

# Communication skills training

## Introduction to the Serious Illness Conversation Guide

Developed with Ariadne Labs

**OUTCOME** – Use this slide to open the workshop, welcome participants, share a karakia and address any housekeeping.

Tēnā koutou Tēnā koutou tēnā koutou katoa

Welcome, one and all. We are excited to have you here with us today to take part in the SICG training...

Brief introduction of self (name) and first names of any co facilitators. Explain we will introduce ourselves a little more fully in a moment...but first

Ask if anyone would like to offer a KARAKIA – pause briefly

**If not ... please use this karakia:**

*Tukua taku wairua kia rere ki ngā taumata,  
Hei ārahi I āku mahi, Kia mau kia ita, Kia kore ai e ngaro,  
Kia pupuri kia whakamaua kia tina (tina!),  
Haumī e! Hui e! Tāike e!*

Let my spirit ascend to the top-most summits as a guide for all that I do, keep it safe so that it will not be lost, preserve and maintain it. Join! Gather! Intertwine!

Thank group for taking time out of their busy days to attend the workshop. Looking forward to spending the next three hours working together.

Consider brief house-keeping here – emergency drill, toilets

- Toilets
- Emergency exits/procedures/assembly point
- Other venue specific information if relevant

Timing: 20 minutes slides 1-6

## Introductions - mihi mihi

### OUTCOME

The group gets to know each other with a twist of fun

### Practical Introductions

Ask the group to *briefly* introduce themselves. Share JUST 3 THINGS

- Who you are (i.e. name and/or short pepeha)
- Role
- + icebreaker (see below)

### Have a little bit of fun to lighten the atmosphere. Examples include

- If you didn't work in your current job, what would you do?
- If you could have one superpower, what would that be?
- Tell us one thing about yourself that nobody else in this room knows.
- What is your favourite chocolate bar or lolly?

Use yourself as the first example (starting with a brief pepeha in Te Reo Māori), then move around the group (including other facilitators)

Please see SICG Trainers Manual for a pepeha template

TIMING: 20 minutes for Slides 1-6

## Objectives

- Describe the evidence-based benefits of serious illness conversations for patients, families and whānau
- Describe your role in improving serious illness conversations
- List the components of the Serious Illness Conversation Guide
- Practice using the Serious Illness Conversation Guide

**OUTCOME** Brief outline of the workshop objectives (read from slide)

**TIMING:** 20 minutes for Slides 1-6

## Plan

- Reflection
- Discuss the evidence-based benefits of serious illness conversations
- Demonstration and debriefing
- Discuss the components of the Serious Illness Conversation Guide
- Skills practice
- Wrap up and next steps

**OUTCOME** Brief outline of the workshops structure (read from slide)

**TIMING:** 20 minutes for Slides 1-6

## Your stories

### OUTCOME

Learners begin the session by sharing a story about a patient in which communication had an impact on care, for better or worse.

This enables them to:

- Reflect on their own clinical experiences and engage emotionally with those experiences
- Reflect on key **communication practices** that make a difference in patient and whānau outcomes

“We are going to start with a reflection, to hear some of your stories”

TIMING: 20 minutes for Slides 1-6

Think of a patient with serious illness who had a poor or a good outcome at the end of life, in which the outcome was related to communication about goals of care

**Identify the elements of communication (or lack of communication) that you think contributed to the outcome**

- **Read the words from the slide**
- **Allow silence:** Its ok if it feels a bit uncomfortable. Silence allows learners to formulate their words before sharing their story with the group
- **Unpack the story:** The aim is to uncover the communication component of the group's stories, trying to make connections with outcomes e.g.
  - What about the communication made this conversation go well?
  - What aspect of the communication made things go badly/left the person or whānau upset?
  - Have others in the group had similar experiences?
- **Write themes on the white board.** This will help avoid repetition. You might want to divide into:
  - Aspects of communication that make things go well
  - Aspects of communication that make things go poorly
- After 2-3 stories, **summarise themes and acknowledge the challenges with empathy** e.g. "these can be emotional conversations for clinicians"... "these conversations can be tricky"

At this stage (and later) other themes or questions may arise that need to be bookmarked – when this occurs negotiate to start a 'Parking Lot' with the group and record this on flipchart or whiteboard

#### Tips

- If you have a talkative learner: Thank them at a pause point; highlight an aspect of their story that demonstrates a positive or negative impact of communication on care; turn to the group to ask for their experiences
- Usually after 2-3 stories their will be common themes developing.
- Resist the urge to let the reflection go beyond the designated time
- Have your own story as a back up if you get nothing from the group. But don't jump in too quickly with this. Give them a good opportunity to bring their experiences to the group.
- Aim for stories from a professional context. If a group member shares a person story – acknowledge and thank them for sharing, then move on. DON'T UNPACK.

TIMING: 20 minutes for Slides 1-6



## Goal: Better care

### Where we are now

Doing some of the right things  
some of the time for some of  
our patients with serious  
illness



### Where we want to be

Doing all of the right things all of  
the time for all of our patients  
with serious illness

What your stories have illustrated is ...

TIMING: 15 minutes for Slides 7-20



## **Ariadne Serious Illness Care Program**

**Mission:** To improve the lives of all people with serious illness by increasing meaningful conversations with their clinicians about their values and priorities



To get there, our mission is to.....

TIMING: 15 minutes for Slides 7-20

## **Evidence-based benefits of serious illness conversations**

Let's look at the evidence base ...

TIMING: 15 minutes for Slides 7-20



## Early conversations about patient values and goals linked to better serious illness care

- Increased care in line with patients' wishes<sup>1,2,4</sup>
- Improved quality of life/patient wellbeing<sup>1,2,5</sup>
- Fewer hospitalisations<sup>2,4</sup>
- More and earlier palliative care<sup>2,4,5</sup>
- Better coping by patient, family and whānau<sup>2,3,4</sup>



A number of studies show if we can move the conversations upstream – can improve outcomes of care

TIMING: 15 minutes for Slides 7-20



## Conversations are infrequent, late and limited

- **Infrequent**

Fewer than one-third of patients with end-stage diagnoses reported end-of-life (EOL) discussion with clinicians<sup>6</sup>

- **Late**

In patients with advanced cancer, first EOL discussion took place 33 days before death.

Fifty-five percent of initial EOL discussions occurred in hospital<sup>7</sup>

- **Limited**

Conversations often fail to address key elements of quality discussions<sup>6,7,8</sup>

- **New Zealand context**

Health and Disability Commissioner: 15 percent of all complaints can be attributed directly to health professionals' attitudes and communication<sup>9</sup>

We also know for a lot of patients and their whanau, that conversations are infrequent, late and limited.

- 2009 Canadian study across 5 hospitals - patients and families identified what quality EOL care meant to them (trust + confidence, not being kept alive when there's no hope, ability to prepare, continuity of care, honest communication) YET less than 1/3 had EOL discussions with clinicians
- 2012 prospective cohort study in US (1200 patients with Ca lung or colorectal cancer) looked at characteristics of EOL discussions (timing, providers, location, aggressive treatment) – found first conversations took place on average 33 days before death and mostly in hospital

TIMING: 15 minutes for Slides 7-20

## Quality of conversation documentation is poor

When conversations take place, outcomes of discussions are often:

- not documented<sup>10,11</sup>
- not documented accurately<sup>10,11</sup>
- not easily retrievable in the clinical notes or electronic medical record<sup>10,11</sup>
- in conflict with other information in the clinical record.<sup>10,11</sup>

We also know that documentation of any conversations that do take place is often poor or doesn't happen at all.

*"For example..." (Choose examples depending on time available and group context)*

28% of elders preferred only comfort measures at the EOL but just 5% of documentation reflected that preference (JAMA)

Agreement between hospitalized patients' expressed preferences for end-of-life care and documentation in medical records was only 35.4% (variability between hospitals).

Among patients who had not completed an advance directive but had given surrogate decision-maker information to their provider, 0-16% had documentation of a surrogate decision-maker in the medical record

Among patients who reported that they had completed an advance directive and had given it to their health-care provider, 15-47% had advance directive information in the medical record

TIMING: 15 minutes for Slides 7-20

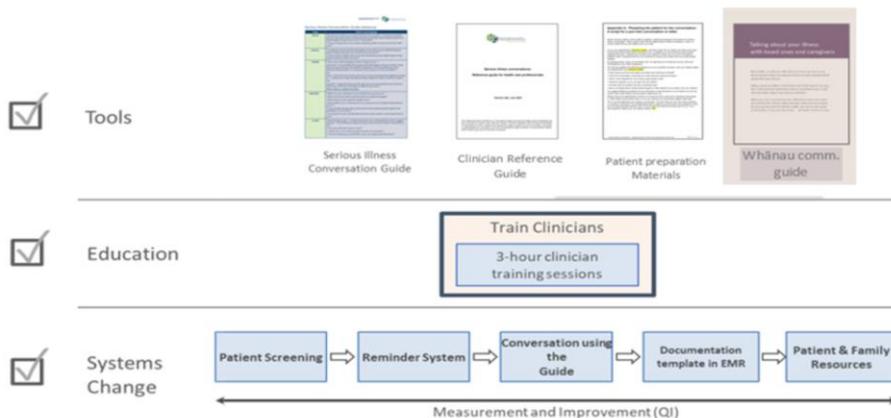
## Pathway toward improvement

All clinicians want to do the right thing, but these conversations are complex for many reasons, and when they do have the conversation the information isn't always captured

There are 'core steps' which are important in these conversations. These can be captured in a guide such as the SICG

TIMING: 15 minutes for Slides 7-20

## Serious Illness Care Program components



The SICG is made up of a number of components:

Looking at the **TOOLS**:

- The SICG itself – we have a NZ version
- The Clinician Reference Guide: also has a NZ version, will make available to you at the end of this session, and this expands on how to deal with difficult situations
- an example of a New Zealand versions of the patient preparation letter is also included as an appendix in the Clinician Reference Guide
- and work is underway on the whānau communication guide.

It is important for clinicians to recognise the importance of preparing patient and whānau for the conversation. If you planning a SICG conversation, it is your responsibility to ensure the patient knows it is going to happen and they have been encouraged to bring along whānau/family/support people.

**EDUCATION** – is this! 3 hours and scalable

**SYSTEMS CHANGE** – as with all innovations in practice this is the tricky bit...

Need to consider patient screening – is the surprise question the best option? (you may have other thoughts). Electronic medical record (EMR) – ideally representing a single source of truth.

NOTE: Many DHBs who are implementing Shared Goals of Care (SGOC), are encouraging the use of the SICG framework to support the SGOC conversation. The SGOC mahi offers opportunity to develop the wrap round systems to support the capturing, documenting and sharing of SICG conversations in the acute and aged residential care settings.

SGOC discussions and SICG conversations are all part of the wider advance care planning process i.e. providing a person the opportunity to develop and express their preferences for future care based on their values, beliefs, culture, hopes and goals, a better understanding of their current and likely future health, and the treatment and care options available to them.

TIMING: 15 minutes for Slides 7-20

## Gentle landings: What can checklists or guides do?



- Bridge gap between evidence and 'real-world' implementation
- Assure adherence to key processes
- Achieve higher level of baseline performance
- Ensure completion of necessary tasks during complex, stressful situations

We use checklists in other situations to make complex tasks doable ...

e.g. pilots preparing for take off, surgical checklists

These help us.... (read from slide)

TIMING: 15 minutes for Slides 7-20

HEALTH AFFAIRS > VOL. 36, NO. 7 : ADVANCED ILLNESS & END-OF-LIFE CARE

## A Systematic Intervention To Improve Serious Illness Communication In Primary Care

Joshua R. Lakin, Luca A. Koritsanszky, Rebecca Cunningham, Francine L. Maloney, Brandon J. Neal, Joanna Paladino, Marissa C. Palmor, Christine Vogeli, Timothy G. Ferris, Susan D. Block, Atul A. Gawande, and Rachelle E. Bernacki  
[See fewer authors](#) ^

[AFFILIATIONS](#) v

PUBLISHED: JULY 2017

<https://doi.org/10.1377/hlthaff.2017.0219>

There is now a body of evidence amassing considering the use of SICG

One example is the 2017 published paper by Lakin, Koritsanszky & Cunningham et al. looking at the impact of SICG communication in primary care.

TIMING: 15 minutes for Slides 7-20

## Sixty-six percent of intervention patients report positive behavior change<sup>12</sup>

<b>Practical planning</b>	'Making changes to my will. Plan my funeral.'
<b>Communication with family</b>	'More realistic in my approach with family and friends about my prognosis.'
<b>End-of-life care planning</b>	'Made a complete list of all my last wishes, such as when I can no longer go to the bathroom myself I want hospice house care.'
<b>Wellbeing</b>	'I am doing the same stuff as before, just feeling less anxious about the future (hope for the best, prepare for the worst).'
<b>Values, goals and priorities</b>	'I have started to think about what my priorities are in terms of quality of life.'
<b>Therapeutic relationship</b>	'Mostly the conversation brought us closer (Dr X).'

Preliminary qualitative analysis

This study found that 66% of patients reported the SICG conversation resulted in positive behavior change. This included concrete actions such as:

- more practical planning, better communication with family, increase EOL Care planning, improved well-being, enhanced focus on values and goals, and better therapeutic relationships with their clinicians.

What is so striking about this data is that patients are talking about the impact that the conversations are having on their lives – not just their medical treatments and procedures.

[If anyone asks, most of the remaining 1/3 of patients report no change from the conversation, but there was a very small number who had a negative response, mostly that the conversation was ill-timed].

TIMING: 15 minutes for Slides 7-20



Research

JAMA Oncology | Original Investigation

# Evaluating an Intervention to Improve Communication Between Oncology Clinicians and Patients With Life-Limiting Cancer A Cluster Randomized Clinical Trial of the Serious Illness Care Program

Joanna Paladino, MD; Rachelle Bernacki, MD, MS; Bridget A. Neville, MPH; Jane Kavanagh, BA; Stephen P. Miranda, MD; Marissa Palmor, BS, MBE; Joshua Lakin, MD; Meghna Desai, MPH; Daniela Lamas, MD; Justin J. Sanders, MD, MSc; Jonathon Gass, MPH; Natalie Henrich, PhD, MPH; Stuart Lipsitz, ScD; Erik Fromme, MD; Atul A. Gawande, MD, MPH; Susan D. Block, MD

Another study by Paladino, Bernacki and Neville et. al, published in March 2019, found...(next slide)

TIMING: 15 minutes for Slides 7-20

## **SICG feasible, acceptable, effective intervention that improves patient experience<sup>13</sup>**

### **Intervention results in clinical practice change:**

- More and earlier serious illness conversations ( $P = 0.005$ ;  $<0.001$ )
- More patient-centered and comprehensive conversations ( $P <0.001$ )
- More accessible documentation in the electronic medical record ( $P <0.001$ )

### **Intervention significantly reduces moderate–severe anxiety and depression**

- Lower levels of anxiety persist for four months after the intervention

The SIC communication intervention resulted in:

- More and earlier serious illness conversations ( $P = 0.005$ ;  $<0.001$ )
- More patient-centred and comprehensive conversations ( $P <0.001$ )
- More accessible documentation in the electronic medical record ( $P <0.001$ )

### **Meaningful improvement in patient’s mental health symptoms**

Proportion of patients with moderate to severe anxiety and depression was reduced by half

Lower levels of anxiety persist for four months after the intervention

TIMING: 15 minutes for Slides 7-20

## Perioperative shared decision-making in the Bay of Plenty, New Zealand: Audit results from a complex decision pathway quality improvement initiative using a structured communication tool

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Heidi C Omundsen<sup>1</sup> , Renee L Franklin<sup>1</sup>, Vicki L Higson<sup>2</sup>,  
Mark S Omundsen<sup>3</sup> and Jeremy I Rossaak<sup>3</sup>

### Abstract

Patients presenting for elective surgery in the Bay of Plenty area in New Zealand are increasingly elderly with significant medical comorbidities. For these patients the risk-benefit balance of undergoing surgery can be complex. We recognised the need for a robust shared decision-making pathway within our perioperative medicine service. We describe the setup of a complex decision pathway within our district health board and report on the audit data from our first 49 patients. The complex decision pathway encourages surgeons to identify high-risk patients who will benefit from shared decision-making, manages input from multiple specialists as needed with excellent communication between those specialists, and provides a patient-centred approach to decision-making using a structured communication tool.

### Keywords

Shared decision-making, complex decision pathway, perioperative assessment, structured communication tool, perioperative advance care planning, high risk surgery, anaesthesia, intensive care

Recent NZ research used the SICG structure to support shared decision making in their perioperative complex decision pathway.

The structure was well received by both patients and clinical staff and was found to be a useful tool. Provisional audit findings from the clinic found just over half (53%) of the patients seen chose a non-operative course, while 39% decided to proceed to surgery and were supported to undertake perioperative advance care planning. The final 4 patients remained undecided at the time of the audit.

TIMING: 15 minutes for Slides 7-20



## Demonstration: Serious Illness Conversation Guide

We've talked a lot about the evidence underpinning the SICG – now it's time to see it in practice

I'm going to show you a video of a conversation using the guide, and I'm curious to hear your impressions

NB Practice a Plan B for if the video doesn't work (e.g. switch to COPD case in Training Manual, run live demonstration with co-facilitator or colleague, follow the Guide exactly)

TIMING: 20 minutes for Demo/Debrief Slides 21-22/23

## Demonstration – Fred

### *Fred...*

- is a 62-year-old retired sailor in merchant navy, lifelong bachelor
- has advanced COPD, is short of breath on minimal exertion despite recently starting home oxygen
- showering and dressing in the morning takes over an hour
- has had recurrent hospitalisations this year
- lives in a council flat with limited social supports
- is here for a follow up outpatient appointment

**Goal for today: Initiate a conversation using the Serious Illness Conversation Guide**

Choose **one scenario** to demonstrate the conversation to the group. Either Option One – Fred (Slide 22) or Option Two – Kevin (Slide 23)

NOTE: You may choose to hide the demonstration slide option you are not showing the group.

Read the scenario and goal, then run the video (or live demo)

Debrief the group, starting with an open question, e.g.

What was your reaction to the conversation? What did you like/not like about the guide?

What are the benefits or trade offs of using a conversation guide?

Use Acknowledge-Ask-Respond feedback structure:

Acknowledge – explicitly acknowledge the observation or concern (occasionally you may need to unpack briefly to clarify). Particularly encourage negative responses

Ask – the group for their thoughts and let them brainstorm

Respond – with a way forward, taking care not to make it feel like ‘rebuttal’. Aim to present ways forward/potential value of SICG process, while simultaneously acknowledging validity of concerns

Model comfort with the skepticism and concerns

NB Response Primers for common observations are in the Training Manual

Continue with open questions and Acknowledge-Ask-Respond feedback for time available

TIMING: 20 minutes for Demo/Debrief Slides 21-22/23

## Demonstration – Kevin

### *Kevin (supported by his wife Julie)....*

- Kevin is in his mid 40's
- He has relapsed leukaemia after a failed bone marrow transplant
- Further chemotherapy has been unsuccessful
- Platelets are low
- Kevin is now blood transfusion dependent. The interval between transfusions have reduced to fortnightly and he is reporting limited impact or improvement in his symptoms post transfusion
- Jane (an ACP facilitator), is leading today's conversation. She worked with Kevin to complete his Advance Care Plan prior to his bone marrow transplant

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TIMING: 20 minutes for Demo/Debrief Slides 21-22/23

## Serious Illness Conversation Guide

Give out copies of the Guide here

“Let’s have a more in-depth look at the guide together ...”

TIMING: 15 minutes for Slides 24-34

## A framework for best communication practices

New Zealand Government 

### Serious Illness Conversation Guide Aotearoa

Stage	Patient-tested language
SET-UP	"We want to make sure you have the best care possible. To do this it would be good to talk about what is happening with your health, what might be ahead and what things are important to you? Is that OK?" "This is an important conversation. Would you like someone to be here with you?"
ASSESS	"To make sure we are on the same page, can you tell me your understanding of what's happening with your health at the moment?" "In terms of your health, how much information about what might happen in the future would you like from me?"
SHARE	"This is my understanding of where things are at..." <i>Uncertain:</i> "It can be difficult to predict what will happen with your health. I hope that you will continue to live well for a long time, but it is possible you could become unwell quickly. It is important we prepare for that possibility." OR <i>Time:</i> "I wish this were not the case, but I am concerned that time might be as short as... (express as a range, eg, days to weeks, weeks to months, months to a year)." OR <i>Function:</i> "I hope that this is not the case, but I am concerned that this may be as well as you will feel and things are likely to get worse." <i>Allow silence, explore emotion</i>
EXPLORE	"What are your priorities if your health does get worse?" "What worries you when you think about your health changing?" "What helps you through the tough times?" "What abilities are so important for you, that you can't imagine living without them?" "If your health does get worse, how much are you willing to go through for the possibility of more time?" "How much does your family/whānau know about what is most important to you?"
CLOSE	"I have heard you say... is really important to you. Keeping that in mind, I suggest that we... This will help us make sure your care focuses on what is important to you." "How does this plan seem to you?" "I will do all I can to help you get the best care possible." "Is there anything you would like to go over again/ask/talk about?"

The Serious Illness Conversation Guide was developed through a robust systematic process. This version that is in front of you is the 105<sup>th</sup> iteration – so it took 105 iterations to get to where it is today, and it was improved with feedback from patients, families, and clinicians of all disciplines and specialties. On the left you will see the conversation flow, or the key domains to address. We will focus mostly on the right, which has patient-tested language. This particular version is the Aotearoa version, customised with input from consumers and health care professionals across NZ.

Often when we face stressful situations, like a serious illness conversation, it helps to have language to turn to in order to make sure that you cover the key questions and also allows you to address these important issues in a patient-centred and efficient way. While the ultimate goal is to adapt these questions to fit your personal style, we do suggest trying the language initially as it is, so you can see how it feels and get comfortable with it, and then the goal is to adapt it and make it your own.

TIMING: 15 minutes for Slides 24-34

## A conversation with an agenda

**Set up** the conversation

**Assess** illness understanding & information preferences

**Share** patient-centered prognosis

**Elicit** priorities, worries, strengths

**Explore** critical abilities, tradeoffs, family awareness

**Recommend** a way forward

The Guide has a number of stages and we will look at each in more detail in a moment

But let's start with a high level overview of the six steps and acknowledge that this is a conversation with an agenda. That agenda being to hear from the person and to listen to what is important to them.

The first half of the SICG process involves setting up the conversation, assessing illness understanding and information preferences and sharing a patient-centred prognosis.

The second half is about 'drawing out' the person. Eliciting their priorities, worries and strengths. Exploring the abilities that are important to them, how much they are willing to go through and what understanding their family/whānau/support people have of where things are at for them. We then use this information to make a personalised recommendation – we will consider how to do this in this workshop

Let's now break down each stage and see what is going on ...

TIMING: 15 minutes for Slides 24-34

## Set up



Introduce the idea



Ask permission



Describe the benefits

### SET UP

The SICG set up happens **after** initial introductions, mihi and whakawhānaungatanga. Use **The Hui Process** as a framework for the conversation with Māori (encourage participants to refer to the *Serious Illness Conversation: Reference guide for health care professionals*, for further information).

The SICG set up builds trust, helps patients feel in control, and allows the conversation to begin gently, without scaring the patient.

There are three steps. Introducing the idea, asking permission, and introducing the benefits of the conversations (or the reason for the conversation).

It is important to reiterate, that this conversation should not happen out of the blue and/or blindsides a person. If you are planning a SICG conversation, it is important you prepare the patient and give them the opportunity to involve any whānau/family/support people.

While we are going to be practicing using the Guide today with one person, we recognize the conversation will often also include whānau, family and other support people. Please refer to the *Serious Illness Conversation: Reference guide for health care professionals* for suggestions as to how you might navigate the conversation with more people present.

TIMING: 15 minutes for Slides 24-34

## Assess



Illness understanding



Information preferences

### ASSESS

Illness understanding: Helps you, as the clinician, assess where the patient is with regard to prognostic understanding and provides information about how much gentle pushing might be needed to prepare the patient for what is ahead.

Discrepancies between the patient's understanding of what is ahead and your medical judgment about prognosis is an indicator that the patient is at risk for potentially poor outcomes at the end of life ("a crash landing")

Information preferences ensure that you are providing the kind of information that patients want and helps you feel confident in moving forward with prognostic communication in a patient-centred way. Information is a common unmet need for patients.

Patients whose understanding and expectations are significantly more optimistic than medical realities appear to indicate, are likely to be at higher risk of future bad outcomes. They will require:

- gentleness
- careful titration of discussion to avoid overwhelming the patient
- extra emotional support
- ongoing discussion

TIMING: 15 minutes for Slides 24-34

## Deliver prognosis



Uncertainty



Function



Time

### **DELIVERING PROGNOSIS** (this slide is animated)

When we think about prognosis, we are often accustomed to focusing on time – how much time someone has left. And that is one example of prognosis. You can see an example of compassionate language for giving a time-based prognosis in the patient-tested language – “I wish this were not the case, but I’m concerned that time might be as short as ... (days to weeks, weeks to months, months to a year)”. As you can see, one thing that is really important about a time based prognosis is that it is expressed as a range rather than a single number, and this reflects the uncertainty. That being said, sometimes a time-based prognosis is difficult or not yet appropriate because there is so much uncertainty about the time or because the patient may not want to know time.

There are two additional kinds of prognosis that both give information to the patient about what may be ahead:

A functional prognosis: “I hope that this is not the case, but I am concerned that this may be as well as you will feel & things are likely to get worse.”

An unpredictable prognosis lets the patient know that while they are doing well now, something could happen quickly and they could get very sick suddenly: “It can be difficult to predict what will happen with your health. I hope that you will continue to live well for a long time, but it is possible you could become unwell quickly. It is important we prepare for that possibility.”

These kinds of prognostic communication allow you to share information with the patient about what may be ahead in a way that meets the patient’s needs.

Note: A third type of prognostic communication happens later in the guide, when patients are asked about critical abilities and tradeoffs. These questions indirectly focus patients’ attention on the idea that things are likely to become more difficult, and that challenging decisions are likely to be ahead. Sometimes, that level of understanding is all the patient can tolerate in the moment.

TIMING: 15 minutes for Slides 24-34



# Take a breath

(Pause and respond to emotion)

## **TAKE A BREATH**

When we are using a Conversation Guide (especially when it is new to us) there is a natural tendency to run ahead to the next 'Stage'

This slide reminds us of the importance of pausing after the first part of the conversation, to explore and to respond to the emotions that come up for the person.

Allowing silence gives the person the time they may need to catch up with the concepts discussed in the first part of the Guide, e.g. new prognostic awareness

Acknowledging, exploring and empathising with emotions demonstrates that we recognise the difficulties faced by the person and are there to support them. It can allow the person to share more about what they think and feel.

**TIMING:** 15 minutes for Slides 24-34



## Elicit



Priorities



Worries



Strengths

### ELICIT

Rationale: All patients have goals besides living longer. Understanding patient goals aids the clinician in tailoring recommendations to address patient priorities. In addition, since it can be hard to hear prognosis, giving patients the opportunity to identify their goals restores the sense of a positive future and can be an antidote to hearing a difficult prognosis.

Rationale for fears and worries: In medical culture, we are often focused on fixing things. Allowing patients to express their fears and worries is therapeutic. Sharing concerns and fears makes patients feel less isolated.

TIMING: 15 minutes for Slides 24-34



## Explore



Critical abilities



Trade-offs



Family/whānau awareness

### EXPLORE

These questions are designed to both foreshadow the future, and to elicit information about values and goals that will be critical in guiding decisions. These general questions are not usually sufficiently specific enough to arrive at medical decisions, like DNACPR. However, they provide guidance to the clinician for future discussions with the patient and family. Some patients, even on a first discussion, may have sufficient clarity about their values and preferences that a medical decisions, including orders, can emerge from this conversation.

By exploring these issues with the patient, the clinician can help the patient develop a plan for engaging family members in these critical discussions.

TIMING: 15 minutes for Slides 24-34

## Recommend



Summarise



Recommend



Affirm commitment

### **RECOMMENDATION** (this slide is animated)

At the end of the conversation, it is helpful to summarise what you have heard the patient say about his/her values and goals and make a recommendation based on the patient's goals and your knowledge of the medical situation and the options available.

The recommendation does not have to be a medical decision if that is not appropriate – it could be a recommendation to revisit the conversation in the future, or to have a discussion including whānau/family if they are not already involved. It could be a recommendation for a palliative care referral, or a suggestion to consider capturing preferences in an Advance Care Plan.

It does not have to be an EOL decision – for example: one oncologist using the Guide learned that for one of her patients with advanced cancer, biking is the patient's passion, the way the patient gets around and sees friends and family, and he would never want to live if he couldn't bike. This led her to have a discussion with the patient about chemo, and she recommended not to increase the dose of chemotherapy because of the high risk of neuropathy and the potential impact it would have on his ability to bike.

Complete the guide prompts by affirming commitment to the patient and checking they (and any whānau/family/support people) don't have any further questions or issues they might like to clarify, ask or talk about.

If whānau/family/support people are present, acknowledge the importance of and your appreciation for their engagement in the discussion. Invite someone to close the meeting with a karakia, if applicable.

**TIMING:** 15 minutes for Slides 24-34



## Key points



### KEY POINTS (this slide is animated)

There are 4 major 'tasks' that the Serious Illness Conversation Guide focuses clinicians on:

- Listen more than talk
- Give a direct, honest prognosis when desired by patient
- Allow silence
- Respond to emotion

A key principle is to **ask about** patient values and goals **before discussing** medical decisions/treatment options

TIMING: 15 minutes for Slides 24-34

## Time to practice SICG drill

### Rationale

- Create a low-risk, playful environment for the learners to read the words on the guide
- Drills make it easier to follow the guide in the following, higher stress small group practice session

Give an analogy about the purpose of this session – such as music practice with scales, practicing netball or basketball shots – to get familiar with the steps of a new framework e.g. “What we are aiming for is for you to get familiar with the words and flow of the Guide, and to have an opportunity to use the entire Guide”.

Emphasise that this is a simple task – a read through, but we have limited time. Encourage the learners to run with it “even if it annoys you”

Direct the learners to pair up around the room and take turns in each role doing a simple read through. Tell the pairs that they will have about 3 minutes to read through both sides of the page, and then switch roles and repeat. Suggest that they have the person with the smallest feet read the clinician part first.

In the reflection ask the group:

- What was it like to say the words?
- What was their experience of using a formatted approach/a framework?
- Get the group to identify parts of the conversation that were additional to the Guide (the shaded boxes – giving the rationale, responding to emotion, bookmarking)
- Get the group to identify the nature of the prognostic statement used in this example (include a comment or question on the other 2 options)
- End by asking each learner to share a brief ‘takeaway’ observation

TIMING: 10 minutes for Drill and debrief

## **Time to practice SICG role play**

TIMING: 90 minutes for role play

## Wrap up and next steps

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If the group has split in to two, make a uniting statement – e.g. “Now we are going to join together to reflect on what we have learned and practiced”

Review any unfinished business in the Parking Lot

Ask the group to consider the applicability of the SICG in their individual work contexts:

- Ask – Can you imagine using this in your practice? Acknowledge responses
- Ask – What barriers do you for see using the Conversation Guide in practice? Acknowledge and brainstorm with the group possible ways to address
- Ask – What might make use of the Conversation Guide easier in practice?
- Ask – What are your takeaways from this workshop? Go around the learners in turn

Now introduce the concept of Next Steps

- Encourage the learners to use the guide with an easy patient over the next week
- Let learners know the HQSC team will email their workshop certificate and the Clinician Guide – which has some trouble-shooting tips that they might find helpful
- Let the learners know you will check in with them in approximately 2 weeks, and that you are available for queries (give contact info)
- Thank the group for their efforts
- Invite a karakia whakamutunga (closing karakia) – give one if none offered

**Karakia whakamutunga** (closing karakia)

Kia whakairia te tapu  
Kia wātea ai te ara  
Kia turuki whakataha ai  
Kia turuki whakataha ai  
Haumi e! Hui e! Tāiki e!

*Restrictions are moved aside  
So the pathway is clear  
To return to everyday activities*

- Give out Evaluations and let learners know that they are free to go once these are completed

TIMING: 15 minutes for Large Group Debrief



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