"I Wish Things Were Different": Expressing Wishes in Response to Loss, Futility, and Unrealistic Hopes

Physicians who care for patients encounter many powerful and painful emotions, including anger, sadness, fear, grief, loss, hopelessness, and blame. Many studies suggest that physicians should express empathy in response to emotion-laden patient statements to ensure that patients feel listened to and understood. These physician responses usually consist of efforts to comprehend how things feel to the patient and to express that understanding back to the patient (1–8).

Situations that evoke loss, guilt, or hopelessness are particularly hard for physicians to respond to empathically. Physicians who think that they have failed a dying patient and who fear depriving the patient of hope may respond by avoiding the topic entirely, by overcompensating with overtreatment, or by apologizing for not "saving" the patient. When a patient expresses overwhelming anger or disappointment with limitations in medicine, physicians may be afraid that any explicit response to the patient's emotion may be construed as evidence of their failure, mistake, or inadequacy.

In these challenging situations, we have observed that many physicians attempt to respond empathically by stating "I'm sorry." This well-intentioned response, although frequently appropriate, may be misinterpreted and misdirected. We have found that saying "I wish . . . (things were different)" to the patient and family is a more effective initial response. We explicate some of the challenges of saying "I'm sorry" and explore the potential benefits of joining with patients and families and saying "I wish . . ." in specific, difficult clinical scenarios.

The Challenges of Physicians Stating "I'm Sorry"

"I am so sorry that this happened to you."

"I'm sorry . . . " is generally intended as an empathic expression of sorrow that acknowledges and shares in feeling the sadness and unfairness of the patient's situation. By expressing sorrow, clinicians show themselves to be human beings with feelings of connection to the patient (9)—the patient's situation has touched them as a person. The clinician, patient, and family are all having similar reactions and see the patient's circumstances in a similar emotional light. Without such expressions, the patient and family might be left wondering how the clinician was reacting to the patient's experience.

Meanwhile, stating "I'm sorry . . . " is potentially problematic for physicians for four reasons.

Confusion with Sympathy or Even Pity

Although sympathy is often an expression of close emotional identification with the patient's feelings (8), it can also put the clinician and patient on very different planes in terms of emotion and power (*I feel sorry for you*). In this context, the patient may hear pious or moral overtones in the physician's expression of sympathy (*I pity you*) (10, 11). For an expression of sorrow to seem empathic, clinicians must convey that they can imagine what it must be like to walk in the patient's shoes (*I feel sorrow with you*).

Shortcutting a Deeper Understanding

When a patient first makes a statement that suggests extreme loss or hopelessness (*I don't know if I can go on*), expressions of sorrow by clinicians may limit further exploration. On the other hand, if the physician precedes or follows the patient's statement with an exploratory inquiry (*Tell me the most difficult part*) and carefully listens to the patient's experience and concerns, then an expression of sorrow might be very appropriate.

Confusion with Apologies

The meaning of saying "I'm sorry . . . " can be very different if an error (perceived or real) in the patient's medical care has occurred. Expressions of sorrow in these circumstances are potentially apologies (*I am sorry that I contributed to your suffering*) and may imply or even be followed by an explicit request for forgiveness (*I hope that you can forgive me for my role in what happened*). These statements become more complex than basic expressions of empathy because the clinician may indeed be "asking something of" the patient (forgiveness) in addition to "feeling with" him or her. After a medical error has occurred, the patient and clinician must explicitly decide if the patient still trusts the clini-

cian enough to continue working together through the next phase of the patient's illness.

Physicians too may confuse sorrow with apology. When faced with dying patients, physicians may question their every decision, by wondering what they could have done differently and what responsibility they have for the progression of the disease. This attitude surfaces in morbidity and mortality conferences, at which every death is considered preventable if medical decisions are examined closely enough. It is also reflected in the common reaction physicians have to being told by deceased patient's families that they did a good job (*If I really did a good job, your loved one would not have died*).

When patients express anger or frustration with limitations in medicine, physicians may feel guilt that they cannot do more to treat the patient's condition. In such circumstances, stating "I'm sorry" may express both sorrow and apology. Patients who feel angry and frustrated by their increasing disability and future losses are unlikely to offer forgiveness. Consequently, the physician may feel more frustrated than empathetic (*I told her that I was sorry. What more does she want?*).

Changing the Subject from Patient and Family to Physician

Because "I'm sorry" describes the physician's feelings rather than the patient's, the focus may shift away from the patient. As a result of the ambiguity between "sorry" and apology, the patient or family may even feel obliged to comfort the physician. A brief exchange can illustrate this problem:

Physician: I'm sorry.

Family: It's okay, doctor; you did the best you could.

Physician: I know it is not my fault, but I still feel badly.

Empathic statements by clinicians should focus on rather than distract from the loss of the patient and family.

THE SIGNIFICANCE OF SAYING "I WISH . . . "

I wish we had more effective treatment for your condition.

I wish I had some other kind of news to give you.

I wish things had turned out better for you.

Wishes stated by clinicians in the medical interview are first and foremost expressions of empathy. The clinician, along with the patient and family, wishes that circumstances were different and simultaneously acknowledges the emotional impact of the loss (12, 13). By expressing wishes, clinicians temporarily suspend their role as scientists and medical experts and respond as human beings faced with overwhelming circumstances that are not of their own choosing. The expression allows the clinician to temporarily walk in the patient's shoes and identify with the unrealistic hope that the reality could be changed.

By expressing a wish, one is not saying that the desired outcome will happen. In fact, wish statements underscore that the desired outcome is unlikely to occur. This expression is very different when one says something hopeful that may not be connected to reality (*I hope we can find effective treatment for your condition*). Whether such statements represent true or false hope depends on the genuineness of the statement and whether effective treatments are realistically available (14). The treating physician should avoid such hopeful statements unless there is a reasonable chance of finding a treatment. Instead, a statement of wish should acknowledge the hope yet simultaneously convey that a successful treatment is unrealistic (*I wish we had more effective treatment for your condition*). Statements in the form of wishes acknowledge the limited control that the clinician has over certain medical matters and the regret that medicine and physicians are not more powerful and effective.

Expressing wishes allows the clinician to enter the patient's world, to defuse potential conflict about medicine's limitations, and to get on the same side of the fence with the patient and family. However, because such statements do not specify what *can* be done for the patient, expressions of wish are only the beginning of a conversation (15). When used to enhance the therapeutic process, statement of wish can initiate a deeper level of conversation. The patient might be invited to share sadness and loss more fully by being asked questions such as *What has been the hardest part?* or *As you look to the future, what is your biggest worry?* (16, 17). The clinician can then begin to address some of these concerns and reaffirm a commitment to face the future with the patient and family no matter what happens (15).

After the wish and disappointment have been explored fully, the patient, family, and clinician must begin to search together for hope and a new direction that are consistent with the patient's clinical condition and values. Medicine's ability to cure or control a patient's disease is but one avenue of hope. The search for hope in other dimensions may include living with the disease rather than curing it, exploring experimental therapy that has not yet been shown to be efficacious, being free of pain or symptoms, achieving closure with family members, exploring spiritual or religious issues, or exploring personal short-term goals (18, 19).

REPRESENTATIVE CLINICAL SCENARIOS IN WHICH PHYSICIANS MIGHT EXPRESS WISHES

Delivering Very Bad News

After telling a patient that his cancer has returned despite experimental therapy, a clinician said, *I wish I had some other kind of news to give you.* Such a statement, initiated by the physician, is an expression of sorrow about the patient's situation and a wish that the clinical reality were different. The physician is responding as a human being and identifying feelings that the patient is likely to simultaneously have.

Responding to Unrealistic Hopes from Patients and Families

A patient who is dying of advanced adenocarcinoma said, *I want to stay alive until my daughter graduates from college.* The clinician responded, *I wish I could promise you that.* After a pause, she might add, *It must be very hard to contemplate missing out on your daughter's future.* This patient had a genuine, easily understandable wish that he knew, at some level, was unrealistic. The clinician felt hard pressed to respond to what seemed like a trial balloon without removing hope and feared unearthing hopelessness and despair by directly confronting the patient's hopes. Yet, she did not want to reinforce false or unrealistic hopes. By reframing the hope as a wish and then acknowledging the tragedy of his situation, the clinician could join with the patient and share his sadness. After fully exploring his grief and acknowledging the reality that his death was probably coming sooner rather than later, the clinician and patient brainstormed together about ways in which the patient could be present for his daughter at graduation. The patient eventually made a videotape for his daughter that she could play on her graduation day, in which he expressed his feelings and aspirations for her future.

Responding to Expressions of Loss, Grief, or Hopelessness

On hearing that her spouse of more than 50 years died suddenly of a myocardial infarction, a woman said, *I don't see how I can go on.* The clinician responded, *I wish I could give you a simple formula for how to proceed, but I will work with you to find a way through this.* The clinician had several choices about how to respond to this patient's statement of hopelessness. He could have evaluated the patient's potential for suicide or given her a list of reasons to continue living, both of which might be appropriate sometime in the future. Instead, he chose to empathize with the patient's enormous loss by acknowledging the shared wish for the type of simple answers that were clearly unavailable. This wish statement was followed by an explicit expression of commitment to face the future together. The patient felt understood and less alone, which was critical at this juncture, and appreciated having a medical partner she could count on to help her find a way to proceed.

Responding to Disappointment in the Physician or in the Limits of Medicine

As he witnessed the relentless downhill course of his wife's amyotrophic lateral sclerosis (ALS), a man asked, *Can't you doctors do more to treat this illness?* The physician responded, *I wish we could do more and that medicine had better answers for ALS.* This husband's statement might have several meanings, including blaming the physicians for not providing adequate treatment or feeling frustration about the limitations of medicine. Often, patients, families, and even clinicians are unsure whether the limits they are confronting are those of the particular clinician or of medicine in general (20). Cognitive responses regarding the limitations of medicine do not acknowledge the emotional unfairness the husband may be feeling. The clinician must let the husband know that she too feels the unfairness of the medical limitations. The clinician and husband had the same wishes, so they were now able to join together and lament the medical limitations in this situation.

Table. **Representative Clinical Scenarios in Which Expressions of Wishes Might Be Appropriate**

Clinical Scenario	Sample Responses
Delivering very bad news	*I wish I had better news to give you.*
Responding to unrealistic hopes from a patient or family	*I wish that were possible. It sounds like all of us would be a lot happier if that were so.*
Responding to expressions of loss, grief, and hopelessness	*It sounds like a terrible loss for you. I wish it hadn't turned out this way.*
Responding to disappointment in medicine or the physician	*I can understand how disappointing this is for you. I too wish we had been able to do more for your mother.*
Responding to demands for aggressive treatment when prognosis is very poor	*It must be very hard to come to the intensive care unit every day and see so little change. I wish medicine had the power to turn things around.*
Responding to medical complications or errors	*This is so hard for you—just when our hopes were so high, for her to have this complication. I wish it had been otherwise.*

Responding to Demands for Aggressive Treatment When Prognosis Is Very Poor

The family of a patient with a massive intracerebral hemorrhage wanted "everything possible done" because they remained convinced that their father could get better even after the physician had explained in detail the patient's poor prognosis. Instead of reiterating the patient's extremely poor medical prognosis, the physician stated, *I wish we had treatments that could turn things around and allow him to wake up.* In this situation, the physician was afraid of giving "false hope" or promoting unrealistic beliefs, but he also wanted the family to know that he empathized with their loss and understood their hopes. Because the clinician could not realistically share their hopeful thinking, he reframed their hope for a full recovery as a wish. Doing so allowed the clinician to join in the family's aspirations while simultaneously acknowledging that the desired outcome is extremely unlikely. The clinician can then build subsequent conversation on the family's response to this beginning phase of exploration. If the clinician encourages decision making about treatment withdrawal too soon without acknowledging the enormous emotional impact of the loss and without first understanding their view of the patient's clinical situation, conflict often ensues. Many problems between clinician and family can be averted if families feel better understood and respected (21).

Responding to Medical Complications or Errors

A patient developed a pneumothorax and required a chest tube and hospitalization after diagnostic thoracentesis. After the patient was stabilized, the clinician who performed the procedure said, *I am very sorry you had this complication. I wish it hadn't happened, but I will work carefully with you to make sure we make the best out of the situation.* Medical complications are expected bad outcomes that occur in relatively few patients who receive a treatment that has been performed properly. They are distinct from medical errors, in which a significant mistake in technique or delivery unnecessarily puts the patient at risk (22). When an error has occurred, the physician clearly must apologize—and be forgiven—before adequate trust can be maintained to move forward (otherwise, the patient may need to change physicians or medical teams). Because medical complication results from a properly performed intervention instead of a physician's mistake, the clinician may express sorrow that the complication happened but not necessarily ask for forgiveness. It is important to listen carefully to the patient's response and not become defensive or engage in a debate about blame. Instead, statements in these circumstances should emphasize a willingness to work together and to do one's best.

LIMITATIONS OF "WISH" EXPRESSIONS

Expressions of wishes have limited effect if they are not preceded by or followed up with further exploration of additional patient reactions and feelings and with reaffirmation of a continuing commitment to face the future together. Although we encourage clinicians to experiment with "I wish . . . " expressions in circumstances such as those in the **Table**, clinicians should always use their own instincts and not rely on such statements if they do not genuinely reflect their inner feelings. Expressions of wishes by clinicians have the potential to defuse tense situations and provide opportunities to share reactions with patients and families, but they may also elicit deeper feelings of anger, hopelessness, or blame that need further attention. Tapping into these emotions is not necessarily problematic because the patient's feelings obviously already exist at some level, but the clinician must be prepared to engage with these strong emotions, once they have been elicited. Wishes potentially acknowledge a reality that the patient and

family may not be prepared to face—that their desired outcome will not happen.

Despite these potential limitations, expressing wishes has the power and potential to humanize the medical encounter in some of its most challenging moments. Such statements can help clinicians and patients to share a similar emotional stance to the patient's condition and yet at the same time tacitly acknowledge the difficult realities of the patient's prognosis. When clinicians feel at a loss about how to react to a patient's questions or statements, one can consider a response that explores the underlying emotion. When the emotion is unrealistic hope, loss, futility, or grief that seems overwhelming or otherwise very difficult to address, physicians should consider joining with the patient and family in the expression of a wish that their circumstances were different.

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