

Courageous Conversations

Many GPs have reported that they are not confident initiating a conversation about end of life care preferences and wishes.

We know that if they do,
**90% of patients will continue the conversation
and most GPs report relief and satisfaction afterwards**

(Dying Matters GP Pilot Project Evaluation, 2010-11)



Golden Nuggets

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More than 1/3rd of GPs

... have not initiated a discussion with a patient about their end of life care wishes

Only 1/3rd of GPs have asked a family member about their end of life wishes,

... and 35% have talked to someone about their own wishes.

(Dying Matters Coalition Survey of GPs and the Public, ComRes, 2012)



Effective Symptom control is impossible without Effective communication

Buckman 2000

Silverman J., Kurtz, S., Draper, J. (2005)
Skills for communicating with patients

Good Communication is much more than being nice.
It leads to effective consultations.

The essence of good communication is **not what we say but how we listen**. We need it for all aspects of the assessment of the patient their families and the change and uncertainty they face.

The strap line of the GP Update team Effective Consultation course is
“Increase your effectiveness, Reduce your clinical (& medico legal risk)”

It sites risky behaviours as

- Devaluing patient or family views
- No information given or done badly
- Not understanding the patient or family perspective

It is easy for the busy health professional to use a variety of **blocking tactics** which inhibit communication, such as hiding behind **task focused practice**.

Barriers

- **The professionals**
 - **Fears** - Opening up a bag of emotions, takes too long and not being able to deal with what they ask
 - **Beliefs** – not my role, if I can't answer the questions why look for them, Can't do anything useful in the time I have as a GP
 - **Skills** I'm out of my depth
 - **Lack of information** on the patient and on support and solutions if problems are identified.
- **Patient**
 - **Fears** of admitting can't cope, breaking down, of having their fears confirmed
 - **Beliefs** – the professionals are too busy. That if they rock the boat raising concerns it'll interfere with the treatment they receive
 - **Difficulties** overawed
 - Language difficulties
 - The relevant questions (openings) are not asked by the Dr

Breaking Bad News Preparation

Where you have the opportunity prepare. It's not always possible in advance.

- Check what information you have.
- Are you the best person for the discussion?
- Do you already have a working relationship or is someone else their regular doctor.
- Do they live alone?
- Do you know their family? If not consider asking "Who's at home and what would they like us to have talked about?"

Continuity, trust and rapport.

With our regular patients there will be many difficult issues that we will have discussed over time. If they are comfortable with us they come back.

The Benefits of a Named GP extend beyond the obvious. Did you know elective admissions increase as being able to consult a particular GP declines

Characteristics of general practices associated with numbers of elective admissions. [JPublic Health](#)

(Oxf).2012 <http://www.ncbi.nlm.nih.gov/pubmed/22448040>

Environment

Surgery room is pretty good in my experience, keep free from interruptions at the door or telephone.

The patients home is even better.

The key environment of course is inside our heads.

Timing

Emotional energy – better earlier in the day than late.

End of morning surgery, or a home visit both give the capacity to take a bit longer.

Consider rescheduling or bring back at end of surgery or "If its Ok with you can we make proper time to talk this through"

Meet and Greet

Do you greet patients?

Do you introduce yourself?

“Hello, my name is....” <http://drkategranger.wordpress.com/2013/09/04/hellomynameis/>

If in doubt ask “Did I pronounce your name correctly?” Names mean a lot to people.

Do you shake hands or offer to shake hands when you greet patients?

With a handshake you are making a strong non verbal connection with a patient.

Might not suit all occasions but generally it's a good start. Consider it.

Did you know that Drs who regularly shake hands generate fewer complaints?

Do patients want to know?

Elisabeth Kubler-Ross in 1969 (yes 1969!) for her book “On death and dying” spent a couple of years interviewing terminally ill patients. She described how doctors were the main reason conversations around death and dying didn't happen. Most patients at some point would like to talk about death and dying, but they are not always ready. The easy conversations are those where the patient is ready. You won't know if you don't ask. If they are not ready, they will have learnt that you are not a doctor stuck in the 60's, and that you are comfortable with such a conversation.

From the Oxford Handbook of Palliative Care. There is increasing evidence that most patients want to know about their illness. Many patients who have been denied this knowledge have difficulty in understanding why they are becoming weaker and are then relieved and grateful to be told the truth. They may be angry with the family who has known about the illness all along and have not thought it right to tell them.

What do they want to know?



ASS U ME makes an Ass out of U and me

There is a balance to be made between fully informing the patient about their disease and prognosis, providing only minimal and inadequate information, and causing distress by ‘information overload’.

So assess

How much the patient knows already?

How much the patient wants to know?

“To help me get my bearings, can I ask you what do you know already and what would you like to know?”

“Are you the sort of person that likes to know everything?”

They may of course ask you to tell them straight.

Consider **ICE**: What Ideas or Concerns do you have about what is going on?...What would you like from me (expectations)?

Take your time!

Patients and families respond badly to being told bad news in a hurried, brusque and unsympathetic manner with no time to collect their thoughts and ask questions. THEIMPACT of the news can obliterate a great deal of the communication that took place.

Breaking bad news with Warning Shots

A warning shot is concerned with preparing a patient that bad news is coming. This allows them to be more receptive than if it comes 'out of the blue'. An example would be, 'I'm sorry to say that the results were not as good as we had hoped.'

Chunks and checks.

Give small amounts of information and check the patient is with you. Avoid Jargon, euphemisms, acronyms and bluffing.

Empathy

Acknowledge the gravity of the situation "That's quite a lot to take in?"

Acknowledge what you see. "I can see you're upset"

Validate: "Its OK to be upset.....It can be very upsetting to get such news"

Pauses – allow them

If you are interrupting a pause "Do you mind if I ask what you're thinking just now"

Explanation and planning

Ask what explanation or information would be helpful.

Chunks and checks

Small amounts and check the patient is with you

Shared understanding

Check understanding, summarise back to them. Use their words.

Shared Planning

Make suggestions and ask for theirs. Reach agreement

Make concrete plans for the next step e.g.

Clarification of outstanding information

The next contact, face to face or telephone with you

Any referrals?

Immediate plans

'What are you doing now?' 'How are you getting home?' 'Who will you tell?' 'How will you tell them?' 'What will you say?' 'How will they cope?'

Such questions can help the patient to start formulating the answers that they will need for their family or friends.

Summarize

For the patient.

Try to get the patient to repeat the key points to ensure they have Understood

For other healthcare professionals

Record details of the conversation in the patient's notes clearly. Convey information quickly to those who need to know, especially the patient's GP if it's not you.

An appointment where a worried patient asks to discuss a **hospital letter.**

What do you do if it's *not* available? Very similar to what you do if the letter *is* available. Check out the patients agenda, first.

- Letter available: The letters here so I can have a look at that. But first can I check with you what you know already, what's your understanding of things?
- No Letter available: The letters not here. If need be (depending on undue delay or gravity of unfolding situation) I can chase that. But first can I check with you what you know already, what's your understanding of things?

In Defence of **Denial**

About 10% of people absolutely do not want to discuss End of Life issues. Across the UK that's a lot of people.

Denial is a coping mechanism and is allowed. Don't force through it
If all you can say (or all they will hear) is that there is no hope, keep your mouth shut.



Key points in exploring denial

Look for any evidence that denial is not absolute (a window), e.g.

Now: 'How do you feel things are going at the moment?'

Past: 'Has there ever been a moment when you think things aren't going to work out?'

Future: 'How do you see your illness affecting your future?'

If there is no evidence of awareness – leave the situation as it is. Ensure regular follow-up to reassess the denial. It may well become much less absolute, especially in light of the changing clinical situation and increasingly unpleasant symptoms.

Collusion

This may occur when a healthcare professional is approached and pressurized by, for example, a relative to withhold medical information from the patient. The HCP is being invited to collude with the relative in constructing or maintaining a conspiracy of either silence or falsehood concerning the seriousness of the patient's illness. The stated rationale is often that the relative knows the patient extremely well and that 'they would just turn their face to the wall'. Alternatively, they would be unable to cope with the truth about the situation, and that there is no reason in the view of the relative for the patient to be bothered or alarmed by unpleasant news.

Focus on:

- The relative's feelings
- The relative's reasons for not wanting to be truthful
- Acknowledging the relative's motives, e.g. protecting the patient from distress
- The strain placed on the relative/patient relationship by not being truthful with someone who they are usually very close to emotionally
- The relative's perception of the patient's understanding. Seek to identify any evidence that the patient might already suspect the truth.

Then:

- Offer to assess the patient's understanding of their illness directly

Reassure the relative that information will not be forced onto the patient if such information is not explicitly requested or wanted. **Such a strategy often results in the patient disclosing to the HCP that they are fully or partially aware of the true nature of the situation.**

In the majority of instances, this information will be seen as **a great relief** to both the relative and the patient.

The power of words

Adjusting the language you use can make discussions easier. Settle on words and phrases that suite you.

http://www.youtube.com/watch_popup?v=Hzgzim5m7oU&vq=medium

or enter “**power of words**” into a google search

Watson, M.S. Lucas, C.F. Hoy, A.M. and Back, I.N. (2009) **Oxford Handbook of Palliative Care**.Oxford: Oxford University Press.

Kübler-Ross, E. (1969) On Death and Dying, Routledge, ISBN 0-415-04015-9

<http://www.gp-update.co.uk/The-Effective-Consultation-Course>