



# Communication in Palliative Care Part II

Strategies for Sticky Situations



**Facilitator:** Diana Vincze, Pallium Canada

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

**Date:** July 5 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.

**Stay connected: [www.echopalliative.com](http://www.echopalliative.com)**

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 –  
University Health Network

Lecturer, Division of Palliative Medicine, Department of Medicine

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

Site Lead - Palliative Care, Toronto Western Hospital –  
University Health Network

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 (SIC)
- Recognize skills that may increase comfort and confidence to lead SIC
- Observe how these skills can be utilized in challenging clinical situations



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# Faculty Presenter Disclosure – Dr. Warren Lewin

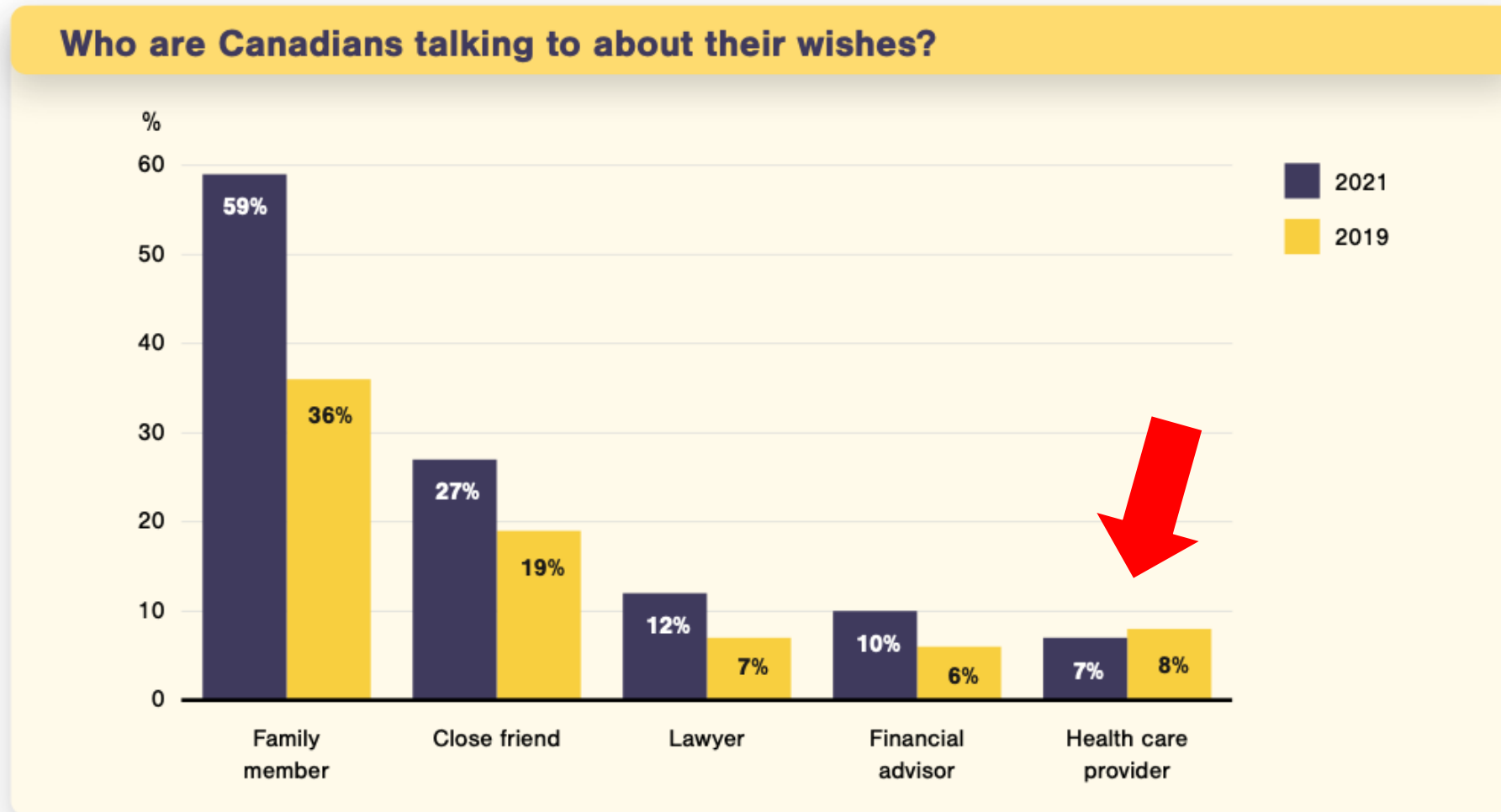
- **Relationships with financial sponsors:**
  - UHN Foundation
  - VitalTalk
- **Mitigating bias:**
  - I do not endorse one program over another
  - Skills learned/taught are generalizable

# 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

# Skills covered in Part I

- **Headline** – pairing information with meaning
- **Expecting emotion** – responding with NURSE skills
- **3 W's** – Wish, Worry, Wonder statements



# What gets in the way?

## Why don't we have these conversations?

Thoughts from the audience?



# What gets in the way?

## Why don't we have these conversations?

- Feeling unprepared/lack of provider skills (**especially with 'vague' requests or situations**)
- Clinical or Prognostic Uncertainty
- Fear (from family or provider) around taking away hope

Aline De Vleminck, Dirk Houttekier, Koen Pardon, Reginald Deschepper, Chantal Van Audenhove, Robert Vander Stichele & Luc Deliens (2013) Barriers and facilitators for general practitioners to engage in advance care planning: A systematic review, *Scandinavian Journal of Primary Health Care*, 31:4, 215-226, DOI: [10.3109/02813432.2013.854590](https://doi.org/10.3109/02813432.2013.854590)

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**Skill: “Best Case, Worst Case, Most Likely”**

## Case:

Katherine, 87F who lives in Long Term Care (LTC)

She is very sharp cognitively and sees her family often. She has been declining physically and needs help with showering, going to the bathroom, and changing her clothes.

Sudden loss of consciousness → hospital. CT HEAD: large stroke.

She is drowsy, not able to respond, and not moving the left side of her body. She is not able to swallow safely or take in much food or water for a week in the hospital.

You are a care provider at her LTC home who knows Katherine and her family well. Daughter requests to speak with you to discuss whether it makes sense or not to place a feeding tube, which the hospital team is asking her to decide upon as daughter is her SDM.

# What are you thinking?

**Strokes aren't irreversible...**

**But this sounds bad....**

**I don't know what will happen!**

**What are you thinking?**

**Without a feeding tube she'll die**

**There is no benefit to feeding tube placement. Why would the hospital team even mention this?!**

**I don't know what life will look like for her!**

# Best Case, Worst Case, Most Likely

- A way to share what *may* happen
- A way to define a 'range' of **realistic** outcomes
- A way to build trust – acknowledge uncertainty
- A way to communicate concrete information when the future can look many ways

# Best Case, Worst Case, Most Likely

- What if you don't have this information?
- Ask yourself 'who might?' and ask them for this information in advance!
- It's OK to say you need to gather more information in order to offer guidance
- It's OK to lean on your past clinical experiences

# Best Case, Worst Case, Most Likely

- **Step 1:** Share the Best-Case scenario **with** the intervention
- **Step 2:** Share the Worst-Case scenario **with** the intervention
- **Step 3:** Share what you feel is the most-likely scenario **with** the intervention



# Best Case, Worst Case, Most Likely

- **Step 4:** Share the Best-Case scenario **without** the intervention
- **Step 5:** Share the Worst-Case scenario **without** the intervention
- **Step 6:** Share what you feel is the most-likely scenario **without** the intervention

# Demonstration

# Demonstration Summary

- Didn't realize even in a **best-case** scenario that her mother will have permanent deficits
- Worries about the risk of her mother living in a “bad way” or “suffering” both in **best-case and worst-case** scenarios
- Does not think her mother would think **most-likely scenario** would be an acceptable QoL
- Dtr used information gleaned from this communication technique to inform her decision

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**Skill:** 'We don't have to pick between hope and planning'

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## Case:

Rick is an 80 M with metastatic prostate cancer. Widowed, one daughter Kim. He used to work in construction and actually built his own home.

Weakness, falls, weight loss → ER → CT Scans show new metastases to bones.

You are his primary care nurse practitioner. You have set up a visit to open the topic of advance care planning, as you are worried at how quickly Rick is declining.

Before starting: Kim asks to speak to you in private.

***“My father is a strong man, I know he can get better. He just needs to stay positive.”***

***“I don’t want you talking about the cancer or anything negative.”***

***“He just needs to keep his spirits up, get stronger, and put some weight back on.”***

# What about hope?

- Fear around taking away hope often comes up when sharing illness information or with advance care planning
- **What does evidence show around having these discussions?**
  - Less caregiver/patient depression or anxiety
  - Improved satisfaction with care
  - Does not take away hope

Wright, A. A. (2008). Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment. *Jama*,300(14), 1665. doi:10.1001/jama.300.14.1665

Temel, J., Greer, J., Muzikansky, A., Gallagher, E., Admane, S., Jackson, V., Dahlin, C., Blinderman, C., Jacobsen, J., Pirl, W., Billings, J. and Lynch, T. (2010). Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer. *New England Journal of Medicine*, 363(8), pp.733-742

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Bakitas, M., Lyons, K. D., Hegel, M. T., Balan, S., Brokaw, F. C., Seville, J., . . . Ahles, T. A. (2009). Effects of a Palliative Care Intervention on Clinical Outcomes in Patients With Advanced Cancer. *Jama*,302(7), 741. doi:10.1001/jama.2009.1198

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# Duality of Emotion:

## ‘We don’t have to pick between hope and planning’

- Useful when patient/family **hope** is preventing future planning discussions
- A way to create psychological safety (example: imagining)
- A way to align yourself with patient/family when they mention **hope** as an important value

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# Duality of Emotion:

‘We don’t have to pick between hope and planning’

- **Step 1:** Acknowledge the value of hope as positive or strength
- **Step 2:** Align yourself with patient/family by expressing support for their **hope** **AND** that you also **worry** that a lack of planning for other potential scenarios may limit their ability to stay in control of their care

*“I can see hope is so important to you both. I **share** the same hopes as you. However, I **worry** that if we don’t use this chance to **imagine** what dad would want if things don’t go well, we may **miss an opportunity** to give him **control** over his future care.”*

# Duality of Emotion:

‘We don’t have to pick between hope and planning’

- **Step 3:** Explain that planning for a future hypothetical situation doesn’t make it more likely to happen
- **Step 4:** Make explicit that they do not need to pick between holding hope VS planning for other situations - **and that you will support them to do both**

# Demonstration

# Note on Code Status

# Duality of Emotion:

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# Using These Skills in Your Practice

A Patient and Family Guide

## Talk with your health care team about the future



**Tell us about your goals and what is important to you.** Members of your health care team may talk with you about your illness and your goals and wishes for your care. We will ask about your goals for when you are well and if you become sick. Having these conversations is important to make sure you get the right care for you.

Talking about your future care does not change the care you get now.

**Think about these questions to prepare for the future.**  Asking yourself these questions now may help you feel less anxious, more at peace and more in control of your future. Preparing for the future now is especially helpful if your health changes unexpectedly.

- **What do I want to know about living with my illness,** such as its impact on day-to-day life?
- **What should I expect in the future,** such as how will my illness change over time?
- **What information do I need to make decisions about my future,** such as what treatments are available or recommended, and if the treatment is meant to cure the illness or make me feel better for a period of time?
- **What is most important for me to have a good quality of life,** such as being at home or with family, not needing a machine to live, or knowing how to manage pain or other symptoms?
- **What worries me when I think about the future,** such as being a burden to others, leaving loved ones behind, having pain, or knowing how to get help when my clinic is closed?
- **Who do I want to make decisions for me if I cannot make them myself?**

**Learn about your treatment options so you know what to expect.** As your health changes you may need to decide what treatment is right for you. Some treatments:

- are meant to cure illness
- make you feel better or comfortable
- are taken at home
- are given at the hospital

Learning what to expect from different treatments can help you have the best quality of life possible.

**Know who will make decisions for you if you cannot.** Ask someone you trust to make decisions for you if there comes a time when you cannot make decisions yourself. Tell them your values, wishes and what matters most to you. This is one of the most important ways to stay in control of your care.

We can help you identify your substitute decision maker or fill out a Power of Attorney for Personal Care [form](#) if required. We will keep the form in your chart so we have it if we need it.

**Share your wishes with us.** We will record your wishes in your chart. Having this information will help us honour what matters to you most.

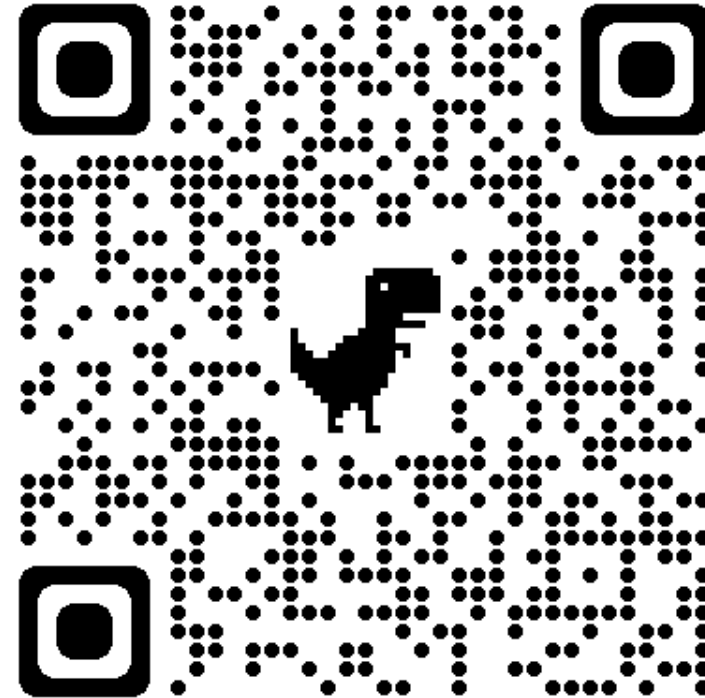
We understand your wishes for the future may change. Tell us when this happens and we will update your chart.

**Know we're here to support you.** We are here to support you and answer questions so you can make the best decisions for yourself.

Visit [advancecareplanning.ca](http://advancecareplanning.ca) for more information.

  Toronto General  
Toronto Western  
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# Summary

- Evidence-based communication skills can be used to lead high quality serious illness conversations
- “Best Case, Worst Case, Most Likely Scenario” is a communication skill that assists clinicians with decision making when **clinical uncertainty** exists
- “Hope/Worry” is a communication skill that allows clinicians to maintain patient/family **hope** when having planning or decision-making conversations



# 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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