

## Flexing Your Core – Domain 3: Communication

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## Session Resources

- 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.
- 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>

## Session summary

### Communication Intro:

- 'Active' and 'curiosity' are keys pieces in communication
- This session is a journey about looking inwards, self-reflection. How do I relate to others? How do I show I care even when I don't understand what they are going through?

### Active listening

- Requires us to pause requires us to resist the 'task-based' nature of our healthcare system
- Pay attention to the non-verbal communication. Your non-verbal communication as well as your patient.
  - Eye-contact and body language overall
  - Patient: Pace at which someone talks, wincing in pain, change in skin colour-flushed/pale
  - Care provider: Turning phone sounds off. Leaning forward. Sometimes taking notes, sometimes not depending on the setting. Making sure person can hear properly, ask for it they want someone else there or translator.

- See the dying person as the expert by asking open-ended clarification questions. Trying to discover their lived experience, putting yourself in their shoes
  - Let someone finish what they are saying and being curious “can you tell me more?”
- Resist the urge to fix by holding an openness to ‘not knowing’.
  - Sitting in the discomfort: acknowledge, validate, rather than put a silver lining on it
- Engage from a place of ‘being’ rather than ‘doing’

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

- Using silence and holding space
- Careful with own facial expression - be sure not to be expressing disbelief of their feelings or critical

**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?

- I appreciated the space given, the positive and engaged body language
- Summarizing what patient said
- Focusing on strengths

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

- Part of the larger Serious Illness Conversation (SIC). The SIC guide is a validated tool to use in care. We see the need though to adapt and build flexibility. Various adaptations are important: cultures, care settings, different care contexts.
- The guide is not necessarily meant to be used word for word.
- 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.
- Framing with ‘I’ statements rather than sharing statistics is more relational, empathetic, and connecting with patients and families.
- **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? Have you ever had the opportunity to use the wish/hope, worry wonder approach with clients? If so, how was that experience for you?
  - I always find this so helpful and use it all the time. Including with families and loved ones, and in many other cases not just palliative care, including
- 2) Could you see yourself using it in the future?
  - Using this framework has opportunity to express empathy. Everyone who provides care can have these conversations
  - Some clinicians worry about these conversations because prognosis piece but there's so much more to having these conversations than prognosis that all clinicians can engage in (and generally do on a regular basis)
  - As healthcare assistants we end up having parts of these conversations. We wouldn't have parts of this conversation (Advanced Directive or Substitute Decision Maker).
    - Communicating observations (HCAs are the eyes, ears, hands with patients) to the care team.
    - These conversations with patients are a team approach. Someone on the team may have one piece of the conversation and another team member another piece.