

Communication 1

Module - 1

Facilitator Guidelines

General Points

- The modules have been developed for presentation by facilitator(s) who are acute hospital-based clinicians, though not necessarily practicing specialist palliative care.
- The modules have been designed as a group (of six), though are independent of each other and can be delivered individually, or out of sequence.
- The target audience is junior medical staff, post graduate years 2-4 of all training streams.
- It is envisaged that each module will take about an hour in total (including discussion time).
- Technical requirements include a computer and data projector, able to run PowerPoint and play DVD's. It is suggested that pre-reading be distributed, electronically or by hard copy prior to the presentation.
- It is hoped that the presentation will stimulate discussion amongst the group and sharing of clinical experiences. Appropriate facilitation and management of these discussions is an essential role of the facilitator.
- The presentations aim to enable attainment of the objectives outlined below.
- There is an accompanying evaluation form, based on the stated objectives.
- A short video is accessible on the accompanying DVD and will be called for during the presentation.
- It is recommended that facilitators familiarise themselves with the material prior to presenting it and contact the authors or local palliative care consult service with any questions.

Module Summary

Good communication with patients, their families, our colleagues and the multidisciplinary team is central to everyday medical practice. It is perhaps even more important when managing patients with life-limiting illness. Poor communication is frequently singled out as the major barrier to "a good death"; and is the basis of many complaints and medicolegal action. Yet it is a skill that requires constant work and development. The purpose of this module is to build on skills already developed, and provide a practical framework and useful tips for the challenging communication episodes that may arise while caring for patients at the end of life.

Objectives

Knowledge:

- Identify what constitutes 'bad news' particularly recognising:
 - that it may depend on the biopsychosocial context of the patient and/or their families
 - similarly the impact and reaction to the news may be variable
- Use the available evidence to identify the principles of running the 'ideal' family meeting, particularly with reference to:
 - preparation
 - the physical and social setting
 - specific relevant and useful communication skills

- awareness of the spectrum of emotional responses, in ourselves, other staff, patients and/or their families
- Consider the use of language when communicating about difficult topic; subtleties can help (or hinder).
- Consider the spectrum of challenging emotional responses and ways of approaching them in the clinical context, again particularly considering useful phrases.
- Recognise that good communication is an imperative in all fields of medicine, and the best means of ensuring patients, families and other staff are satisfied with our professional performance.
- Acknowledge that despite best intentions a situation may remain fraught
 - know how to enlist the appropriate supports in the hospital context

Attitudes:

- Be prepared and professional when communicating with patients and their families.
- Recognise our own emotional responses to delivering ‘bad news’ and that can be a difficult and draining task.

Skills:

- Confidently chair a family meeting, imparting appropriate information and responding to expected questions in a compassionate, thoughtful and honest manner.
- Respond to challenging emotions, particularly anger.
- Apply useful phrases and approaches for communicating about difficult topics.

Pre-Reading

- Clayton, JM et al. **Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers** *Medical Journal of Australia* 2007;186(12):S76-108 (see attached)

Handouts

Nil.

PowerPoint Presentation - notes

SLIDE 1

SLIDE 2

- Communication with patients and their families, informally or more formally with a family meeting is a necessary, though frequently dreaded task in all fields of medicine.
- There is no doubt that having a successful approach and not avoiding this task is enormously helpful in your everyday work, is of huge benefit to your patient and makes work imminently more pleasant!

SLIDE 3

- The definition of what constitutes 'bad news' is very individual and not always the obvious 'life and death' situations we may imagine.
- We should consider how the patient and or their family might perceive what we are telling them, even if we may not necessarily see it as 'bad'.
- While some can be more readily anticipated and therefore you can be prepared for potential questions and reactions, other times it is unexpected and you will need to 'think on your feet'.

SLIDE 4

- Depending on where you are working, and how particular patients may define the news you are telling them, it is likely that this is something you do every day and perhaps even several times a day!
- It is an important therapeutic task and one of our most important roles.
- These are some 'trigger points' or prompts that should get us thinking about meeting to discuss the current situation, and provide updates. It is by no means exhaustive.
- You'll note that while these are readily applicable to caring for patients at the end of their life, they are equally generalisable to most patients in the acute hospital setting – and certainly of equal relevance in that they should prompt meetings and discussions.

SLIDE 5

- The list on the previous slide has been compiled from a medical perspective, yet it is important to have some concept of the expectations of our patients and their caregivers.
- A study, undertaken at the Alfred Hospital, sought to elaborate the expectations of patients, their carers and physicians regarding the communication of clinical information to carer. 102 patients and carers, along with 219 medical staff were interviewed at a variety of outpatient clinics. Patients and carers were consistently of the opinion that medical information should be automatically provided to both patients and carers with updates regularly and routinely - in most cases at every visit. This differed significantly with doctors' views and I am sure that even the most ardent communicators amongst us would find this impractical, even leaving aside potential restrictions imposed by the privacy laws. It is useful however to be mindful that patients and carers expectations may not match our own.

SLIDE 6

- A copy of these guidelines was provided with the pre-reading, and makes a useful and practical reference worth keeping.
- These guidelines were developed by a systematic review of the literature and involvement of an expert multidisciplinary panel, including

‘consumers’ (caregivers and patients). They evaluated the guidelines individually and then met to discuss discrepancies.

- As the title suggests, the group of patients and its applicability is more limited than the general ward sense of ‘bad news’ we have discussed thus far. They were developed mainly for patients with progressive life limiting illness; and therefore not all aspects are appropriate for those with chronic illness and life expectancy greater than 2 years, those having treatment with curative intent or those in whom intensive measures may be effective. Similarly they do not so easily apply to end of life discussion with well elderly people, those with uncertain illness trajectories or in the early stages of dementia.
- However, they do provide some useful generic information and certainly a broader applicability doesn’t require a huge imagination.

SLIDE 7

- For those who like mnemonics, the guidelines have one to guide your approach to family meetings. As noted it is also a useful generic guide to giving information including bad news.
- ‘Prepared’ is indeed very apt, and the importance of adequate preparation cannot be over emphasised. You need to make every effort to ensure you are up-to-date and well informed. This may involve reading the notes, reviewing investigations, liaising with other members of the team, other units or outside specialists.
- Once you are prepared, you need to ensure other team members are prepared, and a brief meeting to clarify your approach and the team understanding of the meetings purpose is invaluable.
- We also shouldn’t forget the patient and family in our preparation, obviously including the appropriate stakeholders is a vital part of preparation. However it can also be helpful to make the goals and aims of the meeting clear to patient and family as well, this will often allay anxiety, but can also encourage them to prepare appropriate questions.
- We will now discuss some of these other points in more detail...

SLIDE 8

- The setting may seem trivial, but is really important particularly in the context of a busy ward and often shared rooms. Appropriate choice will greatly aid good communication.
- Ideally choose a quiet space, with minimal interruptions at a mutually convenient time.
- The patient should attend if they want to and are well enough. Interpreters and other communication aids should be used as required. Equally appropriate caregivers and stakeholders should be involved, and this needs to be clearly established prior.
- It may seem obvious, but it should be ensured that the staff present can answer the likely questions. More specifically that they are of appropriate seniority, and are adequately prepared. If no senior clinician is available, this should be acknowledged early and their involvement in the preparation for the meeting and particularly in current and ongoing decision-making emphasised. For example: “unfortunately my consultant can’t be here, but we have discussed your case together extensively and I will update him/her after today’s meeting”. Equally other team members should be involved where relevant, though with clear reference to the

purpose of the meeting, too larger group of health professionals can be very intimidating.

- Allowing sufficient time is important and often difficult. If time is short set clear limits at the beginning and allocate times for further discussions in the near future.

SLIDE 9

- Open-ended questions are useful because they elicit a greater expression of feeling than closed questions. This will allow you to determine the patients concerns, goals and values.
 - *Ask for examples*
 - Eg. Open-ended question: “Tell me about your illness and how you have been feeling?” (ie. cannot be answered ‘yes’ or ‘no’)
 - Eg. Closed ended question: “Do you have any pain?”
- Aim to maintain an atmosphere of interest and sensitivity

SLIDE 10

- This is a really good place to start, especially if you don’t know the patient or if there are family members or caregivers you haven’t met before.
- You learn a lot from this sort of question, it gives a great insight into the patients concerns, fears and expectations.
- If the discussion is prompted by a question, such as “why isn’t [a certain treatment] being offered”, it is useful to ‘fall back on’ and then consider asking about the motivations (?internet, ?family ?other doctors / health professionals) and what they think will happen

SLIDE 11

- There is considerable evidence suggesting that doctors underestimate patients’ information needs and overestimate a patient and families awareness and understanding of the situation.
- It is very important not to make assumptions, but rather let the patient decide what they want to know and when, and listen carefully and respond appropriately to their questions.
- We also know that patients and their families frequently have misunderstandings about many important aspects of their illness, its prognosis and goals of care. The reasons for this are many - difficulties understanding jargon, distress may limit absorption of information, denial or subconscious ‘blocking out’. But of course, not all fault lies with the patient - doctors often withhold information, again for a variety of reasons.
- A patient and their families desire for information is likely to change over the course of their illness and be disparate. For instance some studies suggest patients may want less prognostic information as they become sicker, while their caregivers are likely to want more.
- Families, particularly of some cultures, may request information to go through certain members rather than directly doctor to patient. This presents a challenge and is surprisingly frequent. Considering an approach to it is helpful and something we will discuss in the Ethics module.

SLIDE 12

- The ‘3rd person’ is a very useful technique, particularly if you are ‘testing the waters’, if you are concerned a patient or family may be unrealistic, or perhaps even to provide that ‘warning shot’. It can make people more comfortable expressing their views, since ‘other people’ may hold the same one. Equally by preventing two extreme views, it can help you lead

the way to a middle ground, without actually suggesting that anyone holds those views.

SLIDE 13

- Facilitating hope is obviously important and desirable, but often it can be very difficult to foster realistic hope in the setting of a terminal illness. The need to maintain hope should be balanced with the imperative of honest and open communication, which is central to the doctor-patient relationship.
- It should be recognised that there is a spectrum of hope, and that a patient can hope for a cure while making appropriate preparations for their death and dying and fully accepting the terminal nature of their disease.
- Equally a patient may not only hope for a cure, but may hope for a peaceful death, to receive good care, to have one last holiday or meaningful time with friends and family.
- This can often be a time when patients search for options outside traditional medicine and consider alternative or experimental therapies. It is important to be respectful and far better the patient feels able to tell you about any other therapies they be having or considering. Try to ensure that adequate information and informed consent is properly obtained for alternative/experimental therapies. “you must do what you feel is important, but remember that these things have not be proven to work. All treatments have down sides as well as potential benefits...”

SLIDE 14

- We’ve probably all seen the bad ones and remember them all too well..... So we have deliberately not included a ‘bad’ example but want you to watch carefully for some tips and particularly useful phrases that may help you ‘do it better’.
- *After watching the DVD, encourage discussion about what techniques may have been helpful (or not), relating to the information on the earlier slides.*

SLIDE 15

- It is important to acknowledge these, quite normal, emotional responses to ‘bad news’.
- Dealing with emotions is the most difficult part of ‘breaking bad news’, as evidenced in the study by Baile et al. but also in many studies of burnout and doctor stress and distress. (Ramirez et al. 1996)
- This list is by no means conclusive, as you will have no doubt have experienced first hand. Special mention should be made however of anger. Anger is not infrequent but can be very difficult to manage, and is most disruptive. Anger and ways to deal with it is really another talk in itself. We will address it a little further, however the essential techniques are containment, listening and good communication skills - hopefully a lot of the techniques we are discussing today.

SLIDE 16

- Awareness of your own feelings (and allowing yourself to have feelings!) is essential for good self-care, and to avoid job related stress and burnout.
- Reflecting on your own feelings and emotions is also essential preparation for good communication and can help overcome any unhelpful behaviours – such as providing premature reassurance, or offering inappropriate/unnecessary therapies.

SLIDE 17

- *Can ask for participation*
- Recognising these helps us avoid them...

SLIDE 18

- Most of the triggers really come down to inadequate communication. Though it is important to acknowledge that there are many reasons for anger, and even with the best communication some patients and their families will still be angry.

SLIDE 19

- Addressing, rather than avoiding conflict is obviously desirable, though there is no doubt that these can be challenging and draining interactions. Preparation is absolutely vital and in this scenario even more so. But be careful to avoid any more anger by being very clear about subsequent meeting times and thorough explanations of any delays.
- Try to hand your pager to someone else if feasible to avoid interruptions and choose an appropriate setting.
- Be careful and selective in who will attend these discussions. But the benefit of support, particularly from a senior clinician cannot be overstated (though unfortunately in a busy hospital their physical presence may not be possible). Other members of the team may be helpful, depending on the points of conflict, such as NUM or social worker. Clearly explain everyone's presence, eg. "I have asked the relevant members of the team along so that we can all hear your concerns and hopefully respond to them adequately". Other benefits of having other team members present may be: support for you, demonstrating the team presence and acknowledging the importance of the concerns raised, etc...

SLIDE 20

- Important never to criticise or blame other medical staff or organizations. However the patients' perceptions and feelings of distress should be acknowledged. It can be very helpful (and therapeutic) to suggest, or even try and facilitate them (or their family members) meeting to discuss their concerns with the doctor involved at an appropriate time.

SLIDE 21

- Active and empathic listening is very important and is a great place to start (rather than with judgements or recriminations). Try not to interrupt, but let the story flow. Obviously this takes time, which is a precious commodity in the acute hospital setting. However it can be a very powerful intervention and can settle an angry situation, so may well be worth it.
- Structure is helpful, particularly in view of the usual time constraints. It is important also to gain confidence (and hopefully some respect) and appear to be 'taking charge' of the situation. Even if things remain difficult, a clear plan for the issues that need to be addressed and the steps that will be taken is essential.
- The main types of limits to consider are:
 - time (being clear from the beginning is helpful). Always be clear about when (and how) the next update or meeting will occur
 - number of people doing the communicating: electing a family spokesperson and a team spokesperson is helpful to aid clarity and consistency.

- Behaviour, clearly expressing what is not acceptable, while remaining empathic and avoid being demeaning or patronising. Limits should be set by the team and communicated to the patient and/or family by senior staff. Depending on the particular limits may be best being non-clinical staff or at least removed from the treating team. The safety of staff and well being of other patients is a clear priority and must be protected.
- Recognising anger is an essential step in the first place, and it is equally important to acknowledge when it isn't settling. Persisting with a futile discussion or frequently being exposed to angry outbursts without sign of resolution is stressful for all concerned and certainly not productive. Agreeing that more work is needed to resolve the conflict and that other resources and approaches should be considered may be the only point of agreement. However agreeing on something is essential, as is clarity about the next step. Abandoning such a situation will never lead to its resolution and will almost certainly result in complaints and litigation.

SLIDE 22

- In the setting of persistent anger ensure senior medical staff are aware and involved. Depending on the situation, a 2nd medical opinion, either internal or external, may be a useful (eg. involving an intensive care physician if the conflict is over escalation of treatment). Equally involving the patient advocate may allow a complaint to be systematically and thoroughly investigated, while leaving the treating team able to focus on patient care. Another option, though not available in every network, may be the hospital Clinical Ethics Service who have the benefits of independence from the clinical issues, insight into the problems and what is often most critical – time.
- Good communication with the team and clear documentation is even more important in these situations. A clear and consistent message can avoid much unnecessary conflict.
- The other, and perhaps even more important reason to communicate and document clearly is to provide support to the team. There is no doubt that these are stressful and often deeply unpleasant situations which can have detrimental health effects on staff and impact on their ability to continue working and caring.

SLIDE 23

- *After watching the DVD, comment of the techniques that were used. What worked well? What didn't? If time allows, perhaps discuss some angry encounters. What settled things then? What might you have done differently?*

SLIDE 24

References

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