2018
28-30 JUNE
VIENNA, AUSTRIA
SUPPORTIVE CARE MAKES EXCELLENT CANCER CARE POSSIBLE

Communication - the good, the bad, and the ugly

Professor Greg Crawford MBBS, MPHC, MD, FRACGP, FAChPM
Senior Consultant Palliative Medicine & Director of Research and Education
Northern Adelaide Palliative Service, Northern Adelaide Local Health Network

Professor of Palliative Medicine
Discipline of Medicine, University of Adelaide, South Australia

Faculty Disclosure

	No, nothing to disclose
X	Yes, please specify:

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SA Health							X	
NHMRC			X					
Palliative Care SA								X Chairman, Board
Australasian Chapter of Palliative Medicine (RACP)								X President

Communication - the good, the bad, and the ugly

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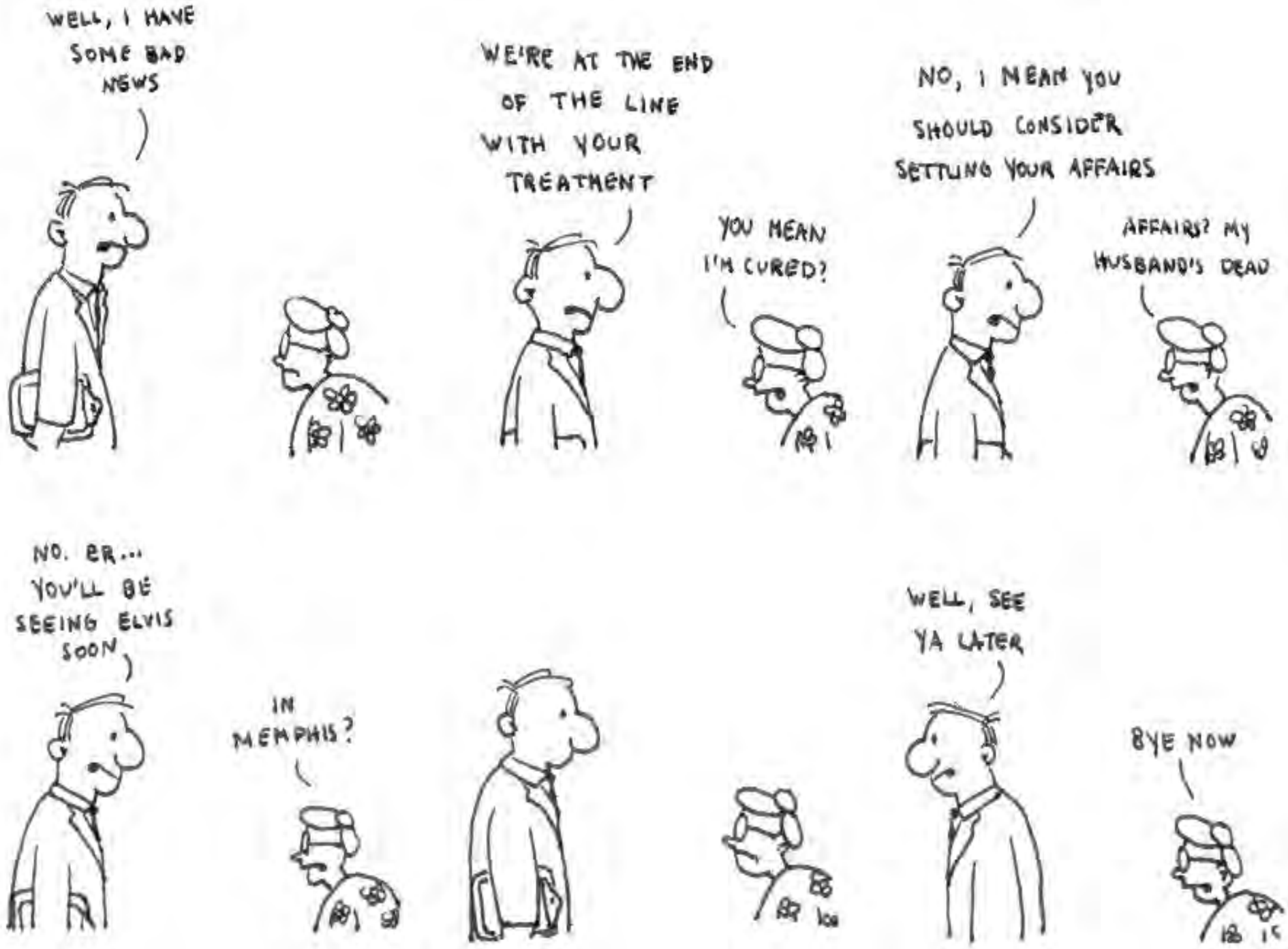
Communication - the terrible, the ugly, insight, then hopefully better


WELL, I HAVE SOME BAD NEWS
WE'RE AT THE END OF THE LINE WITH YOUR TREATMENT
YOU MEAN I'M CURED?
NO, I MEAN YOU SHOULD CONSIDER SETTLING YOUR AFFAIRS
AFFAIRS? MY HUSBAND'S DEAD
NO. ER... YOU'LL BE SEEING ELVIS SOON
IN MEMPHIS?
WELL, SEE YA LATER
BYE NOW

Outline

- What we know
- Why is this so
- Complexity
- Traditional pedagogy
- Breaking bad news models
- Practical scenarios and suggestions
  - Am I going to die?
  - How long have I got?
  - Complaints and angry patients
  - Crying patients and professional boundaries
- Family meetings

What do we know

- There are deficiencies in health professional provision of information about prognosis and end-of-life
- Many health professionals are uncomfortable discussing these issues
- perceived lack of training
- stress
- no time to attend to the patient's emotional needs

What do we know

- fear of upsetting the patient
- a feeling of inadequacy or hopelessness regarding the unavailability of further curative treatment
- Can lead to reduced patient satisfaction and psychological morbidity
- When done badly leads to long-term harms

BUT

- When cancer patients are not adequately informed of their prognosis, they are more likely to choose aggressive anticancer treatments and make decisions that they later regret
- Awareness of prognosis is associated with greater satisfaction with care and lower depression levels in patients

Complexity: ‘runaway world’

- Rising numbers/types of treatments, drugs, technologies, tests
- Staff and patient churn (changing demographics, training/treatment trajectories, short-term relationships)
- Multi-morbidity (we die with +/- 3 diseases; 20% die with 5+ diseases): care complexity
- From treatment of disease to ‘optimisation’: pre-emptive care.

Rising complexity

Implication of complexity

- “life is outrunning the pedagogies in which we have been trained”

Fisher, M. (2003). *Emergent forms of life and the anthropological voice*. Durham NC: Duke University Press.

Traditional Pedagogy: Learning for stability

- Fact & rule memorisation
- Authority resides elsewhere
- Representational knowledge: numbers, reasoning
- Execution of routines
- Measurement and monitoring from a distance: fixed benchmarks
- Cognition: ‘what I know and how I apply it’

Towards a pedagogy for complexity: From acquisition to adaptive response

- Learning for complexity
- Knowledge design
- Authority resides in us
- Experiential knowledge: visualisation, emotion
- Actors' inter-dependence
- Evaluation of local, contextualised practice
- Practice: 'what we do and what its effects are'

Breaking bad news models

- Six-step SPIKES protocol (Buckman 2005)
- BREAKS protocol (Narayanan et al 2010)
- PREPARED (Clayton et al 2007)
- Kay's ten step approach (Kay 1996)

Breaking Bad News
Buckman's 6-step guide

- **S.P.I.K.E.S.**
- **S**etting, listening **S**kills
- **P**atient's **P**erception
- **I**nvite patient to share **I**nformation
- **K**nowledge transmission
- **E**xplore **E**motions and **E**mphasise
- **S**ummarise & **S**trategize

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BREAKS

- Background
- Rapport
- Explore
- Announce
- Kindle
- Summarize

ABCDE

- Advance preparation
- Build a therapeutic environment/relationship
- Communicate well
- Deal with patient and family reactions
- Encourage and validate emotions

PREPARE

- Prepare for the discussion
- Relate to the person
- Elicit patient and caregiver preferences
- Provide information tailored to the individual needs of both patients and their families
- Acknowledge emotions and concerns
- (foster) Realistic hope (e.g. peaceful death, support)
- Encourage questions and further discussions
- Document

Kaye's 10 step approach

1. Preparation
2. What does the patient know?
3. Is more information wanted?
4. Give a warning shot
5. Allow denial
6. Explain if requested
7. Listen to concerns
8. Encourage ventilation of feelings
9. Summarise
10. Offer further

BUT:

- Patients' and caregivers' experience of the healthcare system prior to hearing the news plays an important role in the way the news is ultimately internalized
- Families want different information for themselves and for the patient
- Families ask for guidance in interpreting what clinicians say to them
- Families are often ambivalent about both how much information patients should know and what they themselves are able to cope with and understand

(Shaepe 2011; Russ and Kaufman; Vedel 2014)

The trouble(s) with structures and models

- Based on a
  - linear model of ‘information giving’
  - transmission myth (sender→receiver model)
- Emphasis on physician/patient communication
- Guidelines focus on *clinician* behaviours
- Does not take account of communication complexities (especially context)

The trouble(s) with structures and models

- Often ‘disease-centred’ & focused on diagnosis
- Limits communication to ‘a task to be done’
- Assumes a single disclosure episode applying skills
- Focused on ‘verbal communication’

- “It is incredibly naïve to take conscious verbal communications as the primary way that people respond to each other.” (Buchanan 2009)

An alternative to breaking bad news models…

- “an intersubjective or relational model would pose physician, patient, and family “preferences” as intimately bound together and contingent, and communication as processual, often confused, and multilayered”

(Donnelly 1996:1228; Kaufman 1998)

- ‘Relational dialectics’

(Baxter, 1990; Baxter & Montgomery, 1996)

Difficult conversations for me

- Bad news
  - Diagnosis
  - Recurrence
  - Deterioration (the “progression” word)
- How long have I got?
- How will I know I am dying?
- What is going to happen?
- Can’t you hurry this along?

General principles

- What is ‘bad news’?
  - i.e. recognise
- How would you like to hear information?
- How do you know what your patients want?
- Why is how we give information so important?

- How to set it up
- Where
- When
- Who
  - To be there
  - To do the telling
- Who else
- Follow-up

Generic communication skills

- eye contact (if culturally appropriate)
- body language such as an open posture
- sitting close to the patient
- active listening
  - nodding or making noises of agreement or encouragement to indicate understanding
- reflecting empathically
- showing compassion
  - a warm, caring, and respectful manner

- Clarifying patient and caregiver understanding
- Clarifying information needs
- Facilitating hope and coping

Am I going to die?

- Well aren't we all?
- Not a useful response

What is going to happen?

- What is the question?
  - What is dying like
  - What is death like
  - How are the next …days/weeks/months/years… going to unfold?

What is going to happen?

- What is the question?
  - What is dying like
  - What is death like
  - How are the next …days/weeks/months/years… going to unfold?
- ***BEWARE***
- The question might have been how long is the course of treatment

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www.mascc.org/meeting

Prognosis/How long have I got?

- What is being asked?
- Who is asking?
- How to best answer
- Do I have patient's permission?

Prognosis/general framework

- Why
- What they understand already
- Who has already answered similar questions
- Do they have an idea or thoughts about this

Complaints

- Try not to be the cause of a complaint
- Are you the right person
- Offer to listen and take information
- If someone is already displeased, do not make it worse
  - Might be worth going the extra mile

Angry patients

- Self protection FIRST
- Make yourself small
- Do not touch the person EVER
- Listen
- Check
- Ask what they would like
- Make a plan and commit to it

Crying patients

- Is the tissue box a help or hindrance?
- Does touch help or hinder?

Professional boundaries

- Touch
- Hug
- Kiss
- Silence

Family meetings

- Discussions about
  - Goals of care
  - Site of care
- Mutually beneficial
  - Patients
  - Families
  - Staff
- Share information
- Answer questions and explore other relevant issues
- Not a place for debate
- Not for just a crisis

Facilitator

- Who
  - Pragmatic
  - Skills
  - Not necessarily hierarchy
- What skills
  - Knowledge of the health area
  - Skills in group work
  - Therapeutic communication

Preparation

- Consent
- Who will be present
  - ?patient
  - ?which others - genogram
- How many staff to patient ratio in the room
- Agenda or Anticipated outcomes
- Time
- Location
- Interruptions etc
- Prepare clinical information and likely questions

Meeting

- Welcome
- Introductions
- Ground rules including time allocated
- Clarify purpose of meeting
- Discuss planned issues
- Seek other issues
- Check reception/understanding
- Summarise
- Document

Document

- Date and time
- Who was present
- What was discussed
- Actions to follow and by whom

Self check

- Self awareness
- Self care
- Teams

- not ***what we do*** but ***how we are*** that matters

- "To play a piece of music exceptionally you have to learn the notes well – and then forget them."

from *Shine*

University of Adelaide Simulation clips

- Bad news
- Referral to palliative care and future plans
- Introducing goals of care conversation
- How long and future care plans

Referral to palliative care and future plans

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Introducing goals of care conversation

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How long?

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Summary

- Theory of communication
- Complexity
- Breaking bad news models
- Practical scenarios and suggestions
- Family meetings
- Videos

On line resources

- https://www.caresearch.com.au/caresearch/tabid/3866/Default.aspx
- http://www.pcc4u.org
- https://rise.articulate.com/share/0xG5YMdDHlVtOLPXEiSRwFY34W2-ZAT7#/?_k=b9y9fl

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