



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Educational Exchange

Series Editor: Amy A. Case, MD, FAAHPM

MVP—Medical Situation, Values, and Plan: A Memorable and Useful Model for All Serious Illness Conversations



Robert K. Horowitz, MD, FAAHPM, Laura A. Hogan, NP, and Thomas Carroll, MD, PhD, FAAHPM

Division of Palliative Care, University of Rochester Medicine, Rochester, New York, USA

Key Words

Communication, advance care planning, serious illness conversations, medical education, goals of care, doctor-patient communication, Covid-19, palliative care, mnemonics

Introduction

Serious illness conversations (SICs) are integral to the optimal care of the vast and growing population of seriously ill patients, but they are undertaught in health professions training and widely feared, delayed, or altogether avoided by clinicians.^{1–5} To redress this predicament, medical communication experts have published a variety of communication models designed to aid and promote SIC facilitation.^{6–10} We three clinician-educators are among their many beneficiaries. Yet despite their value, our experience in communication education and clinical encounters has revealed three recurring impediments to their instruction, retention, and usefulness. Although to our knowledge they have not been empirically evaluated, these pedagogic and practical weaknesses are potentially explained by both learning theory and mnemonics scholarship:^{11–15} 1) learning different communication models for different types of SICs demands multiple rounds of information recoding and consolidation into long-term memory, which may overwhelm learners' cognitive load capacity; 2) ostensibly sequential mnemonics (e.g., acronyms) that incorporate nonsequential components may burden working memory, compromise incorporation into long-term memory, and if recalled, muddle the very communication process they are designed to simplify; and 3) content that is selected to conform to a memorable mnemonic, rather than vice versa, may strain the language, increase the number and complexity of elements to be encoded and decoded, and thereby challenge retention and recall.

To overcome these limitations, we introduce MVP, a unified model for all SICs. It is designed to be readily teachable by medical educators and memorable and useful for clinicians. It comprises six essential communication elements, each of which is unambiguously either a sequential step (*MVP*—Medical situation, Values, and Plan) or a continuous skill (Empower, be Explicit, and Empathize). We have distilled these elements into a coherent visual mnemonic (**Fig. 1**) for enhanced retrieval. We hope these features make MVP a valuable contribution to the SIC toolbox, and that its strengths will inspire medical educator and clinician confidence and stimulate teaching about and facilitation of SICs whenever appropriate.

MVP: A Sequential, Fluid, and Iterative Three-Step Process

1. MVP is a sequential process (**Fig. 1**; solid arrows), each step informing the successive one: 1) seeking mutual understanding of the Medical situation, 2) exploring patient Values, and 3) defining a goal-concordant Plan.

M—*Medical Situation*. Every SIC depends on the patient or family achieving the best possible understanding of the relevant illness(es), available treatment options, and prognoses (i.e., life span-, functional-, and/or symptom prognosis). Although clinicians are often hesitant to share bad news with patients, nearly all seriously ill patients want to know at least the basic features of their illness, and most want to discuss prognosis.^{16,17} This understanding is fundamental to informed decision making, optimal personal autonomy, and patient and

Address correspondence to: Robert K. Horowitz, MD, Division of Palliative Care, University of Rochester Medicine, Box 687, 601 Elmwood Avenue, Rochester, NY 14642, USA. E-mail: robert_horowitz@urmc.rochester.edu

Accepted for publication: July 21, 2020.

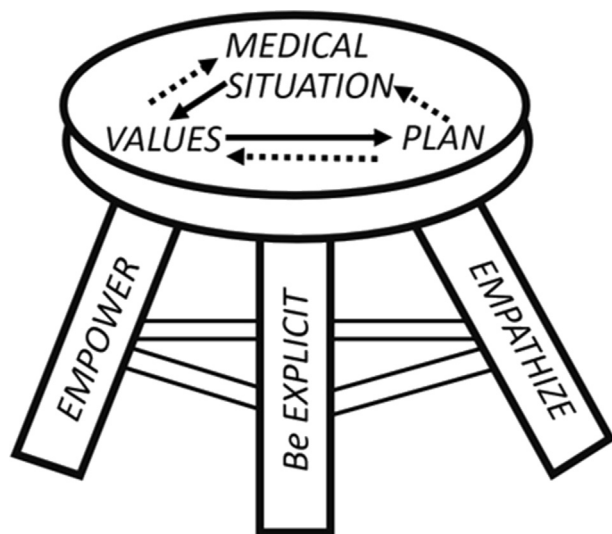


Fig. 1. MVP (Medical situation, Values, and Plan) is a sequential, fluid, and iterative three-step process for all serious illness conversations, resting on three interrelated core communication skills, as represented by this three-legged stool.

family satisfaction with the chosen plan. To the extent that situational urgency allows, the provision of this information should be calibrated to patient and family interest and preferences to enhance its assimilation amidst extraordinarily stressful circumstances.^{18,19}

V—Values. This step explores the patient’s beliefs, goals, priorities, ideology, narrative, hopes, fears, and communicational, informational and decision-making preferences.²⁰ Patient values may be general (i.e., inherent and overarching)²¹ or contextual (i.e., acquired through lived experience),²² both of which are relevant in defining treatment preferences. That is why the Values step follows the Medical situation step; contextual values can only be meaningfully explored when the extant medical situation is understood. In addition, the Values step mitigates the influence of physician values and biases by highlighting the patient’s story, character, and experience. Knowledge of the patient’s values in the unique context of their current medical situation informs the third step, Plan.

P—Plan. A goal-concordant plan integrates the first two steps of the MVP process, and so it necessarily follows them in sequence. That is, it honors the patient’s values in the context of their current medical situation. Notably, a goal-concordant plan may emphasize the communication process itself (the conversation plan), rather than the medical care plan. For example, a “bad news” conversation may be redirected from a distressing exploration of treatment options to a thoughtful deliberation about when and with whom to reconvene the discussion at a later time. The

integrity of either plan is ultimately proportionate with the clinician’s skillful inquiry into and advocacy for the patient’s and family’s perspective in the face of serious illness and deliberation about it.²³

2. MVP is also a fluid and iterative process (Fig. 1; dashed arrows), because SIC starting and ending points can defy expectations and ultimately are discerned through the SIC itself. Accordingly, MVP supports a fluid response to the unpredictable progression of complicated discussions. Although the three steps and three skills are relevant to all types of SICs, their relative emphasis will vary and may intentionally be adjusted in response to the unfolding of the conversation. For example, if a meeting to define the optimal goal-concordant plan (the “P” step) reveals that the patient is counting on an unavailable or futile treatment option, then the clinician should re-explore relevant aspects of the medical situation (the “M” step). This move transforms the conversation from a “goals of care” SIC focused on treatment planning into a “serious news” SIC revealing and exploring heretofore ambiguous diagnostic, treatment, or prognostic information. Note that the MVP model still applies; the change in SIC focus calls not for deploying a different SIC model, but rather for a pivot within MVP. MVP is also iterative, because many SICs will not achieve clarity and closure in a single cycle but instead over a series of them, depending on clinical urgency, patient and family age, developmental, and attentional factors, and participants’ time-, cognitive-, and emotional resources.

MVP is Supported by Three Core Communication Skills

The three core communication skills of MVP (Fig. 1; legs of the stool) are interrelated (the rungs between the legs) and used continuously throughout each step of every SIC:

Empower. An effective SIC requires the clinician to honor patient and family autonomy and personhood by ensuring their assent to answering questions and receiving information; tailoring that information to their needs, abilities, and preferences, as well as the situational urgency; valuing and learning their history and experience; informing them to the extent possible, reasonable and desired; and ensuring their centrality to the shared decision-making process.^{24,25} Clinicians do not empower patients by simply supplying them information or neutrally encouraging them to select from a menu of options. Rather, the empowering clinician seeks to understand patient and family values in the context of the medical situation and then engages

with them to actively and intentionally explore, name, and advocate for the optimal means of transforming these into an action plan.^{26–29} Importantly, in some cases, empowering a patient means honoring their preference to surrender decision-making agency to a surrogate or even to bow out of the SIC entirely.

Be Explicit. The crucial clinician skill of being explicit involves sharing information honestly, precisely, and concisely. This direct approach runs counter to the common practices of sharing copious details (to ostensibly “fully inform” patients),³⁰ hedging, changing the subject, and equivocation.^{31,32} Such attempts to “protect” patients (or ourselves) by sharing more data, evading and euphemizing impose enormous costs: patient, family, and clinician emotional and cognitive exhaustion, patient and family confusion and frustration, deferred discussions and decisions, and ultimately more time expended in subsequent corrective discussions. When being explicit, a clinician should also empower by tailoring the extent of detail sharing to the patient’s receptivity, comprehension, tolerance, and informational preferences.

Empathize. Emotions are fundamental to understanding and relating with patients and families, enhancing trust, and informing a meaningful response.^{20,33} Consequently, effective SICs require that clinicians continuously empathize, by which we mean anticipate, appreciate, validate, and explore the emotions the conversations evoke.^{34–37} Although strong patient emotions are uncomfortable for most clinicians, it is neither empathic nor productive to comfort patients or family members by avoiding, minimizing, or suppressing them. On the contrary, strong emotions are to be expected, and they may actually be evidence of clinician authenticity, skill, and compassion. Importantly, despite our encouragement to empathize continuously, this skill too should be calibrated to patient and family preferences and clinical circumstances; some people simply do not welcome “feeling talk”, and some clinical decisions must be made so emergently that expressions of empathy need to be compressed (Fig. 2).

MVP Memorability and Usability

To assess how memorable and useful MVP is, we surveyed all third-year medical students who participated in a mandatory five-day course which comprised a series of SICs.³⁸ They were instructed in the MVP model in an introductory 30-minute presentation and were encouraged to incorporate it into their encounters with standardized patients. Two successive daily learning objectives were to disclose a serious illness diagnosis and to facilitate a discussion to define a goal-concordant treatment plan.

During the two weeks after the course, we surveyed all 97 students using the REDCap tool (Research Electronic Data Capture), Version 9.9.2, a secure electronic survey platform developed by Vanderbilt University (Nashville, TN). We promised confidentiality to encourage respondents to answer honestly via an automated electronic email with an embedded link to the survey, and up to two weekly reminders for nonresponders. All data were deidentified.

We asked the students to rate on a five-point Likert scale how memorable and useful MVP is for difficult conversations. We achieved a response rate of 100%. Nearly nine of 10 (88%) learners rated the MVP mnemonic moderately to very memorable, and the vast majority (95%) rated MVP as moderately to very useful. When asked what each letter stands for, 75% named all three steps correctly, and 90% named at least two of the three correctly.

These results suggest an immediate and accurate learner perception of MVP’s memorability and, informed by experience, its usefulness. Further study is underway to determine whether MVP’s memorability and usability are similarly positive across the range of multidisciplinary clinician learners at all levels of training and experience. In addition, we will explore whether MVP’s memorability and usability are durable, and, if there is time-linked attrition, whether it can be attenuated with longitudinal support and content reinforcement.

Reprise: MVP for COVID-19

During the completion of this article, the coronavirus disease 2019 (COVID-19) pandemic introduced unprecedented possibilities into the domain of SICs, including a surge of telephone SICs and video SICs as well as SICs about potential resource limits. In response, the authors, T. C. and R. K. H., developed a COVID-focused MVP workshop, which we rapidly disseminated across our medical center. We will describe the teaching format in a forthcoming publication. Fig. 3 is the trifold pocket card we produced to both teach the MVP model and demonstrate potential MVP-informed clinician statements during four hypothetical COVID-specific conversations. Note the applicability of the MVP model to the range of SIC types, including those focused on disclosing serious news and those focused on defining a goal-concordant plan.

Conclusion

MVP is a unified model for facilitation of all SICs. It comprises three sequential, fluid, and iterative steps and three core communication skills, all is encapsulated into a coherent visual mnemonic for pedagogic clarity, memorability, and usefulness. It



Medical Situation

- I'd like to discuss some difficult information with you, okay?
- Before I share the details, it will help me to know what you understand about the disease.
- I'm afraid I have some bad news...
- The treatment isn't working, and another round of therapy probably won't help you live longer or feel better.
- I can see this is hard to hear.
- I wish we had better options.

Values

- Given your medical situation, what matters most to you? What are you hoping for?
- Let me see if I understand. You value ... (ex. *quality over length of life...OR...doing everything to live another day... OR...*).
- Did I hear you right?
- I appreciate how much you want to be here for your family.
- Who is your backup (HCP) if you can't speak for yourself?

Plan

- Now that I understand your values, I'd like to offer a recommendation, okay?
- Given what you've told me, I recommend that we...(ex. *take resuscitation off the table, and treat your symptoms at home...OR...offer a time-limited ventilator trial...OR...*).
- Yes, anyone would find this discussion difficult.
- Does my recommendation make sense? What do you think?
- OK, now let's complete 2 forms (HCP, POLST) to be sure your medical team knows and honors your wishes, okay?
- It's an honor to work with you. You've done a great job taking care of yourself, and your family.

Fig. 2. MVP: putting it all together. Possible clinician statements during a hypothetical serious illness conversation about the progression of an unnamed disease. Each illustrates how throughout the three MVP steps a clinician might employ the three core communication skills (Empower, be Explicit, and Empathize), which are gray-scale coded to the legs of the stool. Patient responses are intentionally omitted. MVP = medical situation, values, and plan; HCP = health care proxy; POLST = physician orders for life-sustaining treatment.

is quickly learned, accurately recalled, and usefully deployed in the unpredictable, stressful, and high-stakes unfolding of SICs. We hope these features, as well as its comprehensiveness and adaptability, will encourage its incorporation into medical communication education. More importantly, we hope that once it is learned, clinicians will welcome it into their conversational armamentarium, thereby easing and advancing the facilitation of SICs for the vast and growing population of seriously ill patients and their families.

Disclosures and Acknowledgments

Authors R. K. H. and T. C. dedicate this article to the memory of their coauthor, clinical teammate,

fellow teacher, and friend, nurse practitioner, Laura Hogan, who died during its writing. Laura told us with delight how well MVP served her during her final hospitalization. She described applauding her oncologist's skill and empathy when he shared the bad news of her cancer relapse. He humbly responded that he had just completed our medical center's Advanced Communication Training course, in which he learned MVP. Laura smiled, took a deep breath, and informed him with tears in her eyes, "I am one of the creators of that course, and I'm so glad it helped." He then paused, took a breath, and with tears in his eyes thanked her for being his teacher. The authors thank Laura for being their teacher too.

Many thanks to our friends and colleagues who reviewed this work and offered their wise perspective and substantial assistance in refining it: Sue Ladwig,

1. CONVENTIONAL SCENARIO
Proactive advance care planning

Medical Situation

COVID is on many people's minds, and I think it is important to discuss with you, OK?

What have you been thinking about COVID?

I am hopeful you won't get COVID, but I am concerned...

... if you do get COVID it could be serious, and potentially life-threatening.

Yes, this is a scary situation. Talking about it now will help us and your family honor your wishes if you do get COVID.

Values

Given your medical situation, what would matter most to you if you were to get severely ill?

If I hear you right, you value... (ex., *quality over length of life...OR...doing everything to live another day... OR...*)

Did I hear you right?

Who is your backup (HCP) if you can't speak for yourself?

I admire your courage in discussing this hard stuff.

Plan

Now that I understand your values, I'd like to offer a recommendation, okay?

If your breathing deteriorates I suggest we... (ex., *take resuscitation off the table, and treat your symptoms at home...OR...offer a time-limited ventilator trial...OR...*)

Does this make sense? What do you think?

Let's complete 2 forms (HCP, MOLST) to make sure we and the medical team honor your wishes fully, okay?

Yes, this is hard. You've done a great job taking care of yourself, and your family.

2. CONTINGENCY SCENARIO
Acute planning, potential ventilator limit

Medical Situation

I'd like to discuss some difficult information with you, OK?

What do you understand about COVID?

Given your serious illness, if this is COVID and you need a ventilator, it is likely you will die, with or without one.

Yes, this is scary. Anyone would be scared to hear this.

I'm afraid that in this crisis there may not be enough ventilators for everyone who would otherwise want one.

I agree. I also hope you don't have to face this possibility.

Values

Given what you've heard, what are you thinking? What are your worries? What are you hoping for? What else?

Let me see if I understand. You're saying... (EX: *quality of life is more important to than length of life... OR... you want anything that might help you live longer... OR...*), right?

I can see how hard this is to imagine.

Who would help make medical decisions if you were too sick to speak for yourself?

I appreciate your openness to discussing these things.

Plan

Now that I understand your values, may I make a recommendation?

Given what you told me, I recommend... (EX: *whatever happens, we focus on comfort and say 'no' to CPR and a ventilator... OR... we provide everything to try to keep you alive, including CPR and a ventilator if needed... OR...*)

How does that sound to you? What do you think?

I'll document your wishes to make sure they are honored.

I admire your willingness to discuss these things. This will lighten your family's load in case of an emergency.

3. CRISIS SCENARIO/EARLY
Acute planning, actual ventilator limits

Medical Situation

I'm afraid I have some difficult news to share. (Pause)

This crisis has depleted our ventilator supply, and there aren't enough for everyone who wants one. So we are applying expert guidelines to everyone, and because of your severe illness, you won't be able to be treated with a ventilator.

I can see this is hard to hear. I wish we had more too.

I'd like to discuss what we can do for you, okay?

We will treat your shortness of breath. We can focus all of our energy on your comfort. We can also provide other treatments to try to keep you alive, but I am concerned that even so, you will probably die.

Yes, anyone would be angry to be denied what they want.

Values

Given what you've heard, if you do get sicker, or appear likely to die, what would you hope for? What are you thinking? What are your worries?

If I hear you right, you would want... (EX: *to be as comfortable as possible until you die...OR...every treatment that could possibly keep you alive...OR...*). Do I understand?

Yes, this is a horrible situation, and it isn't fair.

Plan

Now that I understand your values, I'd like to offer a recommendation, OK?

I recommend that we... (EX: *devote all our efforts to ease your breathing and other discomfort...OR...provide the IVF and meds to try keeping you alive longer... OR...*).

Does that make sense?

OK, let's complete 2 forms (HCP and POLST) so that we can document and honor your wishes.

I can see why this makes you angry.

3 steps

1. Medical Situation
Seek mutual understanding of:

- Illness(es)
- Prognoses
- Treatment options

2. Values
Explore patient & family:

- Priorities
- Hopes
- Worries
- Preferences

3. Plan
Define goal-concordant care

- Conversation plan
- Treatment plan

3 communication skills

A. Empower

- Ask first
- Listen
- Calibrate

B. be Explicit

- Share the facts
- Precisely
- Concisely

C. Empathize

- Expect & respond to emotion

MVP for COVID-19

Steps, skills, tips and scripts to facilitate conversations about COVID-19

MVP is a 3-step sequential, fluid process, supported by 3 core communication skills, to guide serious illness conversations

Horowitz R, Hogan L, Carroll T 2020

4. CRISIS SCENARIO/LATE
Discontinuing a desired ventilator

Medical Situation

Phone call to surrogate

I have some serious news about your father. (Pause)

I'm afraid because your dad is not improving, the guidelines require that we stop his ventilator. He will probably die within minutes, maybe hours, unlikely longer.

I can only imagine how hard this is to hear.

I want you to know that I believe (if sincere) that even with the ventilator, he would die soon.

Yes, I can see why you feel like we're killing him.

We can continue the other treatments to try to keep him alive, but I don't think they'll help, and they won't make him feel better.

Values

Given things as they are, what would your dad say now?

What would be important to him?

Let me see if I understand. You're saying... (EX: *he'd be mad as hell, and would want to go down fighting...OR he'd say he's had a good life, and it's only right that the ventilator go to someone who will benefit...OR...*) Right?

I hear your grief; I really wish things were different.

Plan

Now that I understand your father's values in this unprecedented situation, I'd like to suggest a plan, OK?

I recommend that we use medicine to make him comfortable, then stop the ventilator and... (EX: *continue everything else to try to keep him alive longer... OR...focus entirely on keeping him comfortable as he dies...OR...*)

What do you think about this plan?

I'm sorry you and your Dad are in this crisis predicament.

I promise to honor his wishes and dignity.

Fig. 3. MVP for COVID-19: trifold pocket card. This six-panel trifold card was provided to participants in a COVID-focused MVP workshop. Each panel is lettered a–f in the top right corner, in order of appearance when after cutting the horizontal dotted line, the lower 3 panels are apposed to the back of the top three, and the entirety is folded along the dotted lines such that Panel a is the front and Panel b is the back. Panel a illustrates the MVP three-legged stool visual mnemonic. Panel b depicts MVPs' three-step process and three core communication skills. Panels c–f portray MVP-informed clinician statements during hypothetical COVID-specific serious illness conversations regarding c) proactive advance care planning grounded in worry amidst the COVID pandemic; d) treatment goals for a sick patient considering the possibility of serious COVID infection; e) a seriously ill patient with respiratory failure and unavailability of or ineligibility for a desired ventilator; and f) discontinuation of a desired ventilator. Each illustrates how throughout the three MVP steps of the conversation a clinician might employ the three core communication skills (empower, be explicit, and empathize), which are gray-scale coded to the legs of the stool. MVP = medical situation, values, and plan; COVID-19 = coronavirus disease 2019; HCP = health care proxy; MOLST = medical orders for life-sustaining treatment; CPR = cardiopulmonary resuscitation; IVF = intravenous fluid; POLST = physician orders for life-sustaining treatment.

MPH; Tim Quill, MD; Bob Holloway, MD; Benzi Kluger, MD, MS; Geof Williams, MD, PhD; and Ron Epstein, MD. We are also most grateful for the enthusiasm and generosity of the many multidisciplinary clinician learners who helped us adapt and refine MVP during two years and countless iterations.

This article was reviewed and deemed exempt by the institution's Research Subjects Review Board. The authors declare no conflicts of interest.

References

- Horowitz R, Gramling R, Quill T. Palliative care education in U.S. medical schools. *Med Educ* 2014;48:59–66.
- Fulmer T, Escobedo M, Berman A, et al. Physicians' views on advance care planning and end-of-life care conversations. *J Am Geriatr Soc* 2018;66:1201–1205.
- Quill TE. Perspectives on care at the close of life. Initiating end-of-life discussions with seriously ill patients: addressing the “elephant in the room”. *JAMA* 2000;284:2502–2507.
- Keating NL, Landrum MB, Rogers SO Jr, et al. Physician factors associated with discussions about end-of-life care. *Cancer* 2010;116:998–1006.
- Mack JW, Cronin A, Keating NL, et al. Associations between end-of-life discussion characteristics and care received near death: a prospective cohort study. *J Clin Oncol* 2012;30:4387–4395.
- Baile WF, Buckman R, Lenzi R, et al. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist* 2000;5:302–311.
- Bhang TN, Iregui JC. Creating a climate for healing: a visual model for goals of care discussions. *J Palliat Med* 2013;16:718.
- Childers JW, Back AL, Tulsy JA, Arnold RM. REMAP: a framework for goals of care conversations. *J Oncol Pract* 2017;13:e844–e850.
- Ajayi TA, Shaw D, Edmonds KP. Feasibility and effectiveness of a mnemonic approach to teach residents how to assess goals of care. *J Palliat Med* 2019;22:696–701.
- The complete guide to communication skills in clinical practice. MD Anderson. Available from <https://www.mdanderson.org/education-training/professional-education/i-care.html>. Accessed April 15, 2020.
- Szulewski A, Howes D, van Merriënboer JGG, Sweller J. From theory to practice: the application of cognitive load theory to the practice of medicine. *Acad Med* 2020 <https://doi.org/10.1097/ACM.0000000000003524>.
- Bellezza FS. Mnemonic devices and memory schemas. In: McDaniel MA, Pressley M, eds. *Imagery and related mnemonic processes*. New York: Springer, 1987.
- Baddeley A. Working memory: the interface between memory and cognition. *J Cogn Neurosci* 1992;4:281–288.
- Baddeley A. Working memory. *Science* 1992;255:556–559.
- Kirschner PA, Sweller J, Kirschner F, Zambrano RJ. From cognitive load theory to collaborative cognitive load theory. *Int J Comput Support Collab Learn* 2018;13:213–233.
- Clayton JM, Butow PN, Arnold RM, Tattersall MH. Discussing life expectancy with terminally ill cancer patients and their carers: a qualitative study. *Support Care Cancer* 2005;13:733–742.
- Steinhauser KE, Christakis NA, Clipp EC, et al. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;284:2476–2482.
- Weeks JC, Cook EF, O'Day SJ, et al. Relationship between cancer patients' predictions of prognosis and their treatment preferences. *JAMA* 1998;279:1709–1714.
- Mack JW, Weeks JC, Wright AA, Block SD, Prigerson HG. End-of-life discussions, goal attainment, and distress at the end of life: predictors and outcomes of receipt of care consistent with preferences. *J Clin Oncol* 2010;28:1203–1208.
- Ubel PA, Angott AM, Zikmund-Fisher BJ. Physicians recommend different treatments for patients than they would choose for themselves. *Arch Intern Med* 2011;171:630–634.
- Sudore RL, Lum HD, You JJ, et al. Defining advance care planning for adults: a consensus definition from a multidisciplinary Delphi panel. *J Pain Symptom Manage* 2017;53:821–832.e1.
- Fischhoff B, Barnato AE. Value awareness: a new goal for end-of-life decision making. *MDM Policy Pract* 2019;4:2381468318817523.
- Macauley R. Patients who make “wrong” choices. *J Palliat Med* 2011;14:13–16.
- Jacobsen J, Thomas J, Jackson VA. Misunderstandings about prognosis: an approach for palliative care consultants when the patient does not seem to understand what was said. *J Palliat Med* 2013;16:91–95.
- Weisman AD, Worden JW. The existential plight in cancer: significance of the first 100 days. *Int J Psychiatry Med* 1976;7:1–15.
- Ikonomidis S, Singer PA. Autonomy, liberalism and advance care planning. *J Med Ethics* 1999;25:522–527.
- Johnson SB, Butow PN, Kerridge I, Tattersall MHN. Patient autonomy and advance care planning: a qualitative study of oncologist and palliative care physicians' perspectives. *Support Care Cancer* 2018;26:565–574.
- Virdun C, Lockett T, Davidson PM, Phillips J. Dying in the hospital setting: a systematic review of quantitative studies identifying the elements of end-of-life care that patients and their families rank as being most important. *Palliat Med* 2015;29:774–796.
- Fleuren N, Depla M, Janssen DJA, Huisman M, Hertogh C. Underlying goals of advance care planning (ACP): a qualitative analysis of the literature. *BMC Palliat Care* 2020;19:27.
- Carson SS, Cox CE, Wallenstein S, et al. Effect of palliative care-led meetings for families of patients with chronic critical illness: a randomized clinical trial. *JAMA* 2016;316:51–62.
- Ahluwalia SC, Levin JR, Lorenz KA, Gordon HS. Missed opportunities for advance care planning communication during outpatient clinic visits. *J Gen Intern Med* 2012;27:445–451.

32. Lee SJ, Back AL, Block SD, Stewart SK. Enhancing physician-patient communication. *Hematology Am Soc Hematol Educ Program* 2002;464–483.
33. Pearson SD, Raeke LH. Patients' trust in physicians: many theories, few measures, and little data. *J Gen Intern Med* 2000;15:509–513.
34. Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA* 2008;300:1665–1673.
35. Nubling G, Allmendinger S, Lorenz S. Drug therapy of anxiety and fear in palliative care patients with cancer or other illnesses. A systematic review. *Schmerz* 2012;26:537–549.
36. Miovic M, Block S. Psychiatric disorders in advanced cancer. *Cancer* 2007;110:1665–1676.
37. Jones L, Harrington J, Barlow CA, et al. Advance care planning in advanced cancer: can it be achieved? An exploratory randomized patient preference trial of a care planning discussion. *Palliat Support Care* 2011;9:3–13.
38. Denney-Koelsch EM, Horowitz R, Quill T, Baldwin CD. An integrated, developmental four-year medical school curriculum in palliative care: a longitudinal content evaluation based on national competency standards. *J Palliat Med* 2018; 21:1221–1233.