Initiating a Hospice Talk[1]

1. **Establish the medical facts.** To avoid mixed messages from medical professionals, coordinate with other care providers to gain consensus about the hospice choice.
2. **Set the stage.** Choose a comfortable time and setting for an uninterrupted conversation. It is optimal if key decision makers in the family are present.
3. **Assess understanding of the prognosis.** Begin by asking the patient about his/her understanding of the disease, its severity, and what the likely outcome is to be. This is a time to observe any misunderstandings or denial on the part of the patient or family.
4. **Help patient define his/her goals for the foreseeable future.** These goals can be treatment goals and can determine whether the focus is curative or palliative. Beyond treatment goals, however, it is instructive to ask about hopes and fears. Understanding what the patient hopes to achieve in the near future—even nonmedical goals such as attending a family event or seeing a sibling one last time—can provide hope and personal empowerment even in the face of an incurable condition. Similarly, understanding what the patient/family hopes to avoid—uncontrolled pain, dying in the hospital—can help maximize the patient/family's unique definition of quality of life.
5. **Reframe those goals, as needed, to align with the realities of the prognosis.** If patient/family goals are unrealistic, a realignment process can be initiated with compassion by using "wish statements" (e.g., "I wish I could say that we will be able to …, but we can't. What we can do is …"). It may take time for the family to adjust emotionally to this news. Having this conversation sooner rather than later will provide maximum opportunity for the family to regroup and be empowered to come up with their own achievable goals, be they medical, or personal. It is easier to let go of curative care if there are other hopes to focus on. The hospice option is most appropriately brought up once the patient/family treatment goals are consistent with a palliative approach.
6. **Identify care/service needs, for the patient and family members.** Because many people erroneously associate hospice with "giving up" or imminent death, acceptance of the service can be facilitated by first identifying the patient's symptoms in need of palliation (pain, constipation, fatigue, sadness, anxiety). Next, looking more at the day-to-day realities of living with a serious condition, identify assistance needs such as weekly home visits to address changing symptoms, emotional or spiritual support, a home health aide to bathe and groom the patient, advice concerning financial or other community programs the patient or family may be eligible for, etc.
7. **Introduce hospice as a service that supports goals and addresses care needs.** Once the palliative needs and desired services are identified, hospice can be introduced as a program that is free—or very low cost—and designed specifically to address the patient/family's care and service needs.
8. **Respond to emotions and concerns.** Acknowledging feelings and addressing concerns is paramount before eventually making the official recommendation of hospice. Asking about any past experience or concerns about hospice offers an opportunity to dispel myths and reassert the physician's continued participation in care.
9. **Make a hospice referral.** An initial enrollment visit can be scheduled, or an "information only" visit.

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[1] *Adapted from "I'm not ready for hospice": Strategies for timely and effective hospice discussions. Annals of Internal Medicine, v146: 443-449.*