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Planning

Advance Care Planning Communication
Skills Manual

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Preface

This manual has been developed from some of the content of the ACP Cooperative Curriculum Materials document as well as from the Connected Advanced Communication Skills Participant Handbook. Whereas the ACP Manual provides some basic communication concepts helpful to advance care planning, this manual provides more in-depth communication guidelines as well as frameworks for managing the more complex conversations.

This manual is for all health professionals involved in having advance care planning conversations and will be particularly useful as a reference for those who have completed the Level 2 training.

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Introduction

The importance of communication skills in the context of Advance Care Planning

Talking about future illness and death and dying can be difficult for many people, and strong emotions may be unleashed or may prevent an effective conversation. In addition, some people are very resistant to planning for the future for various reasons – for example they may have an unrealistic perception of their current and likely future health; they may be afraid of what they might be told; or they may feel that the health professional is not interested or that they would be burdening them. Whilst we need to respect a person’s choice not to engage in advance care planning, we do need to ensure the opportunity is offered in a way that is meaningful and accessible to the person. That may mean that we need to help the person deal with certain fears or uncertainties, or help them to understand and appreciate their health situation before, or as part of, an advance care planning conversation.

Barriers to effective communication

In order to communicate with people in a way that is meaningful to them it’s helpful to consider what might get in the way of the conversation.

Barriers have been identified from both the health professional and the patient point of view.

Healthcare professionals’ barriers

Fears

- Fear of unleashing strong emotions
- Fear of upsetting the patient
- Fear of causing more harm than good
- Fear of being asked unanswerable and difficult questions, such as “why me?”
- Fear of saying the wrong thing and getting into trouble
- Fear of taking up too much time
- Fear of dealing with patients’ emotional reactions.

Beliefs

- Emotional problems are inevitable and that nothing can be done about them
- It is not my role to discuss certain things
- There is no point talking about fears when we have no answers
- Talking about concerns that cannot be resolved falsely raises expectations.

Inadequate skills

- Not knowing how to assess knowledge and perceptions
- Not being able to integrate medical, psychological, social and spiritual agendas
- Not knowing how to move both into and out of feelings safely
- Being uncertain how to handle specific situations, for example breaking bad news.

Support

- Feeling that there is no support for the patient if problems are identified
- Feeling no support would be available for you
- Conflict within the team.

Patients' barriers

There is evidence that patients disclose as few as 40 percent of their concerns (Heaven and Maguire 1997), and that those who are most anxious or most distressed disclose least. Reasons for non-disclosure by patients include:

Fears

- Fear of admitting inability to cope
- Fear of breaking down or losing control
- Fear of stigmatisation by admitting psychological problems
- Fear of having their worst fears confirmed
- Trying to protect staff from their distress.

Beliefs

- Healthcare professionals are too busy to listen
- Healthcare professionals are only concerned with certain aspects of care, for example nurses with physical care, doctors with disease and treatment
- Talking about concerns will increase the burden on the healthcare professional
- Life depends on treatment and complaining about treatment will lead to its withdrawal
- Their worries are insignificant.

Difficulties

- Unable to express how they feel
- Unable to find the right words
- When they have tried to express their concerns to healthcare professionals, cues are met with distancing
- Inadequate command of the language
- Healthcare professionals do not ask the relevant questions

Communication Skills

Non-verbal communication

Body language refers to those movements and positions of the head, limbs and body that convey meaning. The function of body language is to give and seek information, express emotion, communicate attitude, establish and maintain relationships and regulate social interaction. Body language includes six aspects:

Personal space

This is the distance that participants maintain between themselves. This can be subdivided into four zones:

- Intimate (45cm or less) – when a loving or intimate relationship exists.
- Personal (45cm to 1.2m) – talking to friends or during an informal conversation.
- Social or consultative (1.2 to 3.6m) – meeting new people in a social situation or consulting a professional advisor.
- Public (over 3.6m) – usually employed by public speakers.

Healthcare professionals usually maintain a social or consultative distance but, because of their role, can legitimately enter the personal or even the intimate zone as diagnosis, treatment and interventions often involve close physical contact.

Touch

Touch is a powerful form of communication. Each culture has rules about bodily contact. Touch evokes powerful reactions, however it must be noted that not everyone likes to be touched. There have been a number of studies published that investigate the effect of touch, both on the well-being of patients and in its therapeutic uses. Few, however, have specifically looked at the use of touch within a clinical interview situation. Expressive touch is the definition given to that form of touch which is a spontaneous expression of affection and not connected to a procedure, such as massage. There is some evidence that expressive touch can increase attention and responsiveness in patients, and possibly reduce anxiety.

Eye contact

This includes how often and for how long a person looks at someone else and whether the gaze is returned. Looking is a channel for collecting information, by getting feedback and monitoring non-verbal behaviour. Eye contact also communicates attitude. It is an important signal for turn-taking in conversation. It can be influenced by culture in that people tend to look more if they are from a culture in which bodily contact is more acceptable. People from some cultures will offer their ear to show they are listening rather than looking in the eye – a sign that they do not believe you. Too much eye contact

may be perceived as threatening or superior, too little may be viewed as inattentive or insincere. Eye contact also changes with mood disturbance; sad or depressed people tend to look less and to look down.

Facial expression

Facial expression signals attitude and emotion. Facial expressions may give information about a person's true feelings by supporting or conflicting with what is being said.

Gestures

Gestures are voluntary movements that communicate a message to another person. They can also indicate the mood of the speaker.

- Emblems are gestures that have a direct verbal equivalent such as waving or nodding. These may be very sophisticated and form a recognised language, for example New Zealand Sign Language.
- Illustrators serve to emphasise, clarify or add to speech for example pointing or mime of actions.
- Reinforcers are actions that help to regulate the flow of speech, such as nodding your head to encourage the speaker to continue.

Posture

Posture can signal the strength of a person's emotional response. Depression is characterised by low tone, drooping head and shoulders. Anxiety is associated with an increased muscular tension. Open position is seen as being more friendly and warm, whereas a closed body position is usually interpreted as less friendly or even rejecting.

Verbal Interviewing Skills

The language we use may vary according to nationality. There will be cultural variations in how language is used. Verbal communication can include language, the words we use, and paralanguage, how those words are said, for example the tone of voice, pitch, clarity or rate.

Questions and question style

We ask questions to seek information. However, questions come in a variety of different formats, some of which are more helpful in encouraging disclosure than others. Questions may be broad open, open directive/focused, directive, closed, multiple or leading.

Broad open questions

A broad open question is 'open' as it requires more than a yes or no answer, so encouraging the patient to talk freely. These questions often start with 'how' or 'what' or 'tell me'. However it is also 'broad' – somewhat vague in nature, giving the patient no clear focus. For example:

“How are you?”

Open directive/open focused questions

An open directive question is one that requires more than a yes or no answer, so encouraging the patient to talk freely at the same time as focusing them on a clear topic or time frame. For example:

“What do you understand about your illness?”

“How do you feel about going back into hospital again?”

“What sorts of things are important to you as you approach the end of your life?”

Directive questions

A directive question is one that while being grammatically open restricts the patient to a predetermined factual answer. It is often used when additional clinical information is being sought. For example:

“Who did you see in clinic?”

“When were you last in hospital?”

“Who is your EPOA?”

Closed questions

A closed question is direct and specific. It anticipates the answer and requires the interviewee to respond yes or no. While useful at times, it is important to recognise that closed questions will severely limit patient disclosure. For example:

“Do you have an EPOA?”

“Did the doctor sign your advance care plan?”

Leading questions

Questions asked in such a way that they assume the answer or put words into the patient's mouth. They provide virtually no freedom for the patient to express themselves. For example:

“I expect that worries you, doesn't it?”

“No trouble talking with your family about these things?”

“That’s good news isn’t it?”

Multiple questions

Multiple questions link a number of questions of any type in quick succession without allowing a response from the patient. Using multiple questions can lead to difficulties as it can confuse patients, and make the response difficult to interpret accurately. Multiple questions can contain questions that are different, or simply a re-phrasing of the same question in different styles. For example:

“When you saw the doctor what did he say? Did you understand him? Who was with you?”

“How are you? Feeling better? Had a chance to think about advance care planning?”

Other verbal behaviours which facilitate communication

Listening

Listening is an active skill that requires great concentration if patients’ cues are to be picked up.

Active listening involves the act of relinquishing preconceived ideas about the patient, giving our attention, completely and freshly, to what is before us, not really knowing what we will hear or what that will mean. We should listen with a willingness to be changed by what we hear.

Silences

Silences are important as they allow both parties time to think and assimilate what has been said. Silences may naturally facilitate the patient to say more by providing a space to talk and follow their own rather than the clinician’s agenda. There is however a delicate balance between comfortable and uncomfortable silence. If the healthcare professional feels that the silence is becoming uncomfortable for the patient so that they appear more anxious or uncertain, the patient may need encouragement to speak. Phrases such as, “You seem deep in thought, can you tell me what you are thinking about?” may help as a prompt to continue.

Encouragement/minimal prompts

Utterances which indicate the patient is being heard and taken notice of include:

“Uhuh”

“Yes”

“Mmh”.

By actively showing interest it encourages patients to continue. For example:

“Really, that is interesting. Please go on.”

Acknowledgement

This is about letting the person know not only that they are being listened to, but also that WHAT they have said has been heard. For example:

PATIENT: “They told me I would have to go back next week for the results”

HEALTHCARE PROFESSIONAL: “Ah, so you haven’t had the results yet.”

Acknowledgement could then be followed by empathy, clarification or exploration (see below).

Picking up cues

Cues are “something that the patient says or does that is a hint to you that there is something more to be explored” (Butow et al 2002; Del Piccolo et al 2006). There is evidence to suggest that doctors who respond to cues appropriately may have reduced consultation times (Butow 2002).

Verbal cues may include:

- A mention of psychological symptoms – “I am worried”
- Words or phrases which describe physiological symptoms of unpleasant emotional states such as fear of dying
- Words or phrases which suggest vague or undefined emotions – “It feels odd”
- Verbal hints to hidden concerns – “It’s difficult”
- Neutral mention of an important/potentially stressful life event – “I lost my job” or “My mum died”
- Repetition of a neutral expression – “I don’t know how I feel”
- Communication of a life-threatening diagnosis – “He told me I had cancer”.

Cues may also be non-verbal. Crying, for example, may indicate negative or distressing emotions. Behaviours such as sighing, frowning or a look of despair often suggests there may be hidden emotions.

Healthcare professionals need to develop skills to pick up and explore such cues. For example:

HEALTHCARE PROFESSIONAL: “How are you today?”

PATIENT: “I’m fine really; it’s the family that have been upsetting me.”

The cue is “the family have been upsetting me”. The way of dealing with this is to use some of the following skills.

Reflection

This technique encourages people to talk about a topic or problem they have raised and may want to discuss further. The words are tentatively reflected back to the patient.

HEALTHCARE PROFESSIONAL: “So the family have been upsetting you?”

Clarification

This is asking questions to ensure the patient’s meaning is understood.

For example:

PATIENT: “I’m feeling so-so today.”

RESPONSE: “What do you mean by that?”

PATIENT: “I feel pretty average, you know...?”

You may wish to explore further.

Exploration

RESPONSE: “Are you able to tell me a little more about how that feels?”

Some questions enable more detailed information to be elicited. This will give more accurate detail on how to plan care. For example:

“You said that you have been worrying about the future. Can you tell me what exactly is worrying you?”

Empathy

Statements which demonstrate understanding from the patient’s point of view will encourage the patient to go into more depth. For example:

“It sounds as if it has all been very hard for you lately.”

“From what you have said, I get the feeling that you have been feeling pretty low.”

NOTE: It is important to recognise that effective empathy is NOT framing the statement from the healthcare professional’s point of view. For example:

“I know how you feel. I understand how you feel.”

Summary

Summarising is the deliberate act of providing an explicit verbal summary of the discussion to the patient. There are two types of summary:

An internal summary focuses on a specific part of the interview. For example:

HEALTHCARE PROFESSIONAL: “So what I’m hearing is there are some things that feel really important for you when you reach the last days of your life. You would like to be at home surrounded by family and to be as awake as possible and alert as possible but without a lot of pain?”

“PATIENT: “Yes that’s right, and I want my music playing.”

An end summary pulls together the entire interview. For example:

HEALTHCARE PROFESSIONAL: “You shared some very important information with me today, about what is important to you, how you would like to be cared for as you become more unwell, and what is important to you at the end of your life. You’ve also shared with me some concerns your family have about your ability to cope at home, and we’re going to arrange to have a meeting with them next week. Is there anything I have missed or you would like to add?”

PATIENT: “No that sounds about right. It’ll be good for you to talk about things with my family.”

As you can see, the summary provides intentional feedback to the patient, demonstrating that you have been listening to their story. It acknowledges what they have said and gives the patient the opportunity to correct any inaccuracies. Both physical and emotional concerns can be summarised.

Challenge

These are questions or statements that challenge discrepancies in what patients say. For example:

“You’ve said you are feeling fine and have no worries but you have just said that you are feeling anxious. Can you tell me a bit more about this?”

“You say that you want to go home as quickly as possible, but you have also said that you cannot be on your own and your daughter cannot help. Can we talk about this?”

Information giving

Patients should be given only the information they require. Assessment of patients’ information needs should be done before giving information. Patients are only able to retain small amounts of information at a time, which needs to be given slowly without using jargon or technical terms.

Behaviours that inhibit communication

There are a number of behaviours that have been commonly identified as inhibiting communication. They fall into the three categories set out below.

Blocking

Blocking is the term used to denote many different types of behaviour that have the function of moving the interviewee away from, or inhibiting them from saying more about how they feel about their predicament. Blocking can happen on a number of levels. It can have the function of:

Overt blocking:

PATIENT: "I was worried about what the doctor told me at the hospital"

HEALTHCARE PROFESSIONAL: "Do you have any pain?"

Moving away from the emotion but maintaining the content:

PATIENT: "I went to the doctor and he told me it was cancer. I was devastated, I had no idea."

HEALTHCARE PROFESSIONAL: "Did he tell you what type of cancer it is?"

Switching focus

Switching focus happens when the interviewer picks up part of the content of what has been said, but changes it so that the interviewee is not free to talk about the worries or emotions hinted at.

Switching time

The healthcare professional moves the time-frame of the interview, so stopping the patient from, for example, talking about how bad it was, and encouraging them to focus on better times. In doing this, the interviewer inhibits the patient from expressing their emotion about past events. For example:

PATIENT: "It was awful, I felt so ill, and so fed up, it seemed to go on forever."

HEALTHCARE PROFESSIONAL: "And how do you feel now?"

Switching topic

The healthcare professional controls the content of the conversation, but picking up only those areas which are factual or which contain no hint of feeling, so inhibiting the patients from talking about their worries or emotions. For example:

PATIENT: "I was so tired and in pain; I was absolutely terrified that I wouldn't get out of hospital."

HEALTHCARE PROFESSIONAL: "Tell me about the pain. How bad was it?"

Switching person

The healthcare professional changes the focus of the interview from the interviewee to a third party, either present at the interview or not. In doing so, the patient is inhibited from talking about how he or she feels. For example:

PATIENT: "I felt devastated when the doctor told me. I thought I was going to die."

HEALTHCARE PROFESSIONAL: "And how did your wife/husband/partner feel about it?"

Distancing strategies

Giving premature advice

There are many occasions in which professionals are called upon to give advice to patients. The giving of advice in itself is not a problem; it is the timing that can lead to the occurrence of blocking.

Giving advice prematurely, that is before the end of an interview, significantly decreases subsequent patient disclosure. Information can act as a block when it is given before the patient has been given the opportunity to express fully how he or she feels about the problem. This is because it focuses on solving the problem and thus deters the patient from saying how difficult the problem is.

Giving premature or false reassurance

In much the same way as information, giving reassurance is something that the healthcare professional is called upon to do on a regular basis. Again it is the timing of the giving of reassurance that acts as a block. If reassurance is given prematurely, that is before the problem, worry, or concern has been explored fully, then it will block subsequent disclosure. Giving false reassurance should be avoided at all times. For example, "I'm sure it will all be just fine."

Passing the buck

This is a particular form of premature advice in which the interviewer, in direct response to the patient's cue or concerns, gives advice about contacting or talking to a third party. While this may be very appropriate advice at the end of an interview after discussing the matter and having allowed the patient the opportunity to ventilate feelings, the inference in using it as soon as a patient mentions a problem, before full exploration, is that you are not interested in hearing about it.

Normalising

This is a particular form of reassurance in which fears are minimised in an attempt to make the patient feel better, but with the function of blocking the patient from talking about or expressing those fears. For example:

PATIENT: "I feel so afraid that I will have to go into a home"

HEALTHCARE PROFESSIONAL: "It's only natural that you don't want to go into a home; most people would feel the same."

Giving reassurance in this manner not only inhibits the patient from saying more but also detracts from that individual's experience. As with giving advice, it may be very reassuring for a patient to know that feeling upset or depressed is not uncommon. It is the timing that is crucial.

Using jargon

Using jargon which patients may or may not understand can be very confusing and can lead to blocking of disclosure. Similarly, allowing the patient to use every-day medical jargon may also lead to confusion, as he or she may simply be repeating words which have been heard but have not been understood.

Structuring a consultation

A consultation or interview that has structure is likely to enhance the gathering and the giving of information. Structure reduces the chance of random information exchange, and therefore helps to maintain focus. If the structure is overt, the interviewer and the interviewee (e.g. the patient) are more likely to both be aware of what is expected during each part of the consultation, thus putting them both on more equal footing. The basic structure of a consultation may comprise:

Introduction

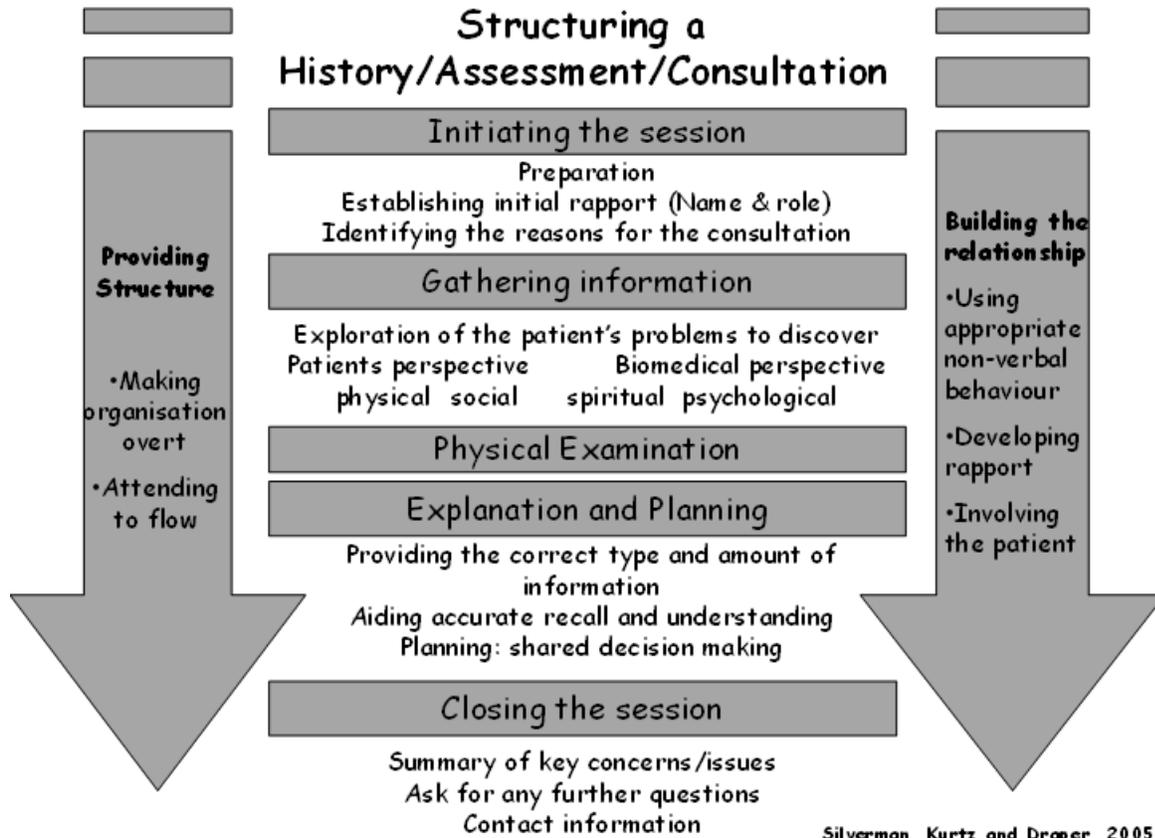
Gathering information

[Physical examination]

Explanation and planning

Close

By following this basic structure, the patient has the opportunity to first tell of their concerns, feelings, understanding and so on, thus increasing their chance of retaining any information they are then given. The Cambridge-Calgary model expands on this basic structure in the addition of an arrow either side of the core structure. One arrow indicates the 'flow' or 'sign-posting of the conversation (in other words making the structure overt) and the second arrow indicates the 'building of rapport'. Both aspects facilitate the communication, and are important throughout the entire consultation (Silverman, Kurtz and Draper, 2005)



Silverman, Kurtz and Draper, 2005

Working with ethnic diversity

Useful strategies

Greeting

- Check with the patient that you are pronouncing his or her name correctly. Our names are very important to our sense of self.
- Welcome the patient in a friendly manner, in terms of verbal and non-verbal communication. If patients are unwell and worried about understanding you and unsure they can make themselves understood, they will already feel under pressure. Anything which helps them feel more relaxed can only help the interaction.

Language style

- Speak in short, clear and grammatical sentences.
- Deal with one point at a time.
- Do not ask more than one question before waiting for an answer.
- Avoid clinical terms unless you are going to explain them. Some explanation of key terms can be empowering for patients.
- Beware of using idioms. These are words and phrases that can be puzzling to a non-native speaker, for example: “Have you been feeling down in the dumps?”
- Try not to use euphemisms, for example: “Passing away” instead of “dying”.
- Do not use local dialect terms unless you know the patient understands them.
- Break down instructions into sort, clear steps.
- Summarise important points at the end of the interaction.

Paralinguistic features

- Speak loudly enough but don't shout. Non-native speakers often find people shout as if their hearing is a problem.
- Speak in an unhurried way but not so slowly that it interferes with the flow.
- Emphasise important words and phrases.
- Look at the patient when you are talking.

Understanding the patient

- Give adequate time for answers. These may take longer to formulate if English is not the patient's first language.
- Ask the patient to explain any words or phrases of which you are unsure.
- Double-check with the patient that you have understood them correctly.

Checking the patient understands you

- Check understanding at regular intervals throughout the interaction.
- For important points, ask the patient what they have understood of what you have said.
- Do not assume that a nod or a “yes” indicates understanding as these gestures are sometimes just to show politeness or deference.
- If understanding seems poor, ask whether they would prefer an interpreter to be present and explain how you can organise this (otherwise they may think they have to both organise and pay for one).

Back-up

- Use pictures or diagrams where they will clarify meaning.
- Write down important points for the patient to take away with them. Even if English reading ability is limited, someone else in the family might be able to help.
- In some cases where there is important information to transmit, a audio recording can be made and given to the patient.

Communicating with people who do not speak English

If a patient speaks no English, then the best option is usually for the health professional to arrange a professionally trained interpreter – physically present or remote interpreting (accessed via a telephone line) and this requires specific skills. Many patients speak some English, but need to concentrate quite hard to understand what a healthcare professional is saying to them and to communicate their questions and concerns. There is a range of strategies that can be used to facilitate communication in these cases. These strategies may be more immediately time-consuming, but ensuring more effective communication can save time in the long run – by reducing the likelihood, for example, of compromised care, poor understanding of treatments and management plans that will entail greater subsequent contacts. It can certainly make the interaction more effective, less frightening and more patient-centred. If possible, plan for a double time slot if you know there are language constraints.

Using lay interpreters

Healthcare professionals commonly resort to using friends or family members, bilingual health staff/colleagues who are called away from their regular duties, or even other patients for the purpose of interpretation with patients. This may reflect inadequate provision of professional interpreting services but is also partly due to lack of awareness and under-use of those that are available. Using such lay interpreters – people who are not professionally trained in the discipline but who may attempt to improve communication between patient and health professional – poses challenges.

While it is possible that some patients might prefer a member of their own family to interpret, it should not be assumed that this is always the case. Indeed there are many problems that can arise as a result of using lay interpreters. For example the patient may:

- Omit important information because they are embarrassed about having to communicate through a particular family member (for example, a woman with gynaecological problems having to explain through her son)
- Attempt to conceal sensitive details about his or her condition from a family member who is interpreting
- Worry that their status in the family might be affected if younger members or in-laws find out what is wrong with them
- Be concerned that their relative might withhold medical information from them
- Fear that confidentiality is at risk if another patient from their community has been asked to interpret.

The person interpreting may:

- Be embarrassed at having to convey intimate details, so may censor them
- Have little or no understanding of medical concepts or terminology so will experience problems in conveying information
- Not understand the importance of conveying a message accurately and completely
- Transmit the wrong messages, omit crucial information or add new information
- Be unable to take notes, so have to rely on their memory, for example when conveying dates, times and medication details
- Not understand the need to be impartial or for confidentiality
- Be unable to cope with more than a few words at a time
- Not have the confidence to say when they do not understand what has been said or when they need something to be repeated
- Tend to use the third person rather than direct address, which may have the effect of marginalising and disempowering the patient
- Have less proficiency in the target language than assumed.

This, of course, is not the fault of the untrained person interpreting who may be doing their best in difficult circumstances and who may well prefer not to be placed in the position in the first place. The onus is on the healthcare professional to secure more effective communication via professional interpreting services.

Similar problems arise when bilingual healthcare professional colleagues are inappropriately asked to interpret for patients, thus requiring them to undertake a role for which they are neither trained nor qualified. Indeed, such distraction from their regular work and experience can be very frustrating and may even compromise their professional and career development. Moreover, their use in this way devalues the status of professional interpreters, whose specific skills may thus be underutilised.

Strategies for working with an interpreter

- Check that the patient and the interpreter speak the same language and the same dialect.
- Allow time for pre-interview discussion with the interpreter in order to talk about the contents of the interview and the way in which you will work together.
- Ask the interpreter to teach you how to pronounce the patient's name correctly.
- Allow time for the interpreter to introduce himself/herself to the patient and explain his/her role.
- Explain that the interview will be kept confidential.
- Check whether he/she as an interpreter is acceptable to the patient.
- Introduce yourself and your role to the patient.
- Encourage the interpreter to interrupt and intervene during the interview if necessary.
- Use straightforward language and avoid jargon.
- Face the patient when you are talking, rather than the interpreter.
- Actively listen to the interpreter and patient.
- Allow enough time for the interview (perhaps double the time for an English-speaking patient).
- At the end of the interview check that the patient has understood everything or whether he/she wants to ask anything else.
- Have a post-interview discussion with the interpreter.

Things to remember

- The pressure is on the interpreter.
- The responsibility for the interview is yours as the healthcare professional.
- Your power as a healthcare professional, as perceived by the interpreter and the patient.
- To show patience and compassion in a demanding situation.
- To be aware of your own attitudes to those who are different to you, including awareness of racism.
- To be aware of your own shortcomings, for example not being able to speak the patient's language.
- To show respect for the interpreter and his/her skills.

For more information and resources, please refer to:

- The Culturally and Linguistically Diverse (CALD) website at <http://www.caldresources.org.nz>
- The Asian Health Guidelines for Advance Care Planning available on the Level 2 site.

Guidelines for specific conversations

Giving complex information

Giving information is a vital part of the healthcare professional's role. To ensure that patients can both absorb and understand complex information it must be tailored to the patient's specific needs. For example:

- Identify and stay with the patient's agenda
- Be logical and organised
- Signpost where the interview is going (warning shot)
- Put complex information into simple language (without being patronising)
- Chunk information into manageable blocks
- Check understanding of the chunked information delivered
- Pick up and explore verbal and non-verbal cues (empathise)
- Acknowledge the impact the information has on the patient by exploring facts and feelings
- Give appropriate but not false reassurance
- Summarise and check if the patient has some further questions
- Arrange appropriate follow up.

Breaking bad news

Bad news is bad news. You cannot change the facts, however you can help the patient's adjustment by the way the news is delivered. The key is to slow down the speed of transition, for example, with giving a cancer diagnosis, from a perception of wellness to the realisation of life-threatening disease.

Preparation

- Make preparations as full as possible and have all the information you require to hand.
- Plan the time (make sure there is enough time) and prepare a place with privacy.
- Involve a relative or friend if appropriate.

Delivering bad news

- Find out what the patient already knows.
- Find out how much the patient wants to know.
- Give a warning signal.
- Break the news using simple but clear language.
- Pause and wait for a response.
- Assess and focus on the patient's feelings.

- Encourage the patient to express his/her concerns.
- Check the patient’s understanding.
- Make a plan of action, including positive practical support, but not false reassurance.
- Assure a follow-up appointment is available.
- Give written information as appropriate.
- Check your own state of mind before seeing the next patient.

Handling difficult questions

There are several strategies to use when patients ask difficult questions such as:

“Is it cancer?”

“Am I dying?”

“What is going to happen to me?”

Key actions

- Find out the patient’s perceptions that lead them to ask the question. For example: “What makes you feel you may be dying?”
- After obtaining a response, repeat the question if necessary by asking if there are any other reasons for the patient feeling this way.
- If the patient gives no other reason or changes the subject, you might say: “You asked about what might be ahead of you, is that something you would like to talk about?” If the patient says “no”, leave it there; they are probably not ready to have the truth confirmed.
- If the patient gives other reasons, confirm the patient’s thoughts if correct. Invite the patient to express their emotions and provide support if appropriate.
- Pause to see if patient spontaneously raises any concerns. If none are raised then invite the patient to voice his/her concerns.
- Address only the concerns the patient raises. Answer realistically and avoid rushing in with premature or false reassurances.
- Invite further questions
- Offer to provide information (written or verbal) that may be relevant
- Assure continuity of care.

Dealing with collusion

For example, when the relative puts pressure on a healthcare professional to withhold medical information from the patient.

When speaking with the relative, focus on:

- The relative's feelings
- The relative's reasons for not wanting to be truthful
- Acknowledging the relative's motives, for example wishing to protect the patient from distress
- The strain placed on the relative/patient relationship by not being truthful
- The relative's perception of the patient's understanding. Identify any evidence that the patient might already suspect the truth.

Then:

- Offer to assess the patient's understanding of their illness directly
- Reassure relative that information will not be forced onto the patient if it is not wanted.

Dealing with anger

The following strategies help to diffuse anger:

- Acknowledge the anger: "You seem to be very angry".
- Ensure the words match the level of anger that is evident. For example, "very angry" or "rather annoyed" and so on.
- Allow the person to vent, to express their feelings.
- Invite the patient/relative to explain the cause of the anger: "Can you help me understand what is making you so angry?"
- Listen to their story to get as much information as possible without defending or justifying your position.
- Focus on the individual's stress/feelings.
- Apologise if appropriate.
- Clarify the situation if appropriate: "It must be very difficult seeing your husband getting more unwell".
- If possible negotiate a mutually acceptable solution.

Exploring feelings

The following techniques can be used to explore feelings such as anxiety:

- Recognition: Non-verbal/verbal evidence.
- Acknowledgement: “I can see you are anxious”.
- Permission: “It’s OK to be anxious”.
- Understanding: “I want to find out what is making you anxious”.
- Empathic acceptance: “You are anxious because...”
- Assessment of the severity and effects of anxiety.
- Alteration (if appropriate) by removing of stress, cognitive challenge, boosting coping strategies, medication.

Patients who do not want to talk

The key task is to assess what is making the patient reluctant to talk. There are many reasons and these include:

- Denial, either of the facts or of a feeling
- Lack of comprehension due to inadequate, or inappropriately pitched, information.
- Depression
- Dementia
- Disengagement
- Talking to someone else
- Previously dealt with and the patient now wants to forget.

Handling denial

Denial is when a patient maintains a positive outlook on their illness or prognosis in spite of receiving medical information to the contrary. Denial is a coping mechanism, its function is to protect oneself against distress that could be intolerable and lead to psychological disorganisation. Healthcare professionals may explore the denial to determine if it is an absolute barrier to understanding but forcing through it could lead to severe psychological problems.

Key points in exploring denial

- Look for any evidence that denial is not absolute (a window):

Now - “How do you feel things are going at the moment?”

Past – “Has there ever been a moment when you thought things weren’t going to work out?”

Future – “How do you see your illness affecting your future?”

Explore these windows of awareness and the impact on the person.

- If there is no evidence of awareness then leave the situation as it is.
- Ensure regular follow-up to reassess the denial.

Unrealistic expectations

When patients or relatives appear to be unrealistic in their beliefs about the possible outcomes of the illness or treatment or length of prognosis, there may be several reasons why:

- They have never been properly informed.
- They have misunderstood the meaning of the information they have been given.
- They are clinging on to false hope.
- They are in denial.

The key to dealing with unrealistic expectations is to establish why patients believe what they do. For example:

- Use the patient's cues to explore their perception of their situation: "You say you have had quite a bit more pain recently. What do you think is causing that?"
- Use negotiation to test out whether they really believe what they are saying, or whether they are simply trying to cling on to false hope.
- Gently challenge unrealistic beliefs about outcomes by confronting any inconsistencies in the story.
- Look for 'windows of worry' by asking if the patient ever worries about the possible outcomes.
- Establish whether the patient is ill informed and needs to be told bad news, or is in denial.

It is important that all healthcare professionals work to elicit patients' problems and concerns accurately but at the same time are able to recognise their professional limitations. They need to be able to identify when patient/carers have needs that are best met by other people such as counsellors/mental healthcare professionals with specialist skills in speaking to children, psychologists, psychiatrists and so on. In such instances, healthcare professionals need to be aware of the specialists/services that exist locally, and how they can refer to these services.

Working with colleagues

Tensions between colleagues in healthcare are inevitable. For example, there may be conflicting opinions between colleagues regarding patient care. Such tension affects communication with patients and so it is worth considering here.

It is sometimes necessary to address difficult situations with colleagues and the following steps may be helpful.

Request a meeting

- Inform your colleague that there is something important that needs to be discussed.
- Negotiate a suitable time to meet, preferably on neutral ground.

During the meeting

- Ensure the seating arrangement provides equal status for colleagues.
- If necessary introduce yourself and your role.
- State the purpose of the meeting.
- Outline the concerns and allow time for information to be assimilated.
- Invite your colleague to give their perception of the situation.
- Acknowledge your colleague's reasons and rationale.
- Ask permission to state your own perspective of the situation.
- If possible, negotiate a solution to help resolve the situation, outlining the consequences of a lack of resolution.
- Arrange a review date if appropriate.

Dealing with conflict

It is preferable for conflict, or conflict escalation, to be prevented in the first place. However despite the best of intentions, conflict does sometimes escalate.

Things to remember

- Ensure communication is clear and unambiguous.
- Be focused and compassionate.
- Identify the basis for the disagreement.
- Ask for support or assistance before the conflict escalates.
- Consider what effect you are having on a dispute and its effect on you.
- Be aware of family dynamics. Avoid labelling.

Strategy

- **Ask** the person to explain their perspective.
- **Clarify** anything you are unsure of.
- **Explore** any underlying emotions (e.g. fears).
- **Acknowledge** what they are telling you (even if you disagree).

- **Validate** their opinions and perspectives (so they know you value them).
- **Reflect** back to them what you have heard (so they know you are listening).
- **Empathise** (so they know you care about their position/experience).
- **Challenge** gently any inconsistencies or factual inaccuracies.
- **Negotiate** moving forward (seek permission to explain your perspective).

Mediation

If conflict amongst family members or colleagues, for example, escalates then mediation may be required.

- Set up a meeting
- Establish ground rules for the meeting (e.g. one person speaks at a time, no personal attack or intimidation, and so on).
- Attempt to get to the core of the disagreement:
 - What is really being said (that is not necessarily being spoken)?
 - What is at stake (e.g. quality care or team effectiveness)?
 - Why are these people upset or angry? What might people be reacting to? Identify if there is a deeper, emotional, issue underlying the anger – e.g. fear, grief.
 - Is this a clash of expectations/cultures/beliefs? If so, what are they?
 - Look for a common interest or goal.

Summary

- Gather before you give, listen before you tell (hear the person's concerns or agenda before attempting to give explanations).
- Explore and clarify understanding and feelings.
- **Acknowledge, Clarify, Empathise** with a person's emotions, concerns, agenda, preferences.
- Use internal summary if a lot of information has been exchanged, or to re-focus the conversation.

Reference

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