important to him, so that the information is accessible to all the clinicians who care for him (Table 2).

Table 2. Key Elements to Document in the Medical Record.

- Prognostic awareness
- Illness understanding
- Patient's hopes and worries
- Prognostic information that was shared (e.g., curable or not curable); continued decline in patient's condition; a time-based prognosis of days to weeks, weeks to months, or months to years
- Assessment of how the patient is coping, including strategies used by the patient and family
- What is most important to the patient and family, including relationships, disability, suffering, and invasiveness of treatment
- Recommendations made to the patient and family

Partnering with patients who have a serious illness to help them live and die well requires iterative conversations about their illness understanding, prognostic awareness, hopes and worries, and what matters most to them as the trajectory of the illness becomes clear. These conversations must take place over the course of the illness, in the context of trusted relationships in which the clinician is attuned to the patient's psychological coping and ability to cognitively and emotionally adapt to the reality of their mortality.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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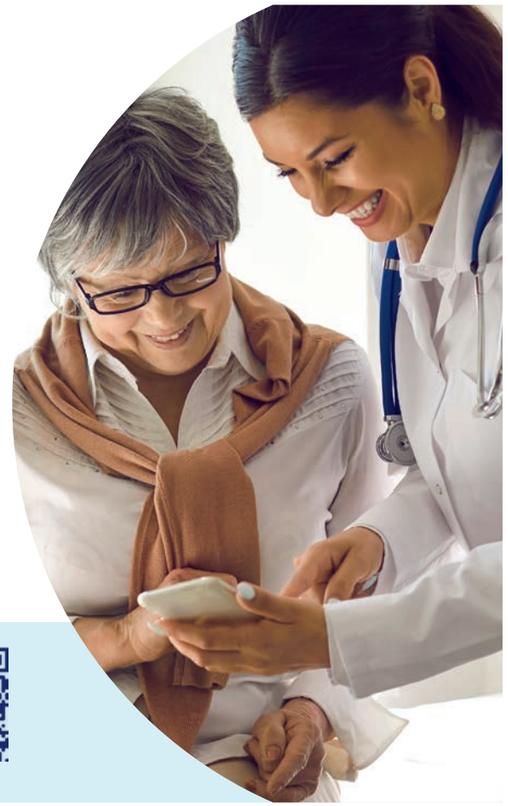

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The **Department of Medicine at the University of Maryland School of Medicine** is recruiting faculty to join our expanding programs in **Endocrinology, Diabetes & Nutrition, Gastroenterology** and **General Internal Medicine**. Opportunities with descriptions and application instructions are at the following link:
https://www.medschool.umaryland.edu/medicine/open-faculty-positions/

Expected faculty rank for all positions will be Assistant Professor or higher. Final rank, tenure status and salary will be commensurate with candidates' qualifications and experience.

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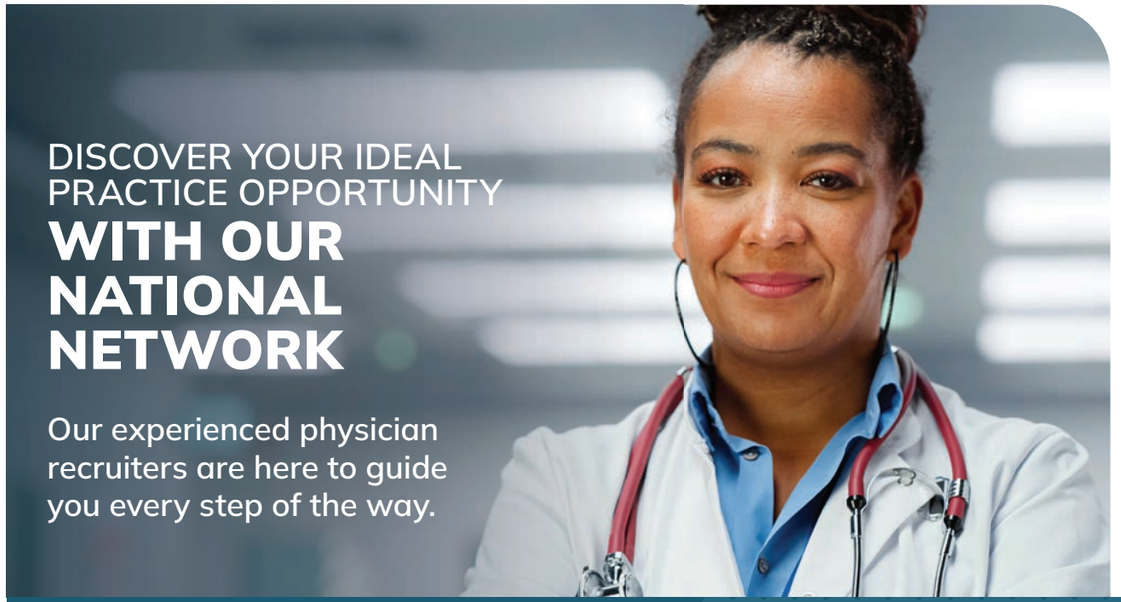

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