Communication
The Essence of the Palliative Approach

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Overview
- Identify difficult conversations and why they are difficult
- Generic communication skills
- Specific difficult conversations
  - Talking about dying
  - Communicating with our medical colleagues

How hard is it for you?

What is a difficult conversation?

Wong-Baker FACES Pain Rating Scale

What is it that makes it difficult?
- Upsetting/bad news to be told
- Strong emotions are present
- You feel out of your depth
- Taken off your guard – not prepared

Difficult conversations
- Think of the most challenging “difficult conversation” you have had
- What are some of the things that made it difficult for you
Communication skills

Good communication skills can facilitate difficult conversations

Evidence

- Communication skills do not reliably improve with experience alone
  - [Cantwell and Ramirez 1997]
- Skills can be acquired and retained with appropriate teaching
  - [Finset et al. 2003 Kurtz et al. 2003]
- Many complaints by patients reflect a perceived failure of effective communication
  - [DOH 2000]

Complaints

(Health Care Commission report 2007)

1. Safety of clinical practice
2. Poor communication
3. Ineffective clinical practices
4. Poor handling of complaints
5. Discharge and co-ordination of care
6. Lack of dignity and respect
7. Poor attitudes
8. Failure to follow consent procedures
9. Poor environments, poor hygiene
10. Disputes about clinical records

How do we communicate?

- Non-verbal communication
  - Verbal communication
  - Facilitating behaviour
  - Inhibiting behaviour

Non-verbal communication

- Body language
- Personal space
- Touch
- Eye contact
- Facial Expression
- Gestures
- Posture

Body Language
**Body Language**

**Verbal Communication**

**Questions**
- Open - broad
- Open - directive/focused
- Directive
- Closed
- Leading
- Multiple

**Facilitating behaviour**
- Listening
- Silences
- Acknowledgement
- Encouragement
- Picking up Cues
- Reflection
- Clarification
- Empathy

**Facilitating behaviour**
- Summarising
- Educated guesses
- Checking
- Negotiation
- Pauses
- Minimal prompts
- Appropriate reassurance
- Exploring

**Listening**

**Pauses and Silences**
**Pauses and Silences**

1. For how long does a doctor let a patient speak before interrupting?
   18 seconds

2. How long would a patient usually speak if not interrupted?
   2 minutes

**Picking up Cues**

**Facts about “Cues”**

- Facilitative questions linked to cues increase the probability of further cues
- Open questions when linked to a cue are 4.5 times more likely to lead to a disclosure
- Facilitating first patient cue is important
- 20% drop in patient cues if first cue is not facilitated

**Scenario**

- 48 year old patient with Ca Pancreas
- Told by oncologist last week that there are no further treatment options
- Admitted to hospice with intractable vomiting
- Much improved with anti-emetics via S/D
- Told she can go home that day
- She looks sad
- What do you do or say?

**Useful starting phrases**

- I’m wondering……
- How would it be…….
- Can you tell me ……..
- It seems like……
- I can’t know how you are feeling but …
- You appear to be ……..
- What are you…….

**Responding appropriately to cues shortens consultation time**

- Oncologists that responded to >90% of informational cues had 20% shorter consultation times
  - Budow et al 2002
- Drs who responded to at least one emotional cue had shorter consultation times
  - GP consultations shortened by 12.5%
  - Surgeon consultations by 10.7%
  - Levinson et al 2000
Difficult conversations

- Talking about dying
- Talking to the doctor

Key Communication Skills in Difficult Situations

- Be non-judgmental. Show warmth
- Be empathetic and show respect
- Pick up on cues
- Silences - allows both parties to think
- Listening - active skill requiring concentration

Quiz

A. With all pts/carers with a life limiting illness of 6-12mths
B. Change in condition or perception of change
C. Treatment decisions to be made
D. Requests or expectations inconsistent with clinical judgement
E. Disease specific treatment not working or related complications of it
F. At referral to palliative care services

When should we talk about “dying”? 

Communicating about dying

Be prepared to discuss with carers, family and/or the patient the following:

- That death is expected
- The dying process
- The plan of treatment and care

Focus group discussions

- I found that the nurses and doctors were approachable and they always told us what to expect or what was happening. I remember the day my father died the staff were in and out all the time. They explained everything and tried to stay with us. I found them all friendly and willing to take some time to talk to us as a family
Focus group discussions

- When I approached the nurses to say or ask anything I got the impression they were busy. Nobody explained how things were progressing. I mean we weren’t kept informed about daily events. It came as quite a shock to me when I became aware that my wife had only about 2 days to live. I knew this would happen of course but I didn’t realize she was as near to dying as she was at that time.

The “SPIKES” Tool

W F Baile, R Buckman et al 2005

- Setting up - the interview - preparation
- Perception - perception of the patient/carer
- Invitation - invitation to patient/carer to give information
- Knowledge - giving information to patient/carer
- Emotions - address with empathy
- Strategy - summary of information and discuss plan

Preparation is vital

- Prepare yourself – knowledgeable, rehearse, consider likely questions, professional support (medical, nursing).
- Prepare the setting – privacy, sit down, try and establish a rapport, allow enough time
- Prepare the patient/family – assess the patient/family’s understanding of the situation.

Things you could say...

- Despite all of the treatment and interventions ‘Fred’s’ condition is continuing to deteriorate
- We can be wrong, but in our best judgement we believe her life is coming to an end
- We think it’s appropriate at this time to shift the focus of care. The care…
- Because time is short we think it’s very important that family are contacted/advised

Getting the best out of your doctor!

- Upsetting/bad news to be told
- Strong emotions are present
- You feel out of your depth
- Taken off your guard – not prepared

What is it that makes it difficult?
SBAR Tool

- Situation
- Background
- Assessment
- Recommendation

Situation
- Who you are
- Where you are telephoning from
- The patient’s name
- What is the main problem? (This is the most important aspect to attract the other person’s attention immediately)

Background
- Date of admission and diagnosis
- Relevant past medical history and treatment to date (It is imperative that this is brief, succinct and relevant)

Assessment
- State your assessment of the patient (For example, vital signs, modified early warning score (MEWS), level of consciousness, acute confusion, medication, resuscitation status)

Recommendation
- Explain what you need
- Be specific about your request and the timeframe
- Ask if there is anything else you can do before the other staff member arrives
- Document the call including date, time and who you spoke to
- If you are worried and do not receive the response you need you may need to escalate to a more senior clinician

Communication structures
Structure 1
- Doctor: Hi this is Matt, the surgical F1, you are bleeping me.
- Nurse: Hello, this is staff nurse on Rose ward. Can you come and review a patient of mine please?
- Doctor: What is the problem?
- Nurse: His blood pressure is low.
- Doctor: What is it?
- Nurse: 88/45.
- Doctor: What was it before?
- Nurse: Not sure, let me go and get his charts. It was 135/70.
- Doctor: What is his urine output?
- Nurse: Not sure, let me go and get his charts. Sorry, can’t find it.
- Doctor: What medications is he on?
- Nurse: Let me go and get his prescription chart.
- Doctor: Don’t worry I will wander up later and review him.
Communication structures

Structure 2
- **Doctor:** Hi this is Matt, the surgical F1, you are bleeping me.
- **Nurse:**
- **Situation:** Hi, this is Sue, staff nurse on Rose Ward. I am contacting you regarding Mr Smith who has suddenly become hypotensive. BP is 88/45.
- **Background:** He had a small bowel resection three days ago and is receiving IV fluids at 125ml/hr. This man is normally fit and well with no relevant past medical history.
- **Assessment:** His airway is patent, respirations 26/min, SpO2 93% on air. I have started him on 6L oxygen and his SpO2 has come up to 98%. Pulse is regular, rate 120/min. BP was 135/70; earlier now 90/40. He is cool peripherally with a capillary refill of four seconds. His urine output has also dropped, over the past three hours 35ml, 20ml, 10ml. At the moment he is alert and complaining of abdominal pain. He has also been vomiting. Temperature is 38.7. I think he is septic, possibly abdominal.
- **Recommendation:** I need you to come and see this patient now.
- **Doctor:** OK, I am on my way
- **Nurse:** What else can I do before you get here?
- **Doctor:** Can you give a stat bolus of 500ml normal saline (trust patient group directive 1013) and organise an ECG.
- **Nurse:** OK, see you in a minute.

Negotiating

What have you learnt today?
Write down 2 take home messages from today

Take Home Messages
- **Practice Facilitating behaviour**
  - Listening actively
  - Pauses and silences
  - Picking up cues and exploring them
- **Utilise “Spikes” tool for breaking bad news**
- **Use SBAR for “handover”**

Thankyou for listening