# Difficult Conversations

*Including Breaking Bad News and DNACPR Discussions*

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# Introduction

- Communication skills are vital skill in modern clinical practice
- Communication skills stations make up around 40% of the marks for finals directly, and are a part of almost all stations. Common themes include:
  - Handover
  - History taking
  - Explaining a diagnosis/management
  - Breaking bad news

- Difficult conversations can present a challenge to any clinician's communication skills and can occur in a variety of settings
- In this talk we will focus on breaking bad news and DNACPR discussions

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# Difficult Conversations

- Difficult conversations in clinical practice (and simulated ones in exams) can take a variety of forms
- It can be difficult to predict when difficult conversations will arise
- If you think a conversation will be challenging – prepare in advance!
- If you find yourself in a difficult conversation unexpectedly and unprepared, always consider whether you can postpone the conversation to a later time to allow you to prepare appropriately

**Difficult Conversations you may encounter:**

- *Breaking Bad News*
- *DNACPR discussions*
- *Treatment Escalation decisions*
- *Patients and relatives who are angry, hostile or upset*
- *Exploring sensitive subjects*
- *Discussions with patients who have communication difficulties*
- *Discussions with patients who lack capacity*

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# Preparing for a difficult conversation

- **TIME** – Ensure that you have adequate time to have the conversation without being rushed or distracted
- **PLACE** – Think about the environment that the patient/relatives would be most comfortable having the conversation in
- **PEOPLE** – Confirm the identity of all present and their relationship to the patient. Identify who needs to be present for the discussion.
- **INFORMATION** – Ensure you have all the information you need in order to undertake the conversation, as well as supplementary information such as leaflets if appropriate
- **SUPPORT** – Bring an additional staff member(s) with you. This will usually be a senior nurse or another member of the medical team. In some cases it may be appropriate to ask security or translators to attend. If you feel out of your depth ask for help!

# If you do have a difficult conversation

- Make sure you document your conversation thoroughly afterwards. Document who was present and ask others to countersign the record if appropriate
- If an issue is unresolved following your discussion seek senior support
- Think about appropriate ways you can reflect and/or debrief afterwards to identify areas you can improve

# If you encounter an aggressive patient

- Assess the risk to the patient, yourself and colleagues

- Attempt to minimize the risk by defusing the situation:
  - Try to identify the problem that could be causing any aggression or violent behavior
  - Remain calm and listen to what the patient is saying. Use open questions and open body language
  - Reassure them and reinforce that you are there to help them. Acknowledgde any greivances they may have
  - Try to resolve any problems that could be causing the behavior if possible

- If despite this the situation is worsening ensure you are a safe distance from the patient and ask for help/support. Patients should not be denied necessary treatment, but it may be appropriate to consider alternative arrangements for providing treatment

# Breaking Bad News


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# Breaking Bad News

- Breaking Bad News is a common occurrence for doctors
- Although it will become a frequent occurrence for you – each patient only receives the bad news you give them once and will remember the circumstances in which they received bad news for a long time.
- You can be asked to break bad news to a patient in an OSCE in a simulated environment eg:
  - Life-changing illnesses
  - Cancelled medical care
  - Revoked driving licence or employment restrictions

# Approach to Breaking Bad News

- Frameworks are available that break down breaking bad news into components:
  - Preparation/Environment
  - Priming
  - Delivery
  - Support/Follow-up

**S** – Setting
**P** – Perception
**I** – Invitation
**K** – Knowledge
**E** – Emotions
**S** – Summary

Baile and Buckman (2000)

# BBN – Preparation/Environment

- Find a suitable place to break the news – usually quiet, private and free from distraction
- Unless strictly necessary try to avoid breaking bad news over the phone
- Prepare by gathering any information you might need, such as the patient's background and the consequences of the news
- Invite the patient to bring a relative or friend for support

# BBN - Priming

- Establish the patient's expectations and what they already understand

  "May I ask what you are hoping to discuss today?"

- Assess whether it is the appropriate time to deliver the bad news

- Deliver a "warning shot"

  *"I've got the results of the biopsies back, and unfortunately I have some bad news"*

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# BBN - Delivery

- When breaking the news, be clear and don't use colloquialisms/jargon

  *"The tests have shown that you have cancer"*

  ***not***

  *"our cytology has shown the presence of poorly differentiated malignant cells"*

- Be patient – allow silence and time for the information to be absorbed.
- Do not overload with information

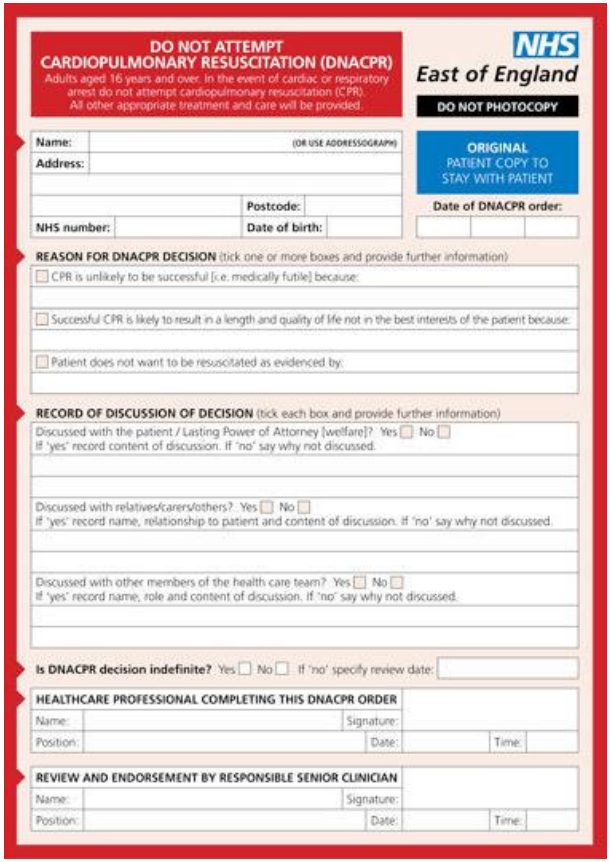
# BBN – Support/Follow-up

- A lot of the information may be forgotten or misunderstood.

- Allow the patient to ask questions.
- You may need to repeat important points.
- Explore any ideas, concerns and expectations

- Offer the opportunity for the patient to contact you or arrange a follow-up appointment. Offer additional information such as leaflets if appropriate

# DNACPR Discussions



**DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)**

Adults aged 16 years and over. In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR). All other appropriate treatment and care will be provided.

NHS East of England

DO NOT PHOTOCOPY

Name: (OR USE ADDRESSOGRAPH)

Address:

Postcode:

NHS number: Date of birth:

ORIGINAL PATIENT COPY TO STAY WITH PATIENT

Date of DNACPR order:

**REASON FOR DNACPR DECISION** (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful [i.e. medically futile] because:

☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

☐ Patient does not want to be resuscitated as evidenced by:

**RECORD OF DISCUSSION OF DECISION** (tick each box and provide further information)

Discussed with the patient / Lasting Power of Attorney [welfare]? Yes ☐ No ☐
If 'yes' record content of discussion. If 'no' say why not discussed.

Discussed with relatives/carers/others? Yes ☐ No ☐
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.

Discussed with other members of the health care team? Yes ☐ No ☐
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

**Is DNACPR decision indefinite?** Yes ☐ No ☐ If 'no' specify review date:

**HEALTHCARE PROFESSIONAL COMPLETING THIS DNACPR ORDER**

Name: Signature:
Position: Date: Time:

**REVIEW AND ENDORSEMENT BY RESPONSIBLE SENIOR CLINICIAN**

Name: Signature:
Position: Date: Time:

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# What is a DNACPR order?

- Refers specifically to initiation of cardiopulmonary resuscitation in the presence of cardiac or respiratory arrest and no other treatments

> *"CPR involves chest compressions, delivery of high-voltage electric shocks across the chest, attempts to ventilate the lungs and injection of drugs."* – Resuscitation Council

- Completed in cases:
  - Where the treating doctor believes CPR is unlikely to be successful
  - Where the treating doctor and/or medical team believe CPR is likely to result in a length or quality of life not in the best interests of the patient
  - Where the patient has expressed a wish not to have CPR

- Not the same thing as a **Treatment Escalation Plan (TEP)** and does not affect other treatments, although should be considered alongside these

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# Why are DNACPR orders important?

- The incidence of in-hospital cardiac arrest is difficult to assess, but previous audits have estimated an incidence of 1.6 per 1000 admissions.
- Overall survival from in-hospital to hospital discharge was 18.4%. This figure falls to approximately 8% in those resuscitated in the community and subsequently brought to hospital
- Successful resuscitation can bring extended and previous life to individuals, however only a minority survive
- CPR is an invasive treatment and attempted resuscitation risks causing unnecessary suffering and prolonging the process of dying

*"Primum non nocere"*

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# DNACPR Discussions

- There is some legal background to DNACPR orders that informs how you should approach discussing it with a patient/relatives:
  - Tracey vs Cambridge Hospitals NHS Foundation Trust 2014
  - Winspear vs City Hospitals Sunderland NHS Foundation Trust 2015

- Useful resources are available from the GMC, BMA and the resuscitation council on approaching DNACPR discussions. The MPS and MDU also provide advice.

# DNACPR Discussions (1)

- Discussions regarding DNACPR orders are complex and sensitive, and where possible should be undertaken by a senior member of a healthcare team
- Wherever possible, the possibility of a DNACPR order being completed for a patient should be discussed in advance before a decision is taken
- Where a patient has capacity their wishes should be explored, including their beliefs about CPR. In the case that they do not wish to discuss CPR, you should seek their permission to discuss it with those close to them
- A discussion regarding a DNACPR should include an explanation of what CPR is, and the reasoning behind a DNACPR order

# DNACPR Discussions (2)

- Where a patient does not have capacity:
  - You should inform those close to the patient about any DNACPR decision and the reasons for it immediately or as soon as possible if it cannot be discussed in advance
  - If there are obvious disagreements with members of family of a patient who lacks capacity that cannot be resolved advice should be sought (senior clinician or legal advice!)
  - Any advanced directives should be respected, and if an attorney, deputy of guardian has been appointed they should be consulted

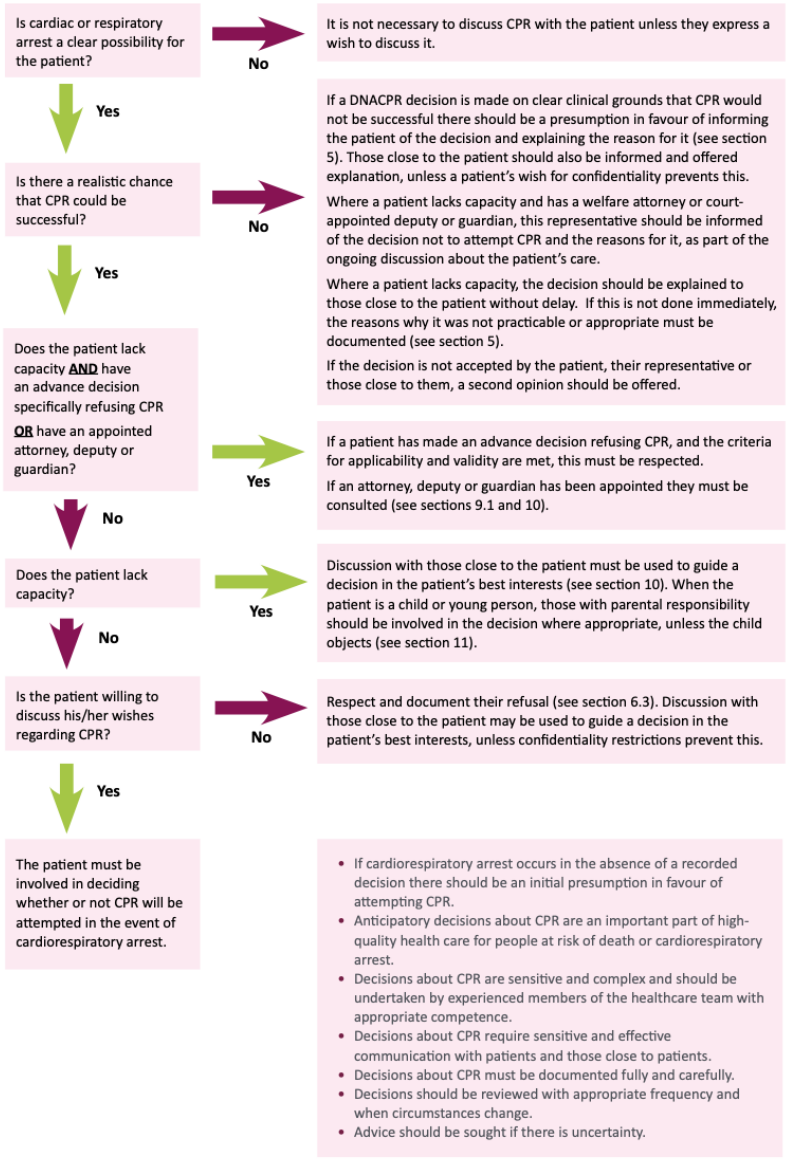
# Lasting Power of Attorney

- Lasting power of attorney for health is when someone appoints an “attorney” who has the authority to make a legal decision on a patient’s behalf regarding their health care in the event they lose capacity

- Lasting power of attorney may be shared between multiple individuals who can make decisions either jointly (all attorneys must agree) or severally – ask to inspect LPAs if any doubt!

- **Remember LPA decisions are only valid when the patient lacks capacity**

## Decision-making framework




**Decisions relating to cardiopulmonary resuscitation Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing** (previously known as the 'Joint Statement')
**3rd edition (1st revision) 2016**

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# Summary

- Communication skills are a vital part of being a doctor, and careful communication can be required to navigate difficult conversations
- DNACPR discussions have some special considerations to keep in mind based on recent legal cases
- There is no substitute for practice, but careful preparation when it comes to approaching difficult conversations can aid effective communication (and help you get marks in the OSCE!)

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# Thank you!


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