Patient-Centered Communication: Lessons Learned

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Learning Outcomes

- Discuss the importance of cultural assessment in communication
- Identify 3 non-therapeutic communication traps
- Discuss 3 verbal and 3 non-verbal techniques that can improve communication
- Name 4 concepts that enhance patient-centered communication

Ms. Brown—You Failed

- You are Palliative Care Social Worker
- 43 year old female Master’s student
- Diagnosed with leukemia
- No definitive treatment locally
- Traveled out of state for clinical trial
- “Failed 2 trials
- Tearful, frightened – in your office – “I failed 2 treatments…what if this one does not work?”
Definition of Communication

- Peereboom and Coyle (2012)

“A complex, continual transactional process that occurs between persons by which information, feelings, and meaning are conveyed through verbal and nonverbal messages.”

Purpose of Palliative Communication

- Relational by nature
- Goal is to support patient’s
  - Values
  - Preferences
  - Beliefs
- Give patient information needed to make medical decisions consistent with above

Why Get It Right

- Patients and families are extremely vulnerable
- Already suffering from symptoms, acknowledging their own or loved ones mortality
- Other health care providers may have previously communicated poorly
- We aim to decrease suffering not increase suffering
Unintended Consequences

- Impaired medical decision making
- Loss of trust in providers
- Increased depression – patients/families
- Increased anxiety – patients/families
- Problematic grieving – patients/families
- Health problems for family members
- Increased physical suffering for patients
- May result in more aggressive care
- Or…requests for physician assisted suicide

Getting It Right

- Culturally-appropriate communication
- Use techniques that improve communication
- Patient-centered communication
- Avoid communication traps

What Makes Difficult Conversations Difficult?

- You tell me…
COMFORT Initiative

- Developed by Wittenberg-Lyles, Goldsmith and Ragan (2010)
- Purpose to help nurses improve palliative communication

C  Communication
O  Orientation
M  Mindfulness
F  Family
O  Oversight
R  Reiterative and Radically Adaptive Messages
T  Team

COMMUNICATION

- ‘Narrative’ approach – goal is to learn the patient’s story to gain empathy
- ‘Witnessing’ – being totally present with patient or family member in order to understand their perspective.
- ‘Interpathy’ – “Interpathy is intentional cognitive and affective envisioning of the thoughts and imagining the feelings of a truly separate other.” (Augsburger, 2013).

Clear & Caring

- Gently express patient’s frailty and continued decline
- Patient/family need to clearly understand expected outcome – Use “D” word – gently
- Goal is for higher quality messaging using fewer words
- Must be patient-focused care not disease-focused
- Should consider all domains of care - physical, emotional, psychospiritual
Orientation
- Communication directed to health literacy level of the patient and family
- Strive to increase health literacy through education and presence
- Develop plan of care
- Acknowledge frailty of patient and stress of family

Mindfulness
- Centered in the present
- Set aside any existing biases
- Help patients/families adapt to multiple changes

Family
- Family as secondary unit of care
- Support system
- Primary care givers
Oversight

- Coordinated care
- Goal is to relieve symptoms of patient and burden of care for caregivers

Reiterative, Radically Adaptive

- This communication requires time
- Encounters must be good quality
- Messages often need repetition over time
- Patient’s needs and acceptance of frailty drives communication—content, quantity and quality

Team

- Interdisciplinary – specially trained in palliative care
- Team assures patients/caregivers that they will journey with patient and not abandon them
- Goal – continuity of care from same team
Plain Language

- Wittenberg-Lyles, et al. (2013) completed a study on using Medical Words with Family Caregivers.
- Found providers used medical words in communications 6X more than family caregivers.
- What did the caregivers do?
- They shut down and don’t ask questions – don’t want to feel dumb.
- Watch for verbal & non-verbal cues of not understanding or need support.
- SW’s/Chaplains – good place for you to intervene.

Open Non-Verbals

- Eye level with patient/family – sit down – if small room – at least one person sit down.
- Put pagers, cell phones on hold.
- Not the time to document as you go.
- If using computer to access records, cue patient/family before you begin searching.

Active Listening

- Give patients/families time to talk about concerns/fears, express emotions.
- Use verbal and non-verbal cues of active listening:
  - Go on…
  - Tell me more…
  - Lean forward
  - Nodding.
Considering Cultural Context

- What is culture?
- Values, beliefs & traditions held by a certain group
- Learned from family or social group
- Arise from environment – physical &/or social
- Might be:
  - Religion
  - Ethnicity
  - Regional – example – Southwestern United States
  - Socioeconomic influences

Developing Cultural Competence

- Jenko & Moffitt (2006) recommend “Know Thyself”
- Assess your own racial/ethnic/religious identity
- Assess what personal cultural traits you value (and which ones you don’t value)
- Assess your own biases
  - Other cultures
  - Different lifestyles
  - Folks involved in illegal activities or history of incarceration
  - Physical/mental disabilities
  - Assess what “pushes your buttons” in others

Assess “Culture” of Family

- Education level of family members
- Health literacy
- Ethnicity – must consider enculturation
- Socioeconomic status
- Medical history
- Meaning of illness – patient and family
- Coping/defense mechanisms
- Communication patterns
- Experiences with death & dying
- Decision Makers
Culture within a Family
- Patient is elderly male from urban Midwestern city – dying in GIP unit in suburb of same city
- Had been living with daughter
- Numerous admissions for hypothermia (in June), sepsis, skin breakdown in past 6 months – two admissions this month
- Open DHSS case for financial exploitation, suspected neglect from leaving debilitated patient alone
- Local daughter refused to participate in hospital POC despite many attempts to contact

PCG-daughter from Florida-Day 1
- Overwhelmed, anxious
- Surprised about Dad’s situation
- Hoped to take Dad home and care for him there
- Bargaining – “Is Dad dying?” “When will he die?” “How do you know he’s dying?”
- Worried about funeral costs – angry about alleged financial exploitation
- Wants Dad to be comfortable
- Does not want Dad to die on her birthday – tomorrow!

Local daughter-Day 2
- Visits for first time on sister’s birthday
- Demands in loud voice “I want all meds stopped”
- Asserts her legal status as PCG
- Believes patient dying because of hospice meds
- Family meeting offered by SW, APRN, RN – refused because daughter asserts “family says it’s all my fault and he’s dying on Friday…I have no say so let’s get out of here”
Florida Daughter-in-Law Day 3

- Calm, relaxed at bedside
- Articulates difficulty with prognosis in patient with long period of chronic illnesses/exacerbations
- Immediately discusses desire of family for comfort plan of care
- Acknowledges signs of dying
- Is an RN
- Very calming, affirming of both sisters-in-law
- Helps facilitate appropriate grieving when Dad dies

What happened?

- Defense mechanisms?
- Coping patterns?
- Health literacy?
- SES differences?

VALUE tool – Curtis & White

- Value family statements
- Acknowledge family emotions
- Listen to the family
- Understand the patient as a person
- Elicit Questions from the patient family

ICU tool for communicating with families – increases family satisfaction, decreases family stress & PTSD
Communication Traps

- Talking too much
- Using “doctor-ese” or “nurse-ese”
- Mismatched Verbal/Non-Verbal Messages

Talking Too Much

- Caring providers often feel ill at ease with silence
- Patients/families need time to process information
- Also need time to process emotion
- Jumping into conversation gaps may suppress emotions that need to be expressed
- Discourages questions
- May seem as if team/providers are in a hurry

“Doctor-ese & Nurse-ese”

- “Mrs. Green – your SCC lung CA is Stage IV, T2N3M3, progressive despite aggressive treatment with XYZ protocol, your ECOG score is 3, we need to get you to hospice PDQ.” They will evaluate your PPS and your MHB eligibility. From there, the medical director will complete a CTI and they will have you sign a NOE.
- Ridiculous, right?
- Also occurs in family meetings – team members use jargon when communicating with each other
Mismatched Verbal/Nonverbal Cues
- Closed non-verbal language negates open, caring communication
- Documenting on the computer, checking messages implies provider’s attention is elsewhere
- Team standing around or “over” bedside transfers power to the team rather than patient/family

Putting It All Together
- Assess key stakeholders – team/patient/family
- Pre-team conference – set goals for the meeting
- Assess what the patient/family understand
- Gain permission to disclose information
- Review of the medical facts – gently – but clearly discuss decline and eventual death
- Therapeutic silence – give time to process information

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Patient/Family Emotions
- Acknowledge emotions – name it if possible
- Normalize emotions
- Tease out underlying concerns – better to allow family to deeply explore emotions
- Express empathy – if genuine
- Assess coping strategies in previous experiences

Fast Fact #224
Bibliography


