How to Have Difficult Conversations With Patients, Families

An Expert Interview With Cyndi Cramer, BA, RN, PCRN May 09, 2012

May 9, 2012 (New Orleans, Louisiana) — *Editor's note: Difficult conversations with patients are necessary and, when done well, can actually empower patients and help them plan for the future.*

Nobody likes conversations with patients about bad news — grave diagnoses, difficult emotions, tough decisions. We don't like these conversations because we don't like hurting our patients.

Cyndi Cramer, BA, RN, OCN, PCRN, clinical administrative supervisor and educator in oncology, palliative care, critical care, and pediatrics at the Tampa General Hospital in Florida, spoke about this issue here at the Oncology Nursing Society (ONS) 37th Annual Congress.

Cramer talked about why good communication skills are so important and discussed strategies for helping patients and families cope with bad news. In an email interview with Medscape Medical News*, she identified things nurses should and should not do when having difficult conversations.*

Medscape: What would you say to nurses who are nervous about having difficult conversations with patients?

Cramer: This is an anxiety-producing scenario for most nurses.

First, they need to remember they are not alone. If they have any kind of palliative care team, these folks are experts on communication and can help them or even step in for them.

Next, they need to not be afraid. The most important thing they need to do is *listen*. If they are doing most of the talking, they are talking too much! Most of these conversations are about encouraging the patient to explore what is going on and what they want.

They also need to be gently honest. No euphemisms, no jargon, just simple explanations of what is going on. Patients want us to show we are empathetic to their plight, but most of them want us to be honest.

Finally, they just need to be "present." Presence is all about being there "in the moment." Eye contact and touch are important, unless the patient gives cues that they are uncomfortable (this is unwanted or even inappropriate with some people and some cultures). Giving the patient your full attention is critical, as is encouraging them to continue talking by repeating or rephrasing their statements or acknowledging their fear.

Medscape: Why is good communication important?

Cramer: Good communication is key to everything we do. If we do not communicate well, misunderstandings, false hope, and distrust can be the result. This can lead to patients and families who are confused and angry. Communication is what helps us bond with our patients.

Nurses are the "constant," as Betty Ferrell says. They are with patients for extended periods of time, whereas other healthcare providers come and go. They are the holistic practitioner who is looking at every dimension of the patient. They are the interpreters of what is going on and what others are saying, and they are the patient advocates who are required to speak up for their patient's needs and goals. If they don't do it, who will?

Medscape: What are some examples of poor and good communication?

Cramer: Poor communication is hurried, where the healthcare provider is doing all of the talking, using medical jargon the patient doesn't understand, being distant, not engaged.

Good communication is the opposite — not rushed, simple words, mostly listening, giving small bits at a time, following cues given, being empathetic, and being "present."

Medscape: Can you elaborate on the guidelines that nurses can use to develop good communication techniques?

Cramer: Some wonderful palliative care experts have been writing about communication for years. There are several great guidelines out there. Dr. Robert Buckman is one of my favorites; he has written a great book — *Difficult Conversations in Medicine*. I really recommend it as a guideline for these conversations.

He gives guidelines and examples of several mnemonics for these conversations. One that he has talked about for years is the SPIKES protocol:

- **S**etting/starting
- **P**erception
- **I**nvitation
- **K**nowledge
- **E**motions
- **S**trategy/summary

Medscape: Can you give some examples of words and phrases that should and should not be used?

Cramer: Don't say:

"We are going to withdraw care." (You mean you are not going to care for my mom anymore? Are you just going to ignore her now?)

"What do you want to do?" (referring to end of life issues: You want me to decide? Aren't you the experts? Shouldn't you be telling me what to do?)

"Do you want to make your mom a DNR?" (You want me to just give up? To just let her die? I love my mom and I don't want her to die.)

Do say:

"I wish I had better news for you. (Pause, this is a "warning shot" before giving bad news.) We've exhausted everything that will do anything that will make your mom better. She is going to die from this (many pauses). Did your mom ever talk about what she wanted?"

"This breathing machine is not helping her and patients tell us it's not a comfortable experience. Do you think your mom would rather we let her die naturally? We will stay right here with her and do everything we know how to make her comfortable. There are many things we can do for her."

"We can't fix this. I wish we could. Miracles are extremely rare and happen even without our help when they do occur.... In my experience, she only has hours to days left. You said your mom said she didn't want to die like this. Do you agree that we should allow her to die naturally and not do CPR (push on her chest) or put her on a breathing machine?"

Medscape: Why is nonverbal communication important, and how can nurses use nonverbal language therapeutically with their patients?

Cramer: Only 7% of communication is verbal; 38% comes from your tone of voice and 55% from your body language. We really need to pay attention to what perceptions our patients are getting from our nonverbal communication.

It goes back to "presence": Being with the patient in the moment; eye contact and touch when appropriate; sitting at the bedside instead of standing above the patient or talking over your shoulder while doing other things; listening more than talking.

It does not take as much time as many nurses might think — remember quality, not quantity. It all comes full circle to developing a trusting relationship in a short period of time. Time spent in initial contacts to develop that trust can yield huge benefits later when these difficult conversations are suddenly something we have to face. It is all about putting the "care" into nursing care.