

## Flexing Your Core – Domain 3: Communication

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#### Session Resources

- What Matters to Me Workbook: <https://www.ariadnelabs.org/2021/11/16/what-matters-to-me-workbook/>. VCH's website has a few other language versions of this workbook: <https://vch.eduhealth.ca/en/permalink/phem3718>.
- Dr. Atul Gawande clip: [How to Talk End-of-Life Care with a Dying Patient - Atul Gawande - YouTube](#). Author of "Being Mortal"
- Frontline documentary with Dr. Atul Gawande: <https://youtu.be/IQhI3Jb7vMg?si=d4SBYTg37iAR3IYo>
- BCCPC [Serious Illness Conversations \(SIC\) resources](#).
- BCCPC has an online module on Learning Hub on the Serious Illness Conversation. It's designed to be a two-part course. The first part is the online module: [Serious Illness Care: More, Earlier, Better Conversations - LearningHub \(phsa.ca\)](#) and the second part is a practical skills building session using the Serious Illness Conversation guide. These training sessions are organized by leads within your health authority. Please contact [sic@bc-cpc.ca](mailto:sic@bc-cpc.ca) if you are interested in getting connected with the lead within your region to inquire about training opportunities.

#### Session summary

##### Active listening

- Pay attention to the non-verbal communication. Your non-verbal communication as well as your patient. Ex. Facial expression, posture, hands tight or open
- See the dying person as the expert by asking open-ended clarification questions. Trying to discover their lived experience, putting yourself in their shoes
- Resist the urge to fix by holding an openness to 'not knowing'.
- Engage from a place of 'being' rather than 'doing'

##### Discussion: **What are some other ways of active listening? Tools you use?**

- Work on listening. Learning from counsellors and Social workers – learning the power of silence
- Reflecting back – clarifying what we heard and to ensure we understand patient/family
- Affirmations
- We are all inside this medical model with an intense demand to fix. How do we feel about being vulnerable and the not knowing piece? How is this?

- Before I go to meet with a family (lots depends on the relationship with family and patient) it's important to check chart and read notes – being mindful of the info they have been told. Give us clues of where their understanding is
- Non-verbal communication is important and helps fill in gaps (we do interdisciplinary team consults). This can help empower patients to communicate that they don't always want things fixed but want quality care.
- I can think I know what's best but I need to sit and listen and understand where the patient is a
- Eye contact and body language and subtleties of this with family/patient – how to not ignore but also not feel the need to fix
- Mindful of how writing notes and ensuring still engaged with conversations, etc
- Client may shut down if they know we are doing of active listening. Important to find your breath, ground self, lean into the curiosity
- Some patients may express they want a fix, can be difficult to navigate this. There are discretionary moments when you can give direction/opinion as you know the health system in a way they do not. Knowing the relationship you have with family/patient is very important if you are going to disclose. What kind of rapport you have with them.

**Demonstration video:** [link](#). A clip from a demonstration video of serious illness conversation

What do you think about this? What was good? What was not good?

- Good, open-ended questions, actively listening, affirmations, kept things going with the client
- Held space for client to tell the doctor what was on their mind. What's going on for you? Medical care didn't even really come up in conversation but space was held for client to share. Helping him focus on what gives him strength powerful
- Leaned in to patient, demonstrating paying attention
- How can this be used from here? Care planning conversations for future. Hope the doctors charts the conversation notes for ACP (Advance Care Planning).

**I wish/hope, I worry, I wonder:**

- The framework of “I wish, I worry, I wonder” is a way for clinicians within palliative care to discuss sensitive topics with patients in order to discover the best plan of care moving forward. It allows for care providers to respond in a way that regards the patient and family as the priority, staying centered on what is important to them while communicating where there might be potential gaps of information or understanding.

- **I Wish/Hope:** This allows us to align ourselves with patient's hopes. E.g., "I wish we could slow down or stop the growth of your cancer and I promise that I will continue to look for options that could work for you."
- **I Worry:** This allows us to be truthful while being sensitive. E.g., "But I worry that you and your family won't be prepared if things don't go as we hope."
- **I Wonder:** This is a subtle way to make a suggestion. E.g., "I wonder if we can discuss a Plan B today."

#### Group discussion:

- 1) How similar or different was this to your usual conversations?
  - some of this I would normally do in a situation. Not everyone does it like this. We had a patient that we really needed to address the I worry part of it. Important to cover all the basis. So important to investigate and develop rapport with patient
- 2) Have you ever had the opportunity to use the wish/hope, worry wonder approach with clients? If so, how was that experience for you?
  - Work in LTC – this framework transfers across any situation. Really diplomatic way of adding conversations to concerns.
  - Done SIC training and have adopted 'tradeoffs' in my language (reframe back to client when physician talks about options). Really helps client in engage with what they want and to consider options
  - Takes practice. Would get things out of order. Don't be hard on your self. It will become part of your language and practice as you work on it. You will find your own style.
  - Depends on where patient is at. May take time and many conversations with patient. Affirming is important through wish/hope piece
  - We learn. How to know and notice when we do make mistakes. Learning this helps and the importance of self-forgiveness.
  - In busy hospital acute settings things happen so fast. As a social worker I try to encourage physicians to have these conversations too. Social workers can have mini conversations and encourage team to have these too. Slow things down as we can. A surgical unit doesn't always take time to find out what patients know.
  - Palliative patients often have reports and info from various clinics but no communication to help them look at the big picture. See this very often. So important to get physicians to have these convos with clients. When palliative needs to be addressed no one seems to really address it. Clients hurting as they are not getting the info they deserve. Significant harmful gaps in the system. How can we keep going and spreading this info?