BSH Heart Failure Nurse and Healthcare Professional Study Day 2017

Presentation title: Difficult Conversations

Speaker: Liz Bryan, Director of Education and Training, St Christopher’s

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Difficult Conversations: Interpersonal Communication at the End of Life

Liz Bryan, Director of Education and Training
End of Life Care Strategy (DoH, 2008)

All people approaching the end of their lives need to have their needs assessed and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan.
New NICE Guidance!!!

Care of dying adults in the last days of life.

Professor Gillian Leng, Deputy Chief Executive of NICE Stated;

“We know the vast majority of people in this country receive very good care at the end of life, but this isn’t always the case…Our guidance will support doctors, nurses and other healthcare professionals so that they can work together to ensure that people die with dignity, whenever possible in the place of their choosing and with their symptoms effectively controlled.”
The new guidance covers 4 Quality Statements:

- **Statement 1:** Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering.

- **Statement 2:** Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan.

- **Statement 3:** Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.

- **Statement 4:** Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options.
Why do we need to get it right?

• Effective communication during consultations is the major determinant of the accuracy and completeness of data collection, influencing both the range and number of symptoms elicited, thus permitting a more precise assessment of the efficacy of treatment (Fallowfield and Jenkins, 1999)

• There is compelling evidence that communication affects numerous other important and meaningful health outcomes, such as adherence to drug regimes and diets, pain control and improvements in physical, functional and psychological well-being (Ong et al, 1995: Stewart, 1996)

• Poor communication can leave patients uncertain about their diagnosis, prognosis, confused about the results of diagnostic tests, unsure about further management plans or the therapeutic intent of treatment (Bruera et al, 2001)
What is interpersonal communication?
Is it like….

• ....an arrow?

• ......or a dual-carriageway?
….or a dance?
What is inter\textit{personal} communication?

Definition: Inter\textit{personal} communication is the process by which people exchange information, feelings and meaning through verbal and non-verbal messages.

(Brooks and Heath, 1985)
Interpersonal Communication

- Relational, i.e. individuals are in relationship (face to face/telephone/email??)
A good patient experience is multidimensional concerning;
1. ‘functional’ aspects of care (such as arranging the transfer of patients to other services, administering medication and helping patients to manage and control pain),
2. ‘transactional’ aspects of care (in which the individual is cared ‘for’, e.g., meeting the preferences of the patient as far as timings and locations of appointments are concerned) and
3. ‘relational’ aspects of care (where the individual is cared ‘about’, e.g., care is approached as part of an ongoing relationship with the patient).
The therapeutic relationship

- A belief that contact is beneficial…… a person feels understood and is thus helped to understand himself better

- We decipher the meaning for the person and then go further to ‘hold’ or ‘contain’ their experience

  (Lanceley, 1995)
Relational care is;

- health care that honours and focuses on relationships (*between persons*), including those between the practitioner and self, practitioner and patient, practitioner and practitioner, and practitioner and community.

Jürgen Habermas (Born 1929)

- Philosopher and sociologist
- Critical theorist and pragmatist
- Theory of Communicative Action

Systems and Lifeworld

(Habermas in a nutshell!!!)
Interpersonal Communication

• Relational, i.e. individuals are in relationship (face to face/telephone/email??)
• Partnership & Permission
• Involves, language, tone, non verbal signs
• More subtly involves awareness, mutuality, trust, negotiation, respect
• Reflects the personal characteristics of the individuals as well as social roles and relationships
…..but what are the costs to the professional?

• Emotional labour vs professional distance?

• Fight or flight?
Why do professionals often avoid these conversations?

• Fear of being blamed
• Fear of the unknown and the untaught
• Fear of unleashing a reaction
• Fear of expressing emotion
• Fear of not knowing all the answers
• Personal fear of illness or death

(based on Robert Buckman, 1984)
A Framework for Professional Interpersonal Communication: 

The 5Ps©

• Draws primarily on theory from humanistic psychology
• However, also recognises the theory of the unconscious and the ‘defended’ self
The Five ‘Ps’

• Person(s)
• Purpose
  • Preparation
  • Process
  • Product

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Applying the 5Ps

Person(s) → Preparation → Process → Product → Purpose
Person?
Person-centred Care?

It’s not being………

• treated like an object when you’re a person
• treated like a child when you’re an adult
• treated as dependent when you have the capacity to be independent
• treated as absent when you’re present

"My name isn't sweetie, dearie or love, I am usually called Dr Elliott."
Professional Practice  (Fish & Coles, 1998)

- Performance aspects of practice (clinical procedures, conversations or information giving) are above the waterline
- Hidden from view are feelings, expectations, assumptions, attitudes, beliefs and values
Core Conditions for a ‘Helpful’ Relationship (Rogers, 1961)

A person is more likely to respond positively if they experience the ‘helper’ as;

• Respectful (Unconditional positive regard)

• Empathic

• Genuine (Congruent)
Purpose?
Purpose

General
• What is my professional role and responsibility?

Specific
• Do I have an agenda? What do I want to get out of this conversation?
• What is the current situation and what are my priorities?
Interpersonal Communication in a Professional Context

Importance of identifying and understanding context and role:

• What is significant about the professional’s role and responsibility?
1. **Beneficence**: doing good for others. The duty to do good and prevent harm and to act in the best interests of the client

2. **Non-maleficence**: the duty to do no harm. Any intervention needs to be weighed against the good and bad effects

3. **Justice**: As applied to the person’s rights, what the person deserves according to their needs

4. **Respect for autonomy**: the freedom to determine one’s own future without external constraints. Relies upon truth-telling, accurate information, respect for confidentiality, varying value systems and understanding

*(Beauchamp & Childress, 2013)*
Interpersonal Communication in Professional Context

Importance of identifying and understanding context and role:

- What is significant about our professional role and responsibility?

- What is significant about the context in which we will be having this conversation?
Preparation?
Preparation

Why prepare?
Preparation

• What do I know or perceive about the person/people? (Culture, insight/understanding, past experience, expectations of me etc)

• What am I trying to achieve? What is my purpose, generally and specifically?

• What am I thinking and feeling? Am I emotionally and cognitively prepared for what may take place?

https://www.youtube.com/watch?v=cDDWvj_q-o8

https://www.youtube.com/watch?v=rbxb3DcaohU
Preparation

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• What clinical facts do I have? (Diagnosis, past medical history, latest blood/scan results, what conversations have already taken place?)

• Do I need anything with me? (Notes, written information, contact details, equipment, interpreter?)

• Where is the conversation to take place? (Environment, privacy?)
Process?
Core Conditions for a ‘Helpful’ Relationship (Rogers, 1961)

A person is more likely to respond positively if they experience the ‘helper’ as:

- Respectful (Unconditional positive regard)
- Empathic
- Genuine (Congruent)
Where to start??

Find out where the person is!!!
What are the obstacles to effective communication in practice situations?

- Starting a conversation – what obstacles and why?
- Keeping a conversation going – what obstacles and why
“On average patients were interrupted 18 seconds after beginning to talk!”

(Beckman and Frankel, 1984)
• Opening
• Picking up cues
• Probing/Questioning
• Challenging
• Reflecting/Responding
• Checking and clarifying
• Information giving
• Paraphrasing
• Summarizing
• Agreeing next moves
• Closing
What are the obstacles to effective communication in practice situations?

- Starting a conversation – what obstacles and why?
- Keeping a conversation going – what obstacles and why
- Closing a conversation – what obstacles and why?
Product?
• Why does having a product matter ........and to whom?
Product?

Reflection:
• Was the purpose achieved or was there another outcome?
• Was the conversation ‘helpful’ for me?
• Was the conversation ‘helpful’ for the patient?
• What went well and what could I have done better?
• What have I learnt for next time?

Action:
• What do I need to share with the team?
• How and where will I document the outcome?
Applying the 5Ps

Person(s)

Purpose

Preparation
Process
Product
In Groups

- Reflect on real case scenarios
- Use the 5Ps as a framework to structure how you might approach the situation
Scenario 1

Tom is a 72 year old married man, with a 10 year history of Ischaemic heart disease and heart failure. He has experienced worsening angina type symptoms over the past 2 years, with frequent admissions with chest pain and palpitations and increasing symptoms of HF with breathlessness and fluid overload. Most of his care has been managed by an interventional cardiologist but there are now no further treatment options. Tom understands that he is for "medical management", but nobody has explained that his condition is life limiting. Tom has been referred for community management, but at no time has Tom or his wife been told that his care was now palliative and that we are looking at managing his care/needs/symptoms/wishes at the end of his life. Tom’s wife was hostile and aggressive on an initial telephone call.
Scenario 2

Sam is a 38 year old man, employed as a dock worker. He has a 2 year old boy and 10 year old girl and is in a long term relationship. He has a history of hypertrophic cardiomyopathy and was admitted with worsening heart failure. He was seen in the HF clinic by a cardiology registrar and told out of the blue that the only "treatment option left available is a heart transplant" but to be eligible for that he must stop smoking.

He arrives at your clinic room in shock with his partner cradling the two year old whilst in floods of tears.
Scenario 3

John is a 24 year old man with Duchene's muscular dystrophy and heart failure. He is approaching end of life both from a respiratory and a cardiac perspective. It is proving difficult to ascertain what John wants in terms of his preferred place of care etc as his mum is unwilling to discuss this and will not allow the medical team to broach the subject with John. She is with him 24/7
Scenario 4

Trevor is a 60 year old married man with a 16 year old daughter and an 18 year old son. He has a long standing history of heart failure, has an ICD fitted. He has been diagnosed with advanced pancreatic cancer and has been told he has weeks to live. His oncologist has asked that his device is deactivated but Trevor and his family are struggling to come to terms with his diagnosis and see his device as something that will help him live longer. Turning it off will hasten his death.
References:


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