Difficult conversations

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Mrs S

- Mrs S is a 75yo with ESRF secondary to T2DM who has been on HD 3 x week for the last 10 years. Her other history includes hyperlipidaemia, hypertension and IHD with NSTEMI x 3 over the last 2 years with diffuse 3 vessel disease on angiogram not amenable to stenting. She also has CCF with an LVEF of 30% on her last echo. She presented this admission with an STEMI and now has worsening heart failure despite optimal medical management with persisting hypotension. Her BP cannot be maintained during dialysis and a family meeting is arranged to discuss cessation of dialysis.

Difficult Conversations

- What are ‘difficult conversations?’

- Why are they difficult?

Difficult Conversations

- What are ‘difficult conversations’?
  - Breaking bad news
    - Diagnosis
    - Response to treatment
    - Stopping treatment
    - Prognostication
    - Deterioration and end of life
    - NFR
  - Questions that we cannot answer
    - Why me?
    - What happens after I die?

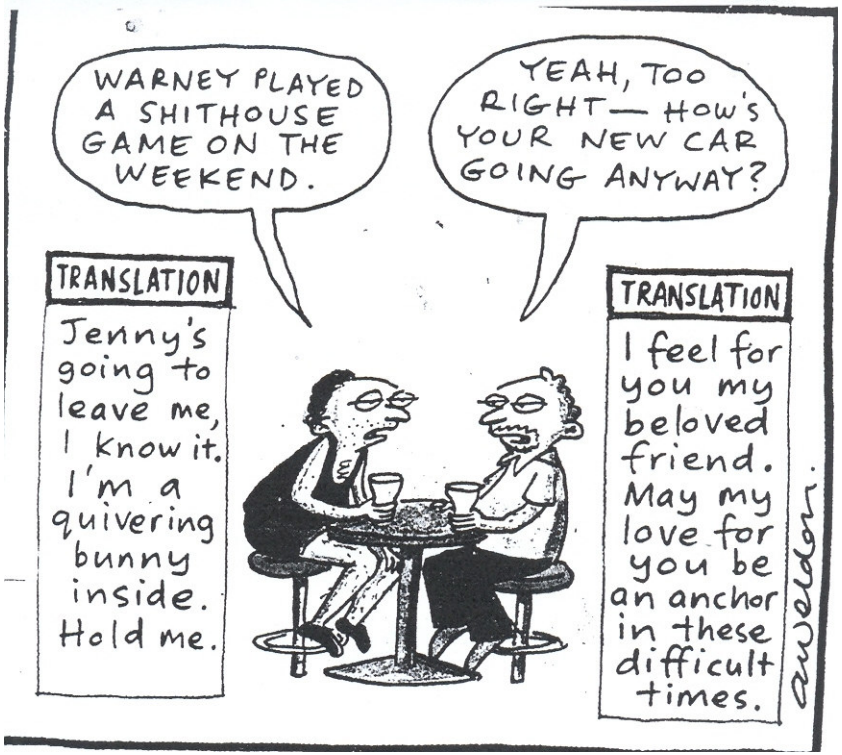
- Why are they difficult?
  - These conversations cause emotion in the patient and caregivers as well as us

So why do we have to have them?

Why are these conversations important?

- Most patients prefer some information about these issues when they have a life – limiting illness

- They may find it difficult to raise the topic themselves so it is important for doctors and nurses to allow the opportunity to discuss end – of – life issues


WARNEY PLAYED A SHITHOUSE GAME ON THE WEEKEND.
YEAH, TOO RIGHT— HOW'S YOUR NEW CAR GOING ANYWAY?
TRANSLATION
Jenny's going to leave me, I know it. I'm a quivering bunny inside. Hold me.
TRANSLATION
I feel for you my beloved friend. May my love for you be an anchor in these difficult times.
aweldon.

A **framework** for difficult conversations

- **S**etup
- **P**erception
- **I**nvitation
- **K**nowledge
- **E**motion
- **S**ummary / strategy

These skills are not only relevant to palliative care

- ‘Bad news’ is not only related to a life – threatening illness

- These communication skills are relevant for all aspects of medicine

SETUP

- How do we get the setting right for these conversations?

PERCEPTION

Explore person's **PERCEPTION**

- Check understanding BEFORE you give any information yourself
  - This helps guide the rest of the conversation
  - It is also an **efficient** way of communicating with the patient and can save a lot of time

- 'What is your understanding of your disease?'

- 'What do you know about the test results so far?'

INVITATION

INVITATION

- Check what the person would like to know **before** you give them the information

- ‘So you’re wondering how long you might have – is that something you want to talk about now?’

KNOWLEDGE

- What are some key skills to remember when we provide patients with medical knowledge?

KNOWLEDGE

- Make sure this is appropriate to the patient's understanding and wish for information
- Avoid medical jargon
- Give a few facts at a time then pause and check they have understood

EMOTION

- When a patient is upset, we often feel we have to ‘solve’ the problem
- It is important to remember that they are emotional because of the news and you don’t have to ‘fix’ it
- Validating and responding to emotion is much more important (and often the emotion dissipates once you have done this)

How can we respond to emotion?

- Nonverbal skills?

- Verbal skills?

Responding to emotion

- **Nonverbal skills**
  - Silence (you don't have to say anything)
  - Touch
  - Posture
- **Verbal skills**
  - Empathic statements

Empathic statements

Name the emotion

Understanding

Respect

Support

Explore

Name the emotion

- Useful if the patient is not naming their own emotion (‘I’m feeling really scared’)
- A suggestion, rather than telling someone how they feel
  - ‘You seem a bit anxious’
- May need to understate the emotion, particularly if they are angry
  - ‘Sounds like it’s been frustrating’

Show understanding

- This is a really useful strategy in all sorts of situations (not just palliative care) and even if you are quite uncomfortable talking about emotion to a patient, it is easy to say…

- ‘Sounds like you have had a difficult few weeks’

- ‘This is a difficult thing to talk about’

Show respect – for patients and carers

- ‘You have done a great job looking after your mother at home’
  - NB this can be really useful if care at home has become unmanageable as often the carers feel that they’ve failed or done something wrong

- ‘I’m impressed you’ve managed to keep on working up until now’

Show support – for patients and carers

- People may feel abandoned as they get more unwell, particularly when ‘active’ treatments such as chemotherapy or dialysis have been ceased

- Showing support can help address this

- ‘Our team will do everything we can to support you through this’

NB make sure you do not promise something that is not going to happen!

Explore

- Can be particularly useful if you feel you haven't got all the information yet
- 'Tell me more about that'
- 'What is the hardest thing for you?'

SUMMARY / STRATEGY

- At the end of your conversation summarize where you got to with - strategy, plan, goal etc

No CPR orders

- What is the survival rate to discharge of CPR?
  - Otherwise healthy patient?
  - Patient with advanced life limiting illness?

- Why do we need to discuss ‘No CPR’?

No CPR orders

- In patients with an advanced life – limiting illness, the survival rate to discharge of CPR is negligible
- NFR orders are important to prevent futile and distressing treatment at the end of life
- Unfortunately, patients and families overestimate the success rate and underestimate the burden of CPR so discussion is generally recommended

When you don't have to discuss 'No CPR'

- As per the NSW health guidelines
  - If the patient does not wish to discuss CPR
  - ***If the patient is aware they are dying and have expressed a desire for palliation only**
  - ***Prior discussion has made the patient's view known**
  - **Recurrent admissions for palliative patients need 'one' conversation**

No CPR orders – general skills

- NFR orders should not be discussed in isolation but as a part of a general conversation about progress and goals of care
- Remember SPIKES
- Remember the empathic statements
- Keep explanations simple and avoid jargon

No CPR orders – the first step

- Check **perception**
  - The patient may tell you that they are dying and just want to be kept comfortable which is essentially an NFR order

- If it is not clear what the expectations are, then more detailed discussion around CPR is necessary

No CPR orders – specific skills

- Strategies may include
  - Clarifying goals and priorities
    - ‘What’s the most important thing to you at the moment?’
  - Discussing CPR in the context of these goals
    - ‘I agree that the main thing is that he doesn’t suffer and as part of that I’d recommend…’
  - Checking understanding of CPR and its outcomes
    - ‘What do you know about resuscitation?’
  - Discussing poor outcomes of CPR in incurable illness and that CPR will not alter the course of the illness
    - ‘Unfortunately in people who are dying with advanced cancer, we know that resuscitation doesn’t work and we don’t recommend it’
  - Emphasising support throughout the dying process (e.g. symptom control)
    - ‘We’ll do everything we can to keep him comfortable…’
- The extent to which these are used depends on the conversation (there is no ‘script’)

No CPR orders – specific skills

- Remember that **you do not have to offer a futile treatment** so the key is in how you express the order
  - When given the choice, most patients will choose active intervention (and carers will feel guilty if they 'refuse' resuscitation)
    - 'If your heart stops, do you want us to do everything?' gives the impression that they have to choose whether to have CPR or not (and 'doing nothing' doesn't sound like a good alternative!)
  - The order is better expressed as a medical recommendation for care at the end of life
    - 'We'll do everything we can to keep you comfortable and as part of that, **I'd recommend that** when you are dying, we allow you to die peacefully without any aggressive measures like resuscitation'

Summary

- These conversations are difficult but are made easier and more efficient with a few key skills

How would you approach this conversation?

- 'Mrs S is a 62yo with ESRF secondary to T2DM who has been on HD 3 x week for the last 10 years. Her other history includes hyperlipidaemia, hypertension and IHD with NSTEMI x 3 over the last 2 years with diffuse 3 vessel disease on angiogram not amenable to stenting. She also has CCF with an LVEF of 35% on her last echo. She presented this admission with an STEMI and now has worsening heart failure despite optimal medical management with persisting hypotension. Her BP cannot be maintained during dialysis and a family meeting is arranged to discuss cessation of dialysis'