PainWeek

ADVANCED EDUCATION

CERTIFICATION SERIES

Communication and Healthcare Decision-Making

Jaime Goldberg, MSW, LCSW

Titles and Affiliations

Jaime Goldberg, MSW, LCSW
PhD Candidate, University of Wisconsin-Madison, Sandra Rosenbaum School of Social Work
Instructor, Online Master of Science and Graduate Certificate Program in Palliative Care
University of Maryland School of Pharmacy

Disclosures

Learning Objectives

1

Discuss why effective communication is essential when discussing serious illness with patients, caregivers, families, and other healthcare professionals

2

Explain the importance of effective goals of care conversation

3

Identify how to effectively deliver serious news and lead individual and family conversations about serious illness

4

Describe the advantages of advance care planning

Transactional Model of Communication

Communicator

Noise

Social Context

Noise

Relational Context

Shared Meaning

Cultural Context

Noise

Personal Context

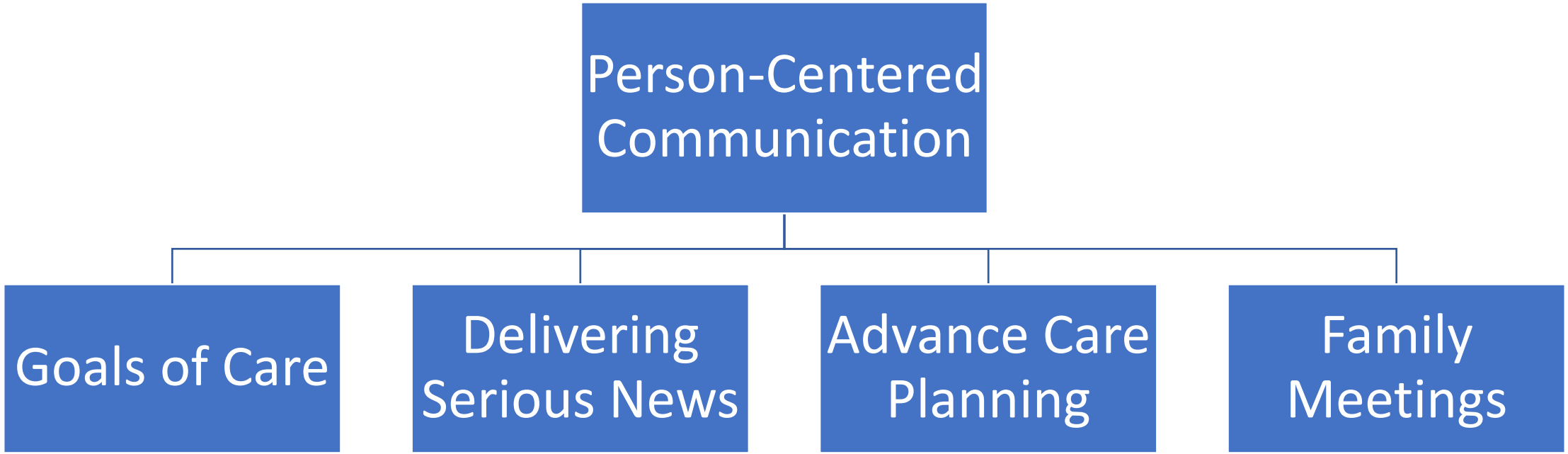
Noise

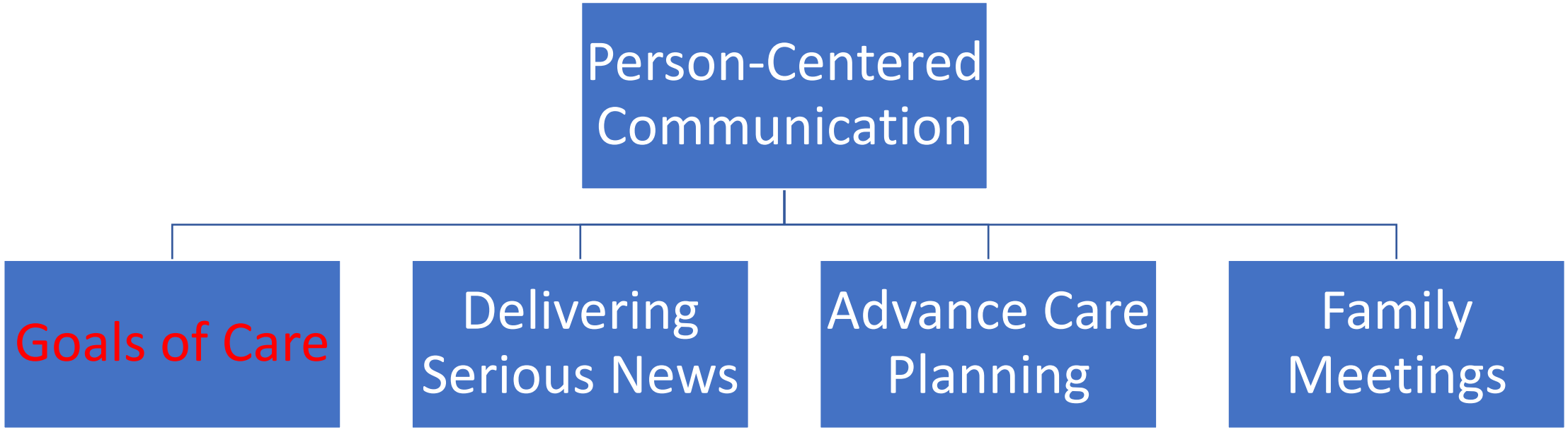
Communicator

du Pré A. Transactional communication. In Wittenberg E et al. eds. *Textbook of Palliative Communication*. Oxford, UK: Oxford University Press; 2016:14-21.

Person-Centered Communication

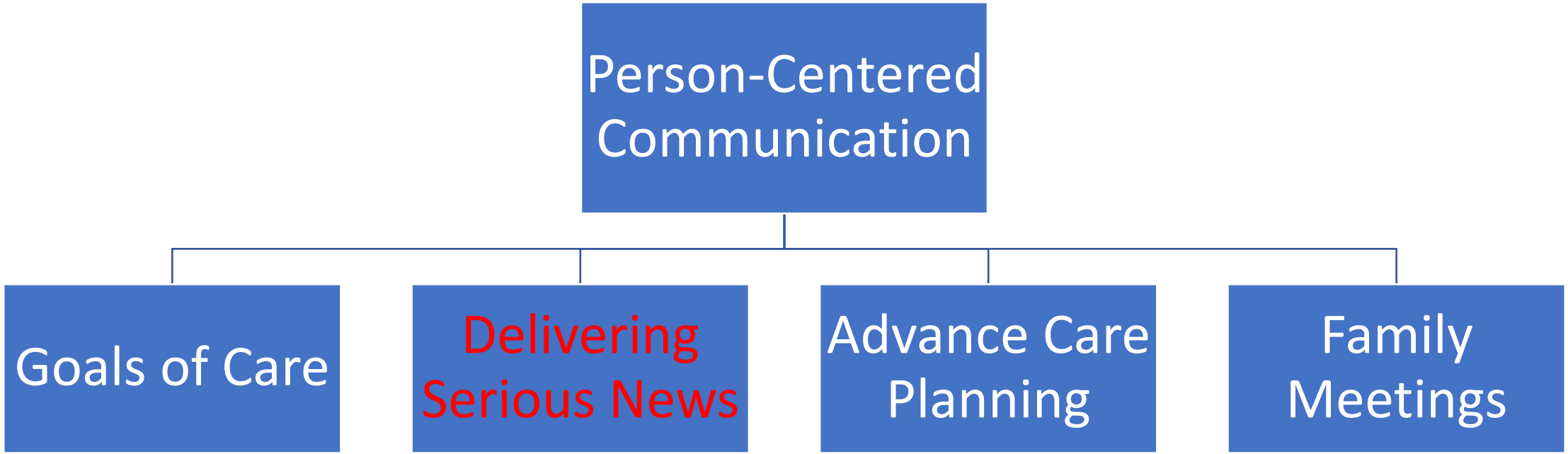
- Empathy
- Cultural humility and curiosity
- Language challenges
  - Use of interpreters
- Health literacy
- Familiarity with healthcare system
- Shared decision-making
  - Patients/families are the experts in themselves


Person-Centered Communication
Goals of Care
Delivering Serious News
Advance Care Planning
Family Meetings


Person-Centered Communication
Goals of Care
Delivering Serious News
Advance Care Planning
Family Meetings

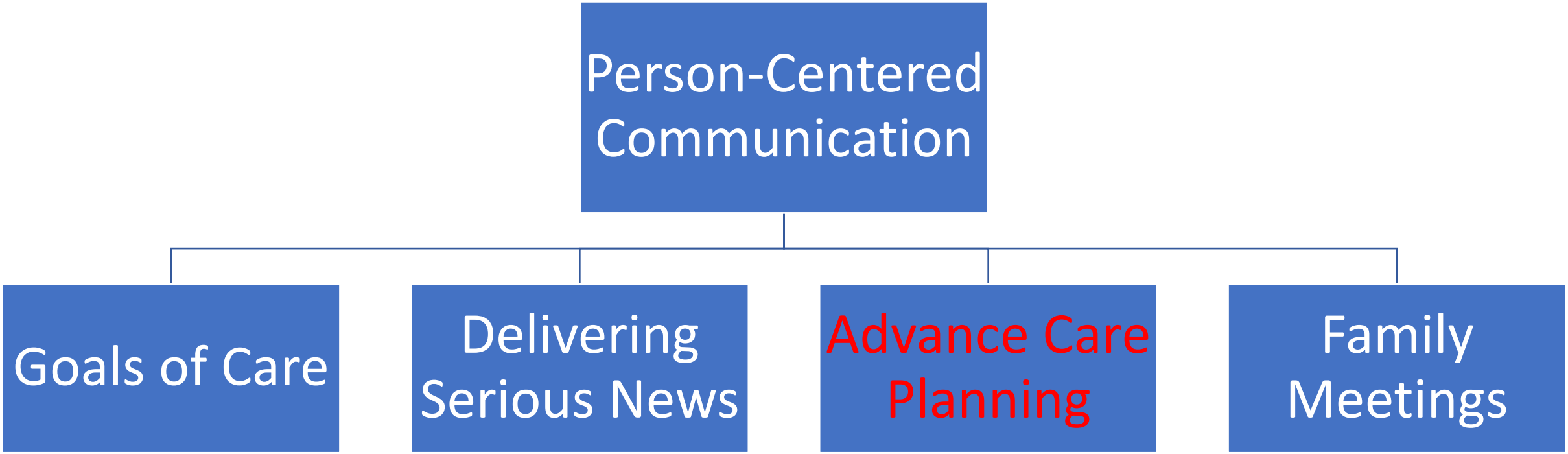
Goals of Care Discussions

Elicit	Elicit patient goals, values, preferences • Who is this person? • What is most important to them?
Ask	Ask permission to introduce the medical perspective
Match	Match patient goals, values, preferences with what is medically achievable
Recommend	Ask permission to make treatment recommendations that match patient goals, values, preferences
Focus	Focus on responding to emotions Keep in mind that in general, individuals and families care about outcomes, not treatments


Person-Centered Communication
Goals of Care
Delivering Serious News
Advance Care Planning
Family Meetings

Delivering Serious News

- Assess for patient/family understanding
- Seek permission to share the news and offer a “warning shot”
- Brief PAUSE
- Offer news in clear, concise language
- PAUSE
- Respond to patient/family emotion
- Summarize and wrap-up


Person-Centered Communication
Goals of Care
Delivering Serious News
Advance Care Planning
Family Meetings

Self-Assessment!

- A goals of care conversation aims to match patient goals/values/preferences with what is medically achievable.
  - A. True
  - B. False

Self-Assessment!

- A goals of care conversation aims to match patient goals/values/preferences with what is medically achievable.
  - A. True
  - B. False

Advance Care Planning

Conversations between patients, family members, and healthcare practitioners to delineate goals, values, preferences for *future* medical care.

www.uptodate.com/contents/advance-care-planning-and-advance-directives.

Introducing Advance Care Planning

Ideally *before* a crisis

Normalize the topic

Respond to emotions—confusion, resistance, anxiety, uncertainty

Hope for the best, make plans just in case…

Use “what ifs” to discuss an illness/ situation in the future

Explore hopes and outcomes that are most important

Advance Directives

Legal document that serves as a **guide**

Durable power of attorney for **healthcare**

Living will for **healthcare**

Advance Directives (continued)

Important to be aware of state laws/statutes

Can only be changed by person completing form

In many states, must be signed by individual who has decision-making capacity

In many states, must be witnessed or notarized

Advance Directives (continued)

Advantages

- Promotes patient autonomy and self-determination
- Brings patient voice into conversations
- Documents can be completed and changed at any time

Challenges

- May not be available when needed
- Not readily available in medical record
- Living wills
  - Cannot predict every scenario
  - Do not immediately translate into physician's orders

Advance Directives: Resources

- Five Wishes® fivewishes.org/
- Respecting Choices® respectingchoices.org/
- The Conversation Project® theconversationproject.org/
- PREPARE™ for Your Care prepareforyourcare.org

POLST/MOLST

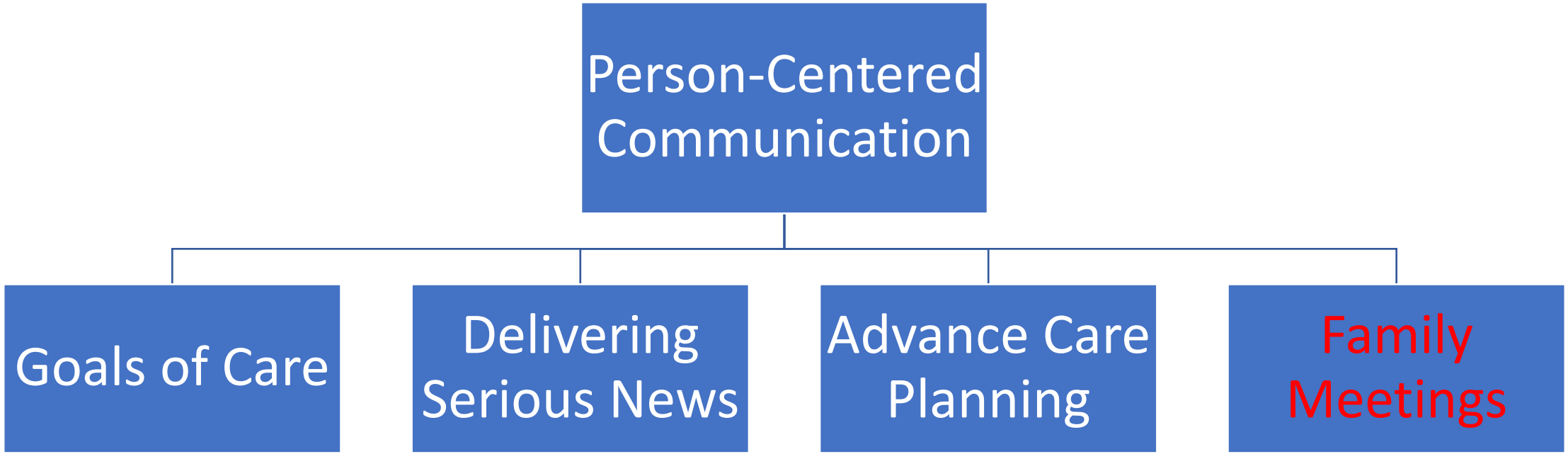
Physician/**M**edical **O**rders for **L**ife **S**ustaining **T**reatment

Out of hospital orders to travel with individuals from one care setting to another

Details vary by state—important to know about your state's form

Recommended for adults with serious illness

For additional information: https://polst.org/


Person-Centered Communication
Goals of Care
Delivering Serious News
Advance Care Planning
Family Meetings

Family Meetings

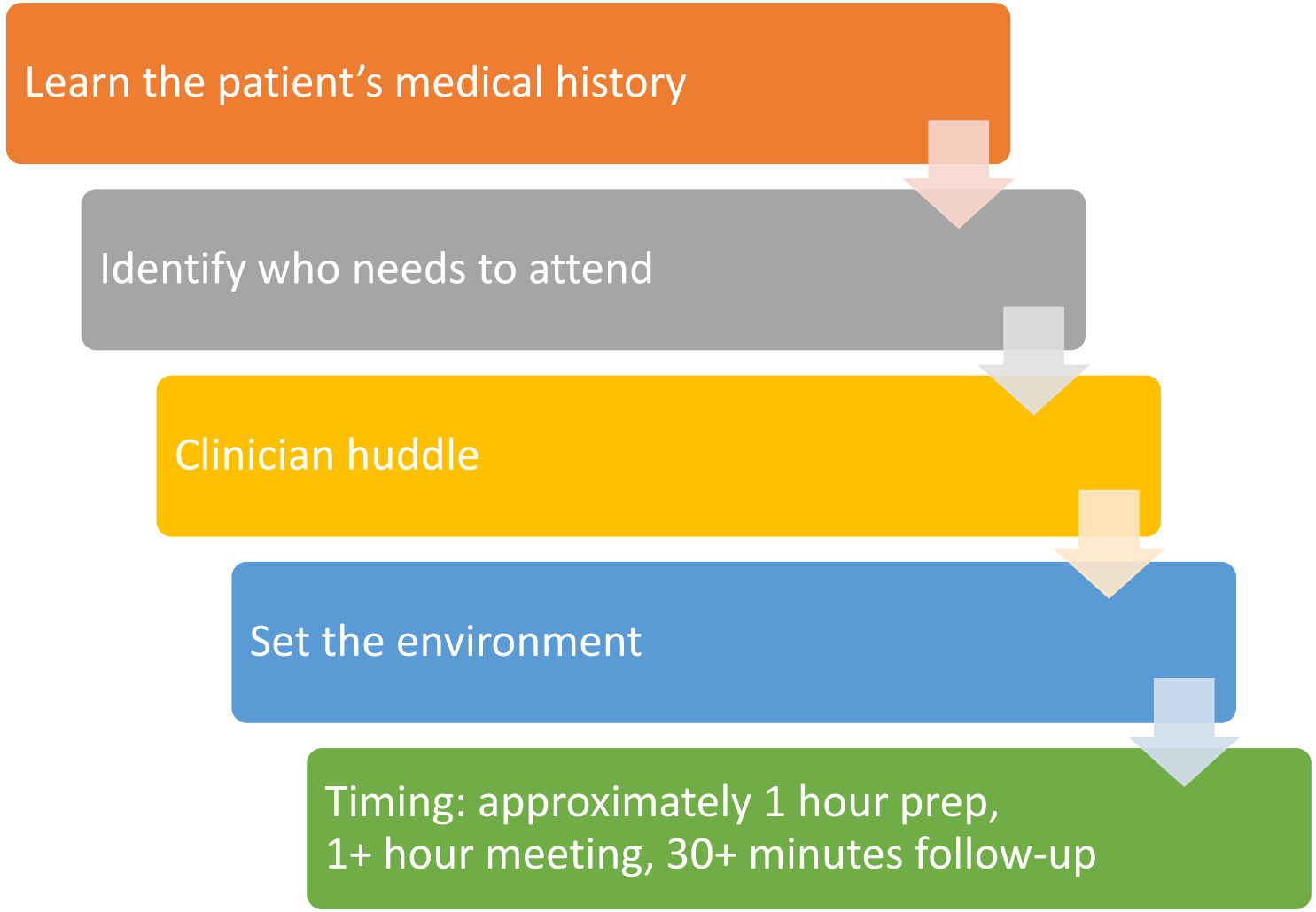
Valuable Clinical Tool

- Communicating medical information
- Discussing goals, values, preferences
- Facilitating decision-making

Participants

- Patient, if able
- Family
- Interprofessional team

Family Meetings — Preparation



Family Meetings — The Meeting Itself

- Introductions
- Assess family understanding
- Allow all family present to speak
- Ask permission to give medical update
- Be careful not to interrupt or interject
- Respond to emotions
- Look for connections
- Be mindful of words and nonverbal cues
- Summarize meeting including next steps
- Provide family with written summary and contact information

Choose Words Carefully

What is said	What is conveyed	Alternative approach
Do you want everything done?	Creates false dichotomy between “all” or “nothing”	We are going to do what makes sense for the patient as a person (based on what has been shared with the medical team) and avoid the things that will not help.
Failed chemotherapy	Patient is a failure = demoralizing	The illness progressed despite the chemotherapy. We have to weigh the potential benefits and burdens of each treatment.
Withdraw care/there is nothing more we can do	Abandonment, fear that all care will cease	We will always continue to care for the patient and the family. The focus of care may shift. We may stop specific treatments that are not helping to achieve patient’s goals.

Family Meeting – Post-Meeting

Attend to family needs

Clinician de-brief

“The Human Connection of Palliative Care: Ten Steps for What to Say and Do”

www.youtube.com/watch?v=7kQ3PUyhmPQ;
Used with permission, Center to Advance Palliative Care (CAPC) – www.capc.org

Key Takeaways

- Communication is about the words we say and how we say them.
- Having goals of care conversations, delivering serious news, facilitating advance care planning, and conducting family meetings are palliative care procedures that need to be learned and practiced.
- Patients and families are the experts in themselves.
- Remember to respond to emotions and use silence.

Self-Assessment!

- Which of the following should be avoided in an “ideal” family meeting?
  - A. Having tissues readily available because it signals distressing news is coming
  - B. Making sure at least the closest family member has a chair to be seated
  - C. The healthcare provider leading the meeting stands at the head of the table to indicate their authority
  - D. B and C should be avoided
  - E. A, B, and C should be avoided

Self-Assessment!

- Which of the following should be avoided in an “ideal” family meeting?
  - A. Having tissues readily available because it signals distressing news is coming
  - B. Making sure at least the closest family member has a chair to be seated
  - C. The healthcare provider leading the meeting stands at the head of the table to indicate their authority
  - D. B and C should be avoided
  - E. A, B, and C should be avoided

Resources

Textbooks

- Wittenberg E, Ferrell BR, Goldsmith J, et al. *Textbook of Palliative Care Communication*. New York: Oxford University Press; 2016.
- UNIPAC 5 Communication & Teamwork.

Videos

- Goodman E. The Conversation Project: An Overview. 2014: 4min32s. Available at: www.youtube.com/watch?v=owH-os9I19I.
- Goodman E. TedX: The Conversation Project. 2014: 12m46s. Available at: www.youtube.com/watch?v=xbWcLYOniWU.
- Prepare for your care. Available at: prepareforyourcare.org/#/. 1min50sec.
- Vital Talk: The 3 Conversations. Available at www.vitaltalk.org/topics/the-3-conversations/.
- Vitaltalk. Conduct a family conference: How to build relationships and promote patient-centered care. Available at: vitaltalk.org/topics/conduct-a-family-conference/. 4min46sec.
- Gawande A. New Yorker Festival (2010). How to talk end-of-life care with a dying patient. 2010: 3min1s. Available at: www.youtube.com/watch?v=45b2QZxDd_o.

Resources (continued)

Palliative Care Network of Wisconsin.

Fast facts and concepts. Retrieved from: https://www.mypcnow.org/fast-facts.

- Fast Fact #368 – The Pre-Family Meeting Huddle
- Fast Fact #16 – Moderating an End of Life Family Conference
- Fast Fact #401 – Time Limited Trials for Serious Illness
- Fast Fact #222 – The Family Meeting Part 1 – Preparing
- Fast Fact #223 – The Family Meeting Part 2 – Starting the Conversation
- Fast Fact # 224 – The Family Meeting Part 3 – Responding to Emotion
- Fast Fact #225 – The Family Meeting Part 4 – Causes of Conflict
- Fast Fact #226 – The Family Meeting Part 5 – Helping Surrogates Make Decisions
- Fast Facts #227 – The Family Meeting Part 6 – Goal Setting and Future Planning
- Fast Facts #6 – Delivering Bad News Part 1
- Fast Facts #11 – Delivering Bad News Part 2
- Fast Facts #29 – Responding to Patient Emotion

PainWeek

ADVANCED EDUCATION

CERTIFICATION SERIES

Communication and Healthcare Decision-Making

Jaime Goldberg, MSW, LCSW