

Conducting Emotionally Difficult Conversations

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How To Break Bad News

Robert Buckman (with contributions by
Yvonne Kason). Baltimore: Johns Hopkins
University Press, 1992. ISBN 0-8018-4491-6



Medical Errors and
Medical Narcissism

John Banja

Go to....

- <http://www.gha.org/pha/video/index.asp>

Emotionally painful conversations are ...

- Inevitable in health care
- Awkward because health professionals are often not trained to conduct them, yet they require considerable (but learnable) skill
- Important to do well since the public, law and, usually, patients demand truthful and effective communications
- Often necessary because resisting them might not only be unethical but result in malpractice litigation

The Model ...

- Is a simple stimulus-response paradigm
- You encounter a situation (e.g., having to break bad news, being confronted with questions) that provokes an uncomfortable feeling
- Your response to and management of that feeling will be critical in managing the communication

When the conversation goes poorly, it's often because some element of our psychological formation has been triggered in a way that compromises our response's being artful, caring, or empathic/therapeutic.

Most often the inappropriate response will derive from the speaker's psychological defenses.

Upsetting Communications...

- “Do you people really know what you’re doing here?”
- “I’ve got WHAT?????”
- “Are you licensed?”
- “Let me tell you something....”
- “Oh God, this can’t be happening to me....”
- “Oh, I hurt so much...why can’t you do something?”
- “How much time do I have?”

The Professional Self



The Professional Self Is Assaulted by the Difficult Conversation!



“We do not see things the way things are, we see things the way we are.”

Anais Nin

“Time flows from the present to the past.”

Zen saying

The difficult
conversation is largely
about feelings—about
respecting,
acknowledging and
controlling them.

A key error that health professionals make in difficult conversations is thinking that the conversation is all about information.

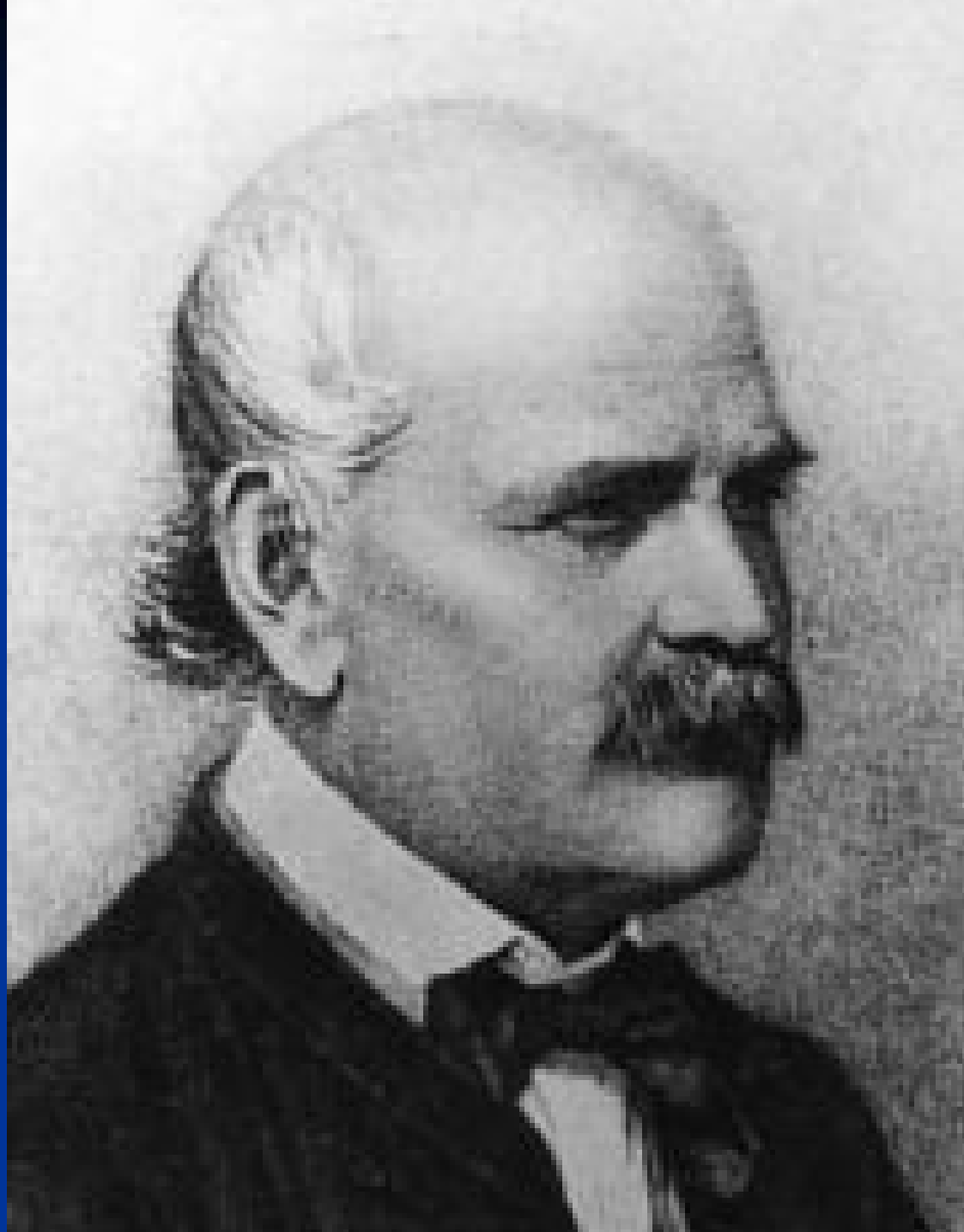
The reason why is that ...

- HEALTHCARE PROFESSIONALS ARE MASTERS OF INFORMATION. THEIR PROFESSIONALISM AND SELF-ESTEEM CONSISTS IN THEIR DEMONSTRATING WHAT THEY KNOW.
- SO, IN DIFFICULT CONVERSATIONS, THEY NATURALLY RESORT TO THEIR STRONG SUIT--WHAT THEY KNOW--TO KEEP THEIR SENSE OF SELF ON TRACK.

What is
going on?

Feelings, Interests,
Values, Desires,
Anxieties, Fears

SELF



The ever-vigilant brain

Risks

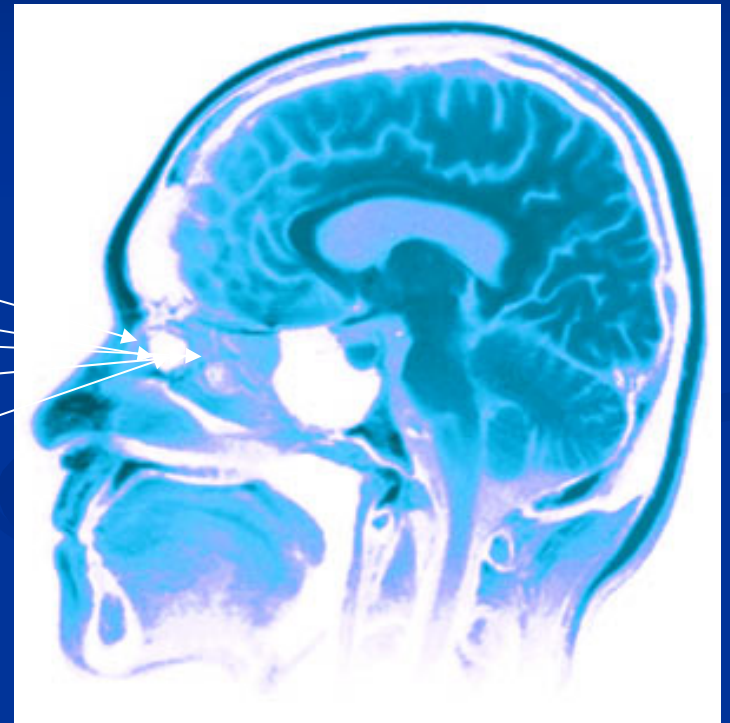
Threats

Opportunities

Desire

satisfaction

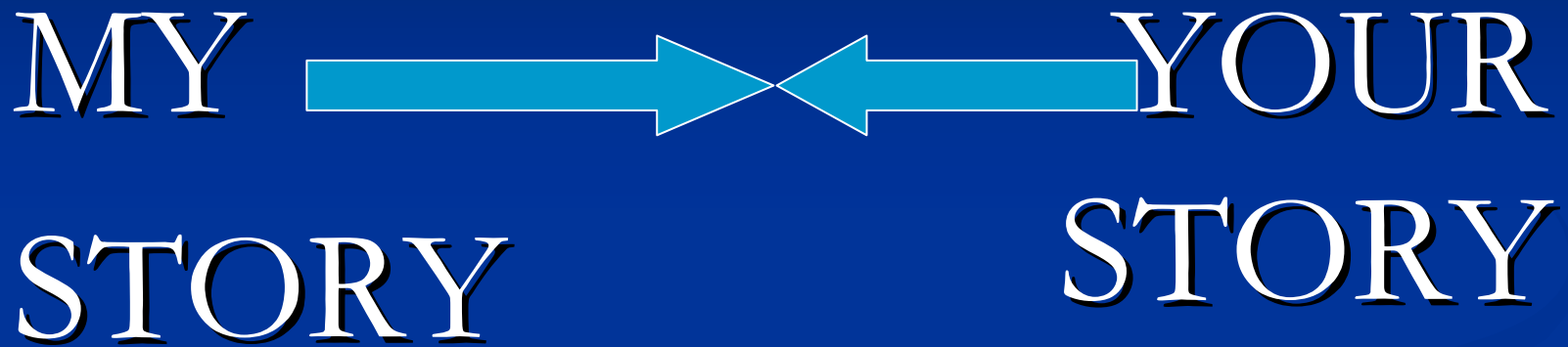
Needs



And what signals the brain?

FEELINGS!!

Difficult Conversations/Experiences



- THE FACTS/WHAT'S IMPORTANT
- THE FEELINGS
- THE CONCLUSION: “What this means...” “What you have to do...”

In difficult conversations, we want our story to dominate and trump the listener's story. We want their story to STOP. We want them to accept our story, because their story makes us feel uncomfortable.

Notice...

My insisting that my story is the story is a form of domination—and that's why listeners get angry with us, because our insistence on our stories make them feel dominated, disrespected, and not in control.

Three levels of STOP IT

- 1st level: evasion, distraction, ignoring, refocusing, or distorting/reinterpreting the event, such that the professional's anxiety is alleviated through distortion;
- 2nd level: lecturing, sermonizing, arguing, threatening, blaming, such that the professional's escalating anger and frustration are alleviated through bullying;
- 3rd level: hatred, hurting, or harming such that the professional's rage is alleviated through causing discomfort or pain.

The Signal Error in Managing Frustrating Clinical Situations!

I insist the my story—my version of the facts—is either the “right” one or the overriding one or the only one. But that’s what the other person is thinking and feeling too. Both parties become very invested in defending themselves, or at least, their stories.

The Goal:

To acknowledge and validate the patient's psychic reality, or at least address it in such a way that it doesn't become harmful or destructive to him or herself or to you.

This is not easy, but it is learnable.

Strong emotions

- DO NOT IGNORE OR DISMISS THEM!
THIS IS ONE OF THE CARDINAL
MISTAKES PERPETRATED IN
PAINFUL COMMUNICATIONS!
- Identify and acknowledge them: “This must be ... dreadful, horrible, awful, confusing, upsetting ... for your to hear.”

What the patient wants

- Understanding
- Respect
- Vitality

Be prepared to listen ...

- By definition, good listeners interrupt minimally
- Health providers talk too much, usually because they are feeling uncomfortable, and they don't know how else to maintain their control and self-esteem
- Learn to tolerate silence

We must replace....

- Informing with Understanding
- WE MUST TRY TO MAKE THE LISTENER FEEL HE OR SHE IS BEING UNDERSTOOD!
- What is it like when you feel that you are being deeply understood, and in a nonjudgmental, nonthreatening way?

When the news is painful, you must :

PREPARE TO HAVE A
CONVERSATION

**Buckman's
6-step protocol
for breaking
bad news.**

I. Introduction and the physical context

- Private environment
- SIT DOWN!
- Introduce yourself, tell what you do
- Who else is there? Do they have the patient's permission?
- No desk between you and the patient; where's the door?

Body language and touching

- Sitting posture, handshake (?) smile (?)
- Eye contact
- Touch shoulder, forearm, hand--never below the waist
- Talk slowly; when the news is at its worst, talk even more slowly; if the patient looks away, stop talking and wait

II. Extent of Patient's Knowledge

- “What have your therapists/doctors told you so far?”
“What have you made of all this so far?”
- Extremely important to determine what the patient knows or believes because it enables “alignment”
- Don't overreact to the patient who claims he or she was never told

III. How much does the patient want to know?

- “Are you the kind of person who likes to know all the details? Or would you rather know in general what’s happening? Or is there someone you would rather I speak to?”
- Some patients would rather not know, and they have a moral right to refuse hearing the information
- If the patient doesn’t want to know, document that and proceed to the treatment plan and the follow through

IV. If the patient wants to know

...

- There is no easy, magical way of breaking the bad news
- Remember not to anticipate what the patient will say or how he or she will react to the news
- Fire a warning shot: “I’m afraid the situation is serious ...” “This is difficult for me to say...”

Slow and steady ...

- Try hard to speak slowly
- Stop frequently; this gives the listener permission to talk
- Ask, “Is this making sense? Do you see what I mean?”
- Validate questions: “That’s an excellent question.” “You raise a very important point.”

Try hard ...

- Not to interrupt; sometimes the best we can do is absorb the patient's feelings (or projections)
- Not to look away, except if the patient is crying (then don't stare)
- Not to be intimidated by silence; remaining silent is respectful and therapeutic

Empathic Language

- “This must be (dreadful, awful, depressing, frightening) for you to hear.”
- “This is obviously making you feel very”
- “I hear you.”
- “Tell me more about that.”
- “And how did you experience (or feel about) that? What was that like?”
- “So, this must have caused/must be causing you a lot of (heartache, sadness).”

More empathic language

- “I wonder what you’re feeling right now.”
- “What is it about that that ... (worries, upsets) you?”
- “What is it about talking about that ... (you don’t like? Makes you anxious? Makes you want to talk about something else?)”
- “What would you like to have happen from this?”
- “Anything else?”
- “Now let me make sure I’m understanding you. You’re asking me ... (whether or not, how it is that) Is that correct?”
- “So, what you’re saying is that ... “
- Repeat the other’s last three or four words.

REMEMBER

The primary thing your patients want to believe is:

THAT YOU UNDERSTAND HOW
THEY UNDERSTAND WHAT IS
HAPPENING TO THEM.

V. Responding to the patient's feelings and reactions

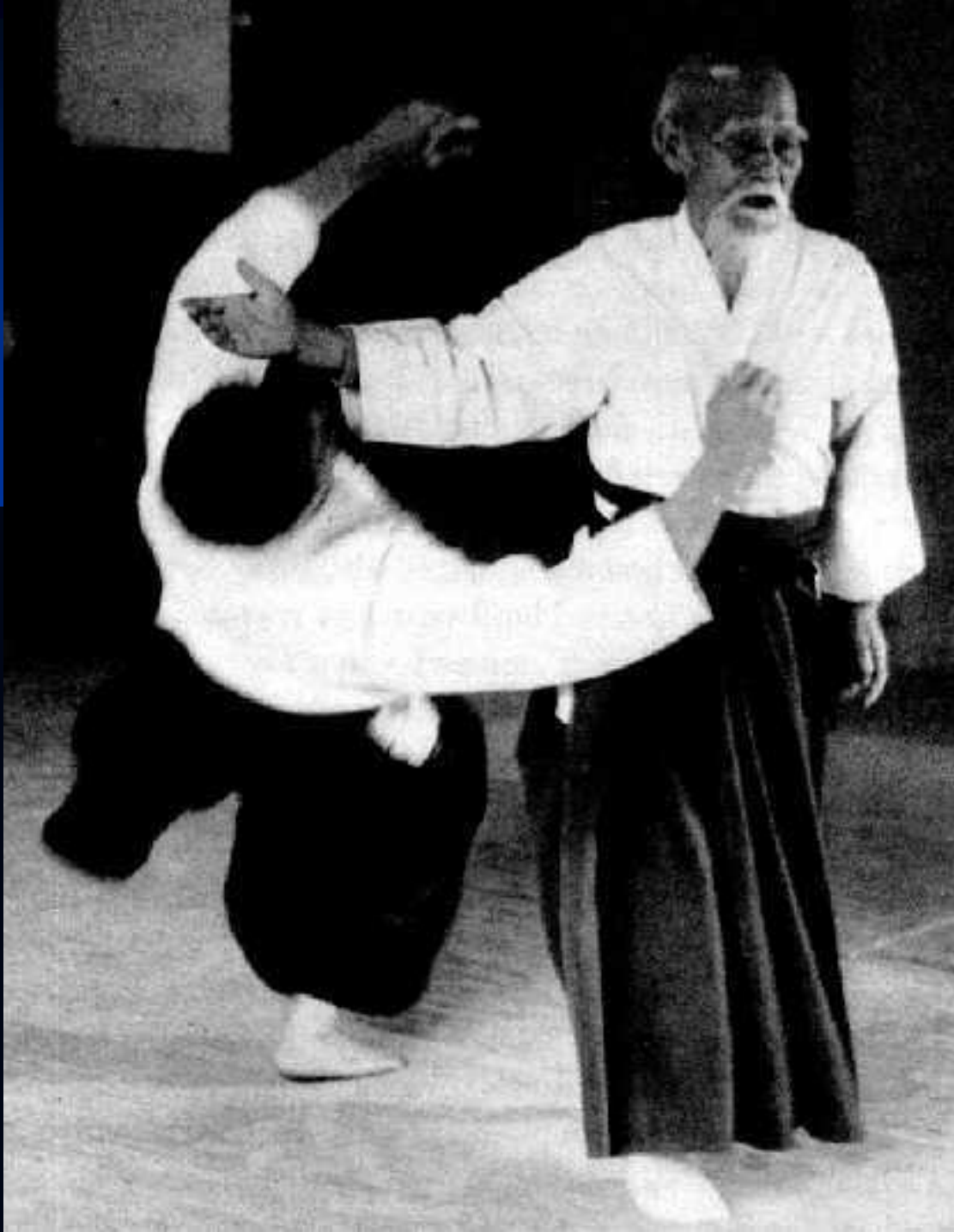
Unfortunately, this takes the better part of a clinical lifetime to master.

VI. Planning and Following Through

- Make a priority or problem list according to the patient's priorities
- Devise and explain the plan to the patient
- Show the patient how the plan supports his or her needs or agenda
- Identify the patient's coping strategies
- Identify other sources of support

No one is a perfect or virtuosic bad news communicator.

The objective of studying these techniques is to make fewer mistakes and not make an already difficult situation worse.



Thanks very
much.