What does great communication look like?

• An ability to handle awkward moments: finding roadmaps for conversations that involve difficult, sad, or emotionally charged topics
  – Be prepared for the answer when you ask a question
  – “What are you afraid of ?”

• A ‘toolbox’ with a variety of communication tools

• The capacity to remain present when difficult topics do come up
What Do Patients with Serious Illness Want?

• Pain and symptom control
• Avoid inappropriate prolongation of the dying process
• Achieve a sense of control
• Relieve burdens on family
• Strengthen relationships with loved ones

“Difficult” Conversations Improve Outcomes

- Multisite, longitudinal study of 332 patient-family dyads
- 37% of patients reported having prognosis discussion at baseline
- These patients had lower use of aggressive treatments, better quality of life, and longer hospice stays
- Family after-death interviews showed better psychological coping for those with conversations as compared to those without

Wright et al. JAMA 2008 300(14):1665-1673.
Families Want to Talk About Prognosis

• Qualitative interviews with 179 decision makers of ICU patients

• 93% felt that avoiding discussions about prognosis is an unacceptable way to maintain hope

• Information is essential to allow family members to prepare emotionally and logistically for the possibility of a patient's death.

• Other themes:
  – moral aversion to the idea of false hope
  – surrogates look to physicians primarily for truth and seek hope elsewhere

# Communication Techniques that Don’t Work

<table>
<thead>
<tr>
<th>Phrases Often Used</th>
<th>Why They Don’t Work</th>
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<tr>
<td>“Do you want everything done?”</td>
<td>Creates conflict between patients and medical team</td>
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<tr>
<td>“It is time we talk about pulling back.”</td>
<td>Implies abandonment</td>
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<tr>
<td>“I think we should stop aggressive care.”</td>
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<tr>
<td>“Do you want CPR or to be put on a ventilator?”</td>
<td>Focuses on treatments and not “the big picture.” Patients / families can’t understand choices, probable outcomes of treatments.</td>
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<td>“What about antibiotics?”</td>
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<td>“Should we turn off your defibrillator?”</td>
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Goal Setting in Patients with Advanced Illness

• Instead of focusing on treatments, focus on outcomes and overall goals
  – What is the desired outcome?
  – What is the “fate worse than death”?

• Some common goals
  – Be able to interact in meaningful way
  – Be free of pain
  – Live as long as possible
Tailor Treatments to Goals

• Once have established goals, can make treatment decisions
  – Clinicians helps patient and family by guiding them through treatment options
  – “If goal is to be able to interact with family, then perhaps putting you on a ventilator may not get you back to that goal.”

• Clinicians may not always agree with goals, but easier to determine treatment decisions
How do we elicit these goals?

- Having a roadmap for the conversations makes them easier
- Present an idealized framework
  - Not every conversation includes all of these elements every time
  - Order is not always this linear
  - Changes based on urgency, location, and clinician-patient relationship
- Effective communication is a process that occurs over time, not a one time event
RECIPE for Communication

• **RE**view
• **C**larify
• **I**nterventions—includes implanted devices
• **P**lan
• **E**mpathize
RECIPE for Communication

• **REview**
  – Review the patient’s overall understanding of heart failure, including recent events
• Clarify
• Interventions–includes implanted devices
• Plan
• Empathize
REview using ASK-TELL-ASK

• ASK
  – Permission to begin
  – Patient understanding of the disease process

• TELL
  – Clarify any misconceptions and explain information that may be helpful in terms of guiding decision-making

• ASK
  – What patient heard / now understands "talk back"
RECIPE for Communication

• REVIEW

• CLARIFY
  – Clarify the patient’s overall goals of care – determine their hopes for their healthcare to determine framework patient uses to make medical decisions

• Interventions – includes implanted devices

• Plan

• Empathize
Clarify the desired goals

• What makes you happy?
• What do you want most to accomplish?
• What are you hoping for?
• What do you hope to avoid?
• What do you think will happen?
• What are you afraid will happen?
RECIPE for Communication

• REview
• Clarify
• Interventions—including implanted devices—Review the role of the various potential interventions, including devices, within goals of care and determine if they will help achieve the desired goals
• Plan
• Empathize
Interventions / Implanted Devices

- Discuss the role of various interventions within the context of these goals of care
  - Dialysis? Inotropes? Transplant / VAD?
  - Repeated hospitalizations?

- When discussing implanted devices
  - Re-educate about role (ICD vs. pacer)
  - Have the benefits/burdens changed?
  - Deactivation may not need to be done now
Helpful Phrases to Relate Interventions to Goals

• “Given your wish to maintain your independence, maybe sending you to the ICU again doesn’t make sense.”

• “I understand you want to be able to see your grandchild be born, so if your kidneys continue to get worse maybe we should think about a trial of dialysis.”

• “Since you said your goal is to be free of pain, we should talk about whether the ICD still serves the same role it once did.”
RECIPE for Communication

• REVIEW
• Clarify
• Interventions—includes implanted devices

• PLAN
  – Once goals and appropriate treatments outlined, create a concrete plan to clarify the next steps

• Empathize
Plan

• Once goals /treatments outlined, create a concrete plan to clarify the next steps
  – “Time limited trial of critical care”
  – “Repeat the conversation with your daughter here at the next appointment”
  – “Have the nurse come in and deactivate the shocking function of the ICD”

• Creates a framework for patients in the midst of an emotional conversation
RECIPE for Communication

• REview
• Clarify
• Interventions—including implanted devices
• Plan
• Empathize
  – Acknowledge the emotional nature of the conversation and how shifting goals of care may be upsetting to the patient.
Empathize

• 40 seconds of empathetic comments in conversations can improve patient satisfaction related to communication
  

• Simple phrases often all that is needed
  – “I wish things were different.”
  – “This must be upsetting to hear.”
  – “I can’t imagine how hard this is for you.”
  – “You’re doing such a great job coping with your illness.”
Verbalize Empathy

• Naming
• Understanding
• Respecting
• Supporting
• Exploring
NURse

• Naming
  • You seem frustrated, worried, relieved...

• Understanding
  • It must be so hard to go through all of this, I can see how much the pain is affecting you, It must be so hard facing all these uncertainties…

• Respecting
  • I am so impressed you have been here everyday to visit your mother, I have to tell you how strong you have been through all of these difficult treatments…
nurse

- Supporting
  - Don’t worry I will be back in a few hours to check on you. My team and I will be here to help you through this. Here’s my card so you know exactly how to reach me if you ever need me…

- Exploring
  - Tell me more about how that made you feel. What do you mean when you said that…
When Patients Can’t Speak for Themselves or Don’t Want to be Included

• Same techniques apply
• To elicit goals, use phrases such as:
  – “Have you ever had a conversation with him/her?”
  – “What would your loved one say if he/she were sitting here right now?”
  – “Was there ever another family member who was sick like your loved one is now? Did he/she express an opinion about the care of that person?”
  – Ask about television shows or cases in the news the patient may have discussed with family members
Easier said then done…..

• Never time
  – Often best time is when the patient comes to the clinic after a hospitalization
  – “I want to review what happened and check-in with you after your hospitalization. Is that ok?”

• Patient/Family says “No”
  – Ask “Why don’t you want to know?”
  – Opportunity to learn more about their understanding and fears
Easier said then done…..

• Goals change
  – Review when hospitalized and when status changes
  – “I know we’ve talked about this before, but now that you’re back in the hospital I want to see if you still feel the same way.”

• Emergent Decision Making
  – Preparing for in-the-moment decision making