# A GUIDE TO DIFFICULT CONVERSATIONS

## THE ART OF LANGUAGE IN THE TIME OF COVID

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# OUTLINE

- Common Language Mistakes
- Breaking Bad News
- Communication Critical to COVID
- Communication Techniques
- What NOT to say
- Critical Questions
- Specific to COVID

An 85 year old Leukemic was brought into ER by her son due to increasing confusion and lethargy.

Scans showed progression of disease and the ER doc felt she should be made palliative.

After discussion with the family they decided that any further treatment at this time would be futile.

They elected to make her a DNR and started her on regular narcotics to keep her comfortable.

An 85 year old woman with Leukemia was brought into the ER by her son due to increasing confusion and lethargy.

Based on his assessment, the ER doc felt she was approaching end of life.

After discussion with the family they decided that any further treatment would not be consistent with her goals of care.

They opted to focus on comfort measures only and allow her to die naturally.

# WHAT WORDS DO WE USE MAKE YOU FEEL UNCOMFORTABLE

HOW COULD WE ASK IT BETTER?

# BASIC PRINCIPLES FOR END OF LIFE COMMUNICATION

- If they ask, patients want the truth
- You will not harm your patient by talking about end-of-life issues
- Anxiety is normal for both the patient and clinician during these discussions
- Patients have goals and priorities besides living longer
- Learning about patient goals and priorities empowers you to provide better care

# HIPPOCRATES

Hippocrates advised on the importance of…

*"concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity…revealing nothing of the patient's future or present condition. For many patients…have taken a turn for the worse…by forecast of what is to come."*

# AMERICAN MEDICAL ASSOCIATION

1847, the American Medical Association's first code of medical ethics stated,

*"The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits."*

# CLINICAL EVIDENCE ON THE VALUE OF SERIOUS ILLNESS CONVERSATIONS

- Facilitates adaptation to illness realities, appropriate decision-making.[1]

- Associated with better quality of life, reduced use of life-sustaining treatments near death, earlier hospice referrals, and care that is more consistent with patient preferences. decision-making.[2]

# CLINICAL EVIDENCE ON THE VALUE OF SERIOUS ILLNESS CONVERSATIONS

- Patients who received early palliative care showed significant improvements in quality of life and mood, and survived 25% longer.[3]
- Preparation for the end of life is associated with improved bereavement outcomes for family.[3]
- Strong preponderance of evidence shows no increased depression, anxiety, hopelessness

# 8 COMMON COMMUNICATION TECHNIQUES

AND WHAT THE EVIDENCE SAYS

# WHAT DO WE KNOW ABOUT DIFFICULT CONVERSATIONS?

- Review of conversations/analytic studies
- Identified 8 practices
- How to Communicate with Patients about future illness progression and end of life : a systematic review
  - *-Parry, R. et al. BMJ Support Palliate Care 2014*

# 8 TECHNIQUES SURVEYED

- Fishing Questions
- Indirect references to difficult topics
- Linking to what a patient has already said or not said
- Hypothetical Questions
- Framing difficult matters in universal or general
- Conveying sensitivity with touch, hesitancy
- Long silences
- Steering away from negative towards positive

# 1. FISHING QUESTIONS

*"Are there any issues you'd like to discuss?"*
*"What are your greatest concerns?"*

- They fish for but don't directly target difficult future topics
- Usually ineffective in eliciting talk about difficult future talks but gives guidance for future
- Patients can easily avoid answering them with serious matters
- Rationale for using them : can give thoughts about readiness to broach difficult future topics

# 2. INDIRECTNESS, EUPHEMISMS, ALLUSIVE TALK

- *referring to "it" or "that' instead of the cancer*
- *Talking about "when things get worse" or if you get "very very sick"*
- *Talking about people in general*

- Often results in shift away from topic or stoicism from patients
- However, often a good FIRST step towards difficult conversations

# 3. LINKING TO WHAT A PATIENT HAS ALREADY SAID OR NOT SAID

- *when posing a question repeat something patient has said*
- *Making note of something they have not asked*
- *"I notice you haven't asked about prognosis" is that something you would like to ask about?*

- Allows you to show you have been listening
- Makes it difficult for patient to avoid answering it as they have already shown it's a "Safe word"
- Can work to construct atmosphere of agreement and that the patient is leading the show

# 4. HYPOTHETICAL QUESTIONS

*"Saaay….down the road…and we can't say for sure what you would do…but say you DID  become sick…or very sick…and are unable to answer for yourself…"*

- In order to be effective they are posed partway through a conversation and it is emphasized that it is hypothetical
- Often spoken with hesitancy to convey seriousness
- Highly effective - Pts. usually engage in this manner
- Creates a distance b/t patient and difficult scenario
- Allows physicians to partake in conversation with out prognostication

# 5. FRAMING DIFFICULT MATTERS IN UNIVERSAL OR GENERAL

*"Some people in your situation do not feel they want their life prolonged any more…do you ever feel that way?"*

- Works to downplay the relevance of illness progression or dying to this particular patient
- Helps patient to engage safely speaking about others
- Similar efficacy as hypothetical questions

# 6. CONVEYING SENSITIVITY WITH TOUCH, HESITANCY

- Delays, hesitations and turbulence in speech i.e. stuttering or halted speech when broaching difficult topics
- Conveys sensitivity and seriousness of the matter
- Especially effective when done with hypothetical situations
- Touch – reaching out and touching pt.'s hand
- May also be helpful to convey sensitivity and support during a difficult conversation

# 7. LONG SILENCES

- It is rare in every day conversation to have gaps >0.3s after questions
- Silence of >1s is socially uncomfortable
- Often patients fill the gaps
- Small amount of evidence supports this
- Can make people feel uncomfortable

# 8. STEERING AWAY FROM NEGATIVE TOWARDS THE POSITIVE

- Making reference to fighting, perseverance and hope, "facing illness together"
- Often shuts down future conversation
- Effective, however, if this is the last thing the doctor refers to

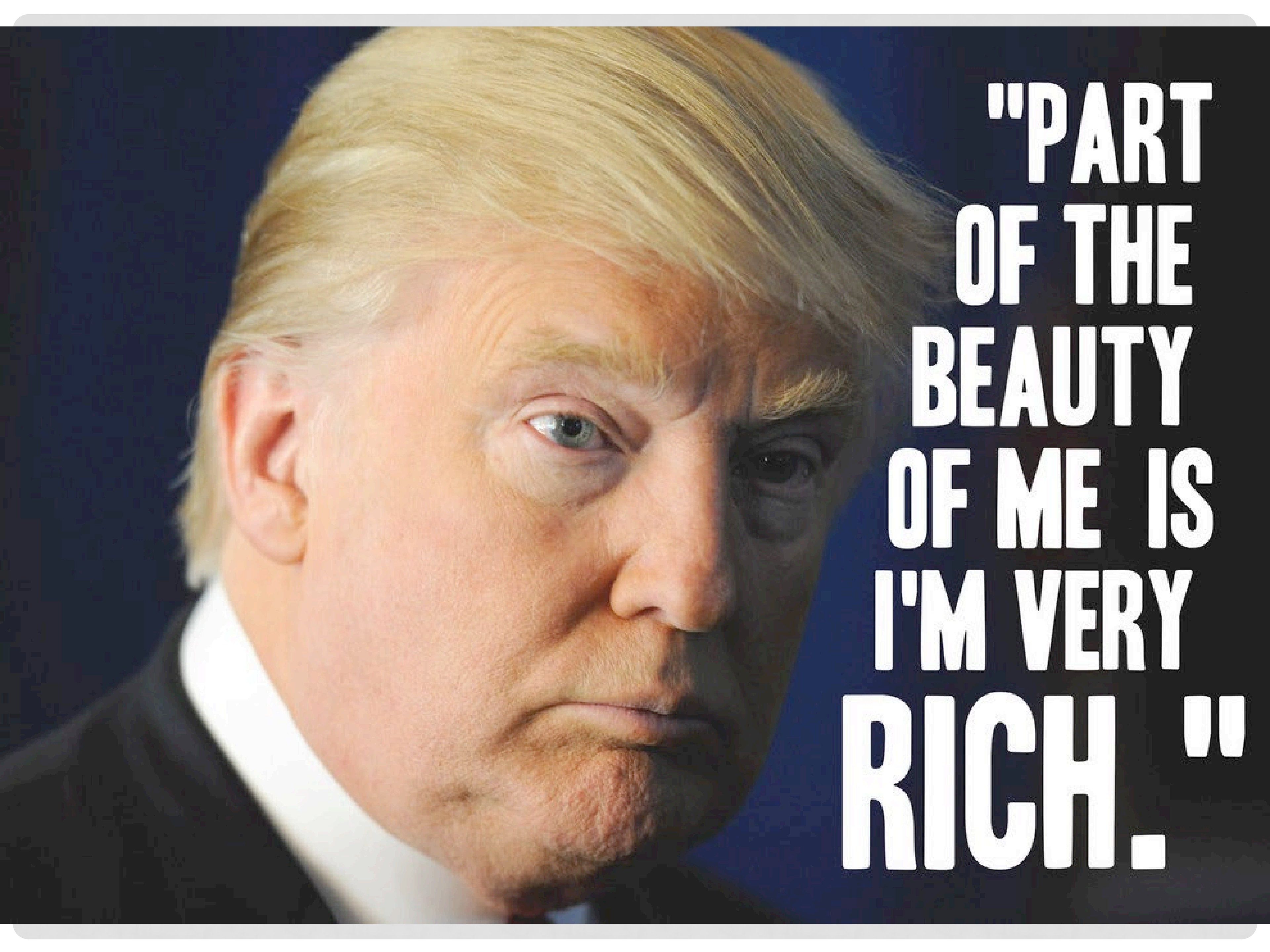
# SUMMARY

- Start open ended to gauge their willingness
- OK to Shelve it for the first visit (trust your instincts!)
- Ask in the hypothetical, relating back to what patient has already said
- Convey sensitivity with hesitancy and stuttering
- End with optimism to show you believe in their hope

# WHAT DO FAMILIES WANT?

- How should we talk about palliative care, death and dying?
  - Palliative Medicine 2018

- Qualitative study from caregiver's perspective
- In general we underestimate caregiver needs for information
- Need for detail – written resources supplemented by conversations, ideally over time
- Once death is imminent, carers want spoken acknowledgment that death is close
- Direct language : death and dying


"PART
OF THE
BEAUTY
OF ME IS
I'M VERY
RICH."

# WHAT NOT TO SAY

- I know how you feel
- Everything happens for a reason
- I know just what you should do
- You'll be fine
- Everyone dies sometimes
- Don't Worry
- Relating what they are going through back to yourself
- Criticizing or blaming colleagues

# WHAT TO SAY TO SOMEONE WHO'S GRIEVING -NY TIMES FEB 14, 2019

- Rule #1 : It's not about you
  - "Let me know if you need anything" = exit line
- Rule #2 : There is No Bright Side
  - Never start sentence with "At Least"
  - Validate feelings and acknowledge situation
- Rule #3 : Be Careful with Religion
  - "God Never Gives you More than you can handle"
  - Unless certain that people share you're faith don't add that
- Rule # 4: Let them Feel
  - Don't tell a Grieving person how to feel
  - "Stay strong" or "Be Strong"

# SO WHAT SHOULD WE SAY?

- I’m Sorry
- *“Whatever you are feeling, whenever you are feeling IT IS OK.”*
- *“I can’t imagine what you are going through but I am here to listen if you need me.”*
- Personal anecdotes
- Do something

# "IT'S NOT THE ANSWERS YOU GIVE BUT THE QUESTIONS YOU ASK…"

DIGNITY CONSERVING THERAPY

# DIGNITY CONSERVING CARE

- “What are the things at this time in your life that are most important to you or that concern you the most?”
- “How are you coping with what is happening?”
- “Are there things about you that this illness does not affect?”
- “What about yourself or your life are you most proud of?”
  - Chochinov H. Dignity and the essence of medicine : ABCD of dignity conserving care BMJ 2007; 335:184-187

# DEEMED BEST DIGNITY CONSERVING QUESTION

"What do I need to know about you as a person in order to give you the best care possible?"

*Chochinov H. Dignity and the essence of medicine : ABCD of dignity conserving care BMJ 2007; 335:184-187*

# MY FAVOURITE QUESTIONS

- “What is your understanding of the severity of your illness?”
- “I know this is a hard thing to talk about right now but sometimes these conversations are easier to have at a time of calm than during a time of crisis”
- “If you were nearing the end of your life, what would make your time meaningful?”
- “Have you made any preparations for a time when your condition worsens?”
- Tell me your story
- “What makes you angry?”
- What questions do you have?

# LANGUAGE SPECIFIC TO COVID

THESE ARE UNPRECEDENTED TIMES

# PANDEMIC PALLIATIVE CARE: BEYOND VENTILATORS AND SAVING LIVES

- Sandy Buchman, James Downar, Amit Arya, Bruno Gagnon
- Highlights importance of conversation
- Many old/frail will not ask for live prolonging treatments and prioritize honest conversation
- In times of scarcity- we many not be able to offer life prolonging treatments

# SHARE : FOR CRISIS USE ONLY

- S : Show the guideline
- H : Headline what this means for the patients care
  - Be sure to start with what you WILL do before what you won't do
- A :Affirm the care you will provide
  - "We will continue to do xyz and hope for recovery"
- R : Respond to Emotion
  - "I can see that this upsets you"
- E : Emphasize that the same rules apply to everyone
  - "We are using the same rules with every other pt in shi hospital/Ontario. We are not signing you out"

# WISH/WORRY/WONDER

- “I wish” : allows for aligning with the patient’s hopes
  - “I wish your father had not contracted this/was responding better to treatment”
- “I worry” : allows for being truthful while sensitive
  - “I worry that we may not have anything more to offer him if he continues to decline
- “I wonder” :  is a subtle way to make a recommendation
  - “I wonder if we can talk about what more we can offer him to ensure that he is comfortable…”

# HELPFUL PHRASES : WHEN RESOURCES ARE LIMITED

- "These are extraordinary times"
- "There is a lot of fear and uncertainty right now"
- "We are trying to use resources in a way that is fair to everyone"
- "This is a time when we wish we had more for every single person in this hospital"
- "I wish things were different"

# WHAT WORDS DO WE USE MAKE YOU FEEL UNCOMFORTABLE

HOW COULD WE ASK IT BETTER?

# CONCLUDING POINTS

- Don’t shy away from difficult conversations
- IF they ask the question they want to know the answer
- First, understand – what they know, what they need to know, and who they are
- It is not the Answers you give, it’s the Questions you ask

# I CHALLENGE YOU!

- Use a new communication technique
- “What do I need to Know about you as a person to give you the best care?”
  - Dignity Question
- Tell me your story
- Use “AND” or Allow Natural Death in place of DNR
- Wish/Worry/Wonder