

# Communication

## In Palliative Care



**Facilitator:** Diana Vincze, Pallium Canada

**Presenters:** Drs. Jalal Ebrahim & Warren Lewin

**Date:** March 8th 2023

# Territorial Honouring



# The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness and their families.

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The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.



# LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by the CFPC and Royal College.



Learn more about the course and topics covered by visiting

[www.pallium.ca/course/leap-core](http://www.pallium.ca/course/leap-core)

# Welcome & Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from, your role and your work setting.
- Your microphones are muted. There will be time during this session when you can unmute yourself for questions and discussion.
- You are welcome to use the chat function to ask questions and add comments throughout the session.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session.

# Disclosure

Relationship with Financial Sponsors:

## **Pallium Canada**

- Not-for-profit
- Funded by Health Canada

# Disclosure

## **This program has received financial support from:**

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

## **Facilitator/ Presenter:**

- Diana Vincze: Nothing to disclose.
- Dr. Jalal Ebrahim: Nothing to disclose.
- Dr. Warren Lewin: relationships described on subsequent slides.

# Disclosure

## Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content

# Introductions

## Facilitator:

**Diana Vincze, Pallium Canada**

Palliative Care ECHO Project Manager

## Presenters:

**Jalal Ebrahim, MD, FRCPC**

Education Site Co-Lead - Palliative Care, Toronto Western Hospital –  
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Lecturer, Division of Palliative Medicine, Department of Medicine

**Warren Lewin, MD, CCFP (PC)**

Site Lead - Palliative Care, Toronto Western Hospital –  
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Assistant Professor, Division of Palliative Care, Department of Family  
& Community Medicine

## Support Team:

**Aliya Mamdeen**

Program Delivery Officer, Pallium Canada



# Communication in Palliative Care



# Session Learning Objectives

## Upon completing the session, participants will be able to:

- Appreciate that a defined set of communication skills can be used to increase quality of serious illness conversations
- Recognize skills that may increase comfort and confidence to lead advance care planning conversations



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# Faculty Presenter Disclosure

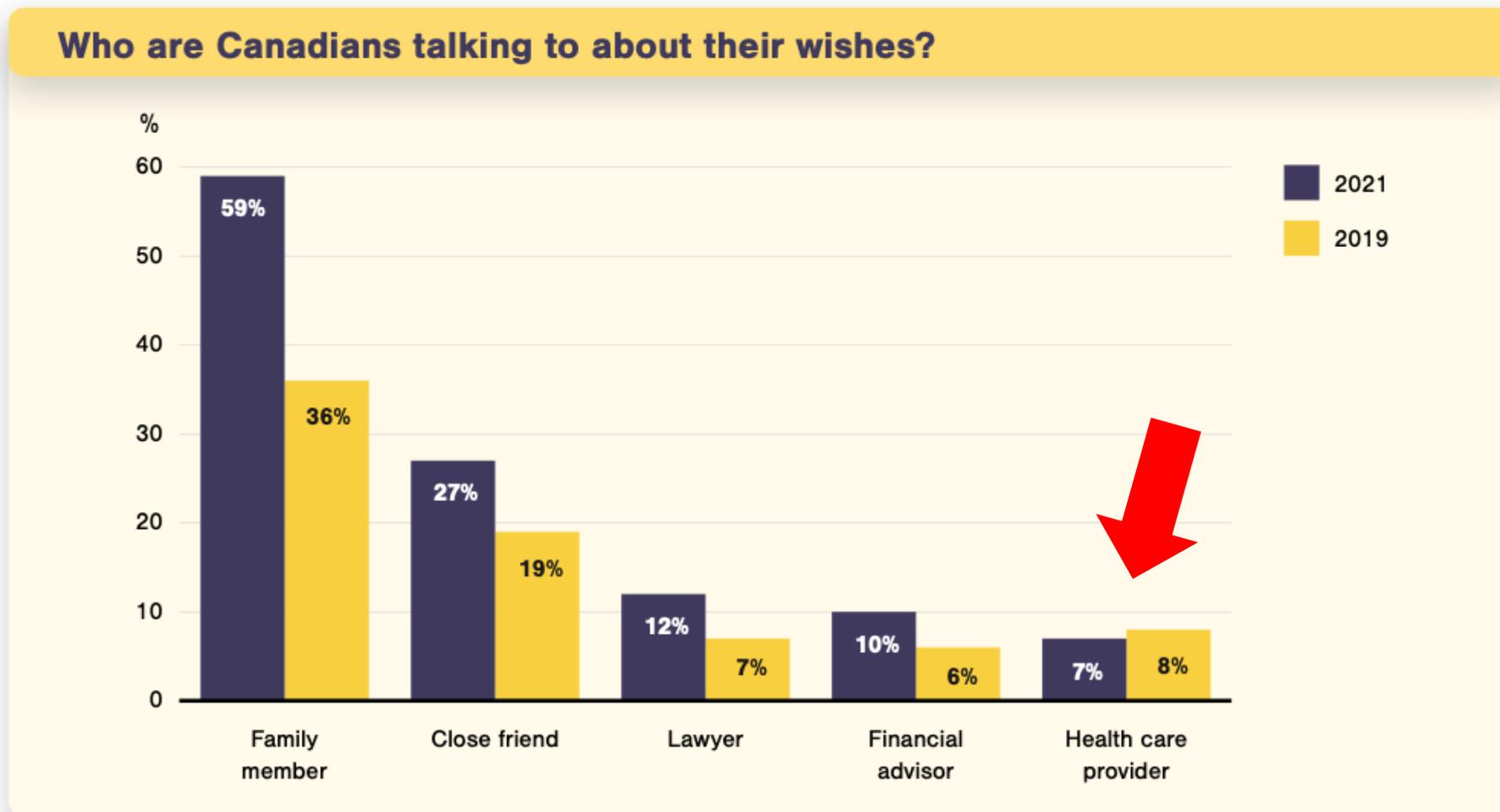
- **Relationships with financial sponsors:**
  - Department of Family & Community Medicine
  - UHN Foundation
  - VitalTalk
- **Mitigating bias:**
  - I do not endorse one program over another
  - Skills learned/taught are generalizable

# Serious Illness Conversations

80%

of Canadians say they are comfortable talking about their end of life care and related issues

# Serious Illness Conversations

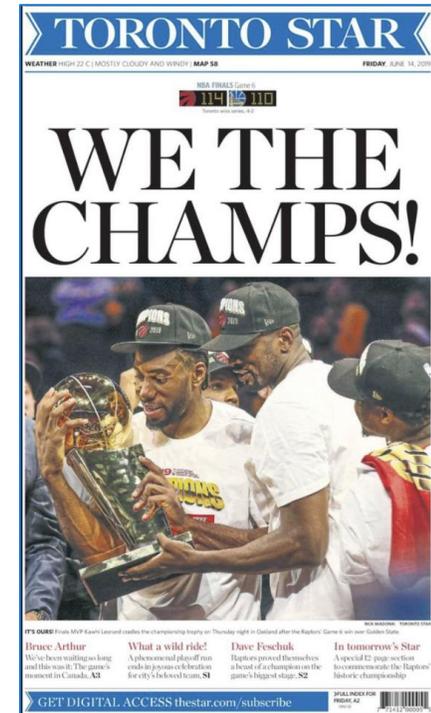
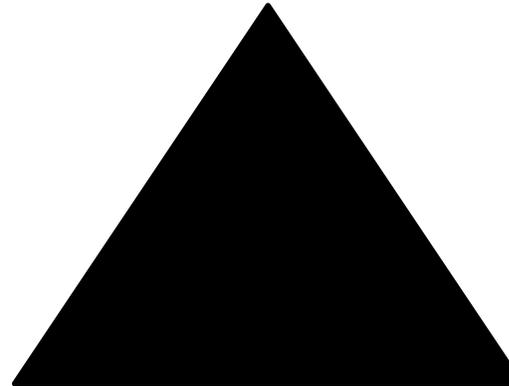


Source: Canadian Hospice Palliative Care Association, Feb 2021 Nanos Poll of >3000 Canadians

# Headline

- A way to succinctly share difficult health information
- Pairs (1) information with (2) its associated meaning

- The bottom line!



## Case:

Jamal is a 64M w/ progressing NYHA III heart failure and 2 hospitalizations to manage exacerbations in past year. Spending more nights sleeping in recliner chair to minimize breathlessness. Books an appointment to discuss a new medication that he is hoping will better 'treat' his dyspnea.

You've spoken to his cardiologist and unfortunately there are no further disease-modifying therapies to reverse his disease. He is not a transplant candidate. Titration of diuretics is his best option to manage symptoms moving forward.

# Headline = information + meaning

Unfortunately, your heart is getting weaker, which is why you are having more difficulty breathing.

# Headline = **information** + meaning

Unfortunately, your **heart is getting weaker**, which is why you are having more difficulty breathing.

# Headline = information + **meaning**

Unfortunately, your heart is getting weaker, which is why you are having **more difficulty breathing**.

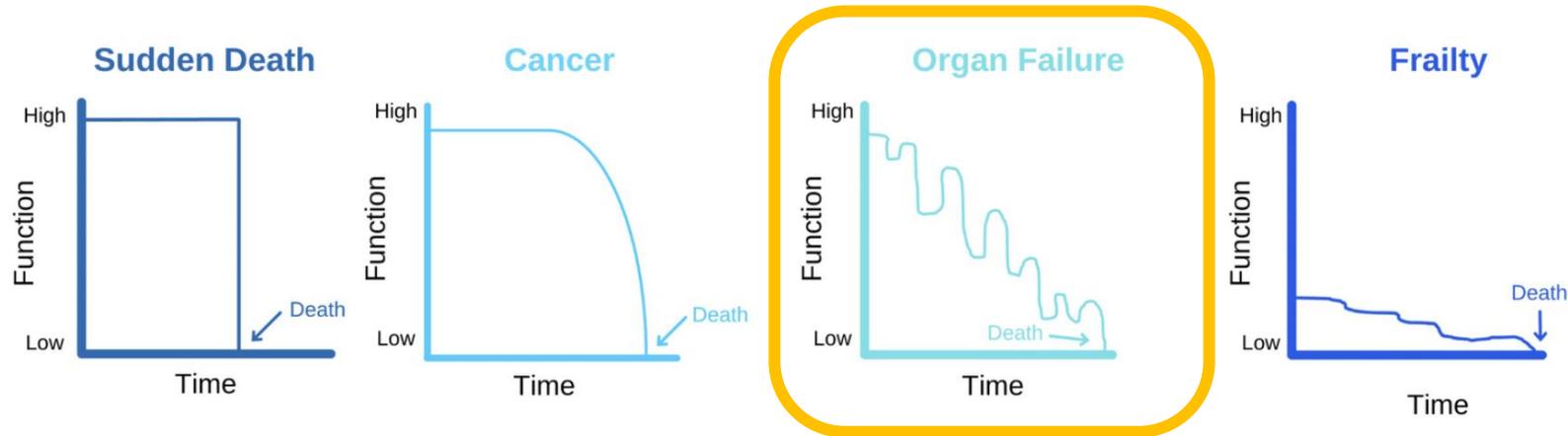
**Tip: link a symptom to health-related information**

# Headline = information + **meaning**

Unfortunately, your heart is getting weaker, which is why you are having more difficulty breathing.

As your heart weakens, I'm worried you are likely to be less independent or have episodes where you're breathing acutely worsens and I think it's important for us to **plan for these possibilities.**

# Understanding the ‘meaning’ is Key for ACP

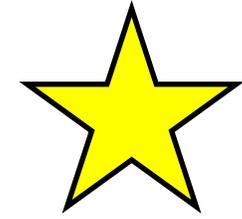


Modified from: Lunney, JR, Lynn, J, Foley, DJ, Lipson, & Guralnik, JM. (2003). Patterns for functional decline at EOL. JAMA, 289(18); 2387-92

1. **Function** – “ ... I’m worried that you may get weaker or that your health may worsen over time.”
2. **Time** – “... I’m worried that time may be short... on the order or weeks to months.”
3. **Dying** – “... I’m worried that time may be very short.... they is showing signs dying.”

“ ... and I think it’s important for us to have a plan to ensure we provide you with the best care.”

# Take Home Point



- Emotions are processed faster than cognitive information when under threat
  - **1<sup>st</sup> expect emotions**
  - **2<sup>nd</sup> respond with empathy**
  - **3<sup>rd</sup> be silent**
  - **4<sup>th</sup> give information**



# Skill

Responding to emotion with empathy  
using NURSE statements

# NURSE Statements

- Phrases that articulate empathy in response to emotion
- Builds rapport by aligning you and your patient/family and allows them to feel heard

**N** **NAME**

It sounds like you are surprised to hear this news.

**U** **UNDERSTAND**

I can't imagine how difficult it must be to hear this information.

**R** **RESPECT**

You are doing an amazing job managing your heart disease.

**S** **SUPPORT**

I am going to continue to do everything I can to support and care for you.

**E** **EXPLORE**

Tell me more..... / Tell me more about what you mean when you say.....

# Demonstration

# Skill

Using "I wish" statements instead of  
"I'm sorry"

# "I wish" statements

- Another way to articulate empathy is to align yourself with patient hopes
- "I wish" statements:
  - "I wish I had different news for you"
  - "I wish things were different"
- Alternatively, "I had hoped....."
  - "I had hoped for a better outcome."
  - "I had hoped for a different result."

# Skill

Using 'wish/worry' statements to respond to unrealistic expectations

# "Wish/Worry" statements

- **When patient or family has an unrealistic treatment goal/hope**
  - “**I wish** I had treatments that could make your heart stronger.”
  - “Unfortunately, given how advanced the heart disease is **I worry** that our focus is shifting now to how we can help you feel your best instead of how we can reverse/change what’s happening.”
- **Can be helpful if people are uncomfortable having ACP conversation**
  - “**I wish** we didn’t have to have this conversation. **I’m worried** if we don’t, we won’t have a plan to help you stay in control of your care if you get sicker.”

# Skill

Using 'I wonder'

statements to move a conversation  
forward

# "I Wonder" statements

- **When trying to move a conversation forward**
- **A way to gently ask if it's okay to think about the 'what if's'**
- **A way to give back control to them**
  - **"I wonder"** if we can talk about some other ways that I can help you to feel better?"
  - **"I wonder"** if you're okay to chat about the 'what ifs'?
  - **"I wonder"** if you're okay to have me share my understanding of what's likely to come as your heart continues to weaken?

# Demonstration

# Using a Guide to lead ACP

**Clinician Conversation Guide**  
An approach to discussing what matters most with a seriously ill person

**GRATITUDE AND CHECK IN**  
"Hi, my name is \_\_\_\_\_. I am a doctor on your team. Thank you for taking time to talk to me today. How are you doing?"

**PURPOSE**  
"I'd like to spend time today sharing information and also hearing about any concerns you may have about your illness. This will guide us in knowing how to best care for you. Is this okay?"

**EXPLORE UNDERSTANDING**  
"I've read your chart. However, it's helpful to hear directly from you. What is your understanding of where things are at **now** with your illness?" OR "What have the other doctors told you is going on with your illness right **now**?"

**VALIDATE**  
"You have a great understanding of what's going on. I have the same understanding as you do."  
OR  
**RELAY**  
"Thank you for sharing that. Would it be okay if I share some additional information?"  
"While I'm hoping for the best, I'm worried that even with more treatment for your \_\_\_\_\_ you may continue to get weaker over time and I think it's important to plan for that possibility. Can we discuss this now?"  
OR  
**REFRAME**  
"Thank you for sharing that. Would it be okay if I share some additional information? I'm worried we're in a different place now. At this point there are unfortunately no additional treatments to likely help you get stronger."  
Pause for emotion and respond with empathy (e.g., "I can't imagine how upsetting this must be to think about." OR "I wish things were different.")

**MAP OUT VALUES AND GOALS**  
"Given this news, have you ever had conversations with anyone about what would be most important to you if you got sicker?"  
"What would you be **hoping** for if your condition worsens or if time were short?"  
"What **worries** might you or your loved ones have as you think about (the possibility of) getting sicker?"  
"Is there anything else that comes to mind as you think about your future?"

**ALIGN**  
"What I'm hearing is most important to you is \_\_\_\_\_ and that you're concerned about \_\_\_\_\_. Did I get that right?"

**PLAN**  
"Based on what matters most to you, and based on my understanding of what's to come, would it be okay if I make a recommendation?"  
"I recommend the following..... [say what you will do before what you will not do]. How does this plan sound to you?"

**KEEP THE DOOR OPEN**  
"Thank you for taking the time to have this conversation today. I'll update your chart and follow up [say when]."

Visit [theconversationlab.org](http://theconversationlab.org) to learn more.

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- Patient-tested language
- Feasible
- Adaptable
- Interprofessional
- Common language – everyone on same page
- Top → Bottom
- Build towards a recommendation based on values

# Summary

- Specific communication skills can be used to increase quality of serious illness conversations
- Evidence-based skills can increase comfort and confidence to lead advance care planning conversations
- Sample Resources:
  - [Advancecareplanning.ca](http://Advancecareplanning.ca)
  - Ariadne Labs – Serious Illness Care Program
  - VitalTalk
  - The Conversation Lab ([theconversationlab.org](http://theconversationlab.org))

# Questions



# Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- Thank you for your participation!

# Thank You



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