Conducting Emotionally Difficult Conversations

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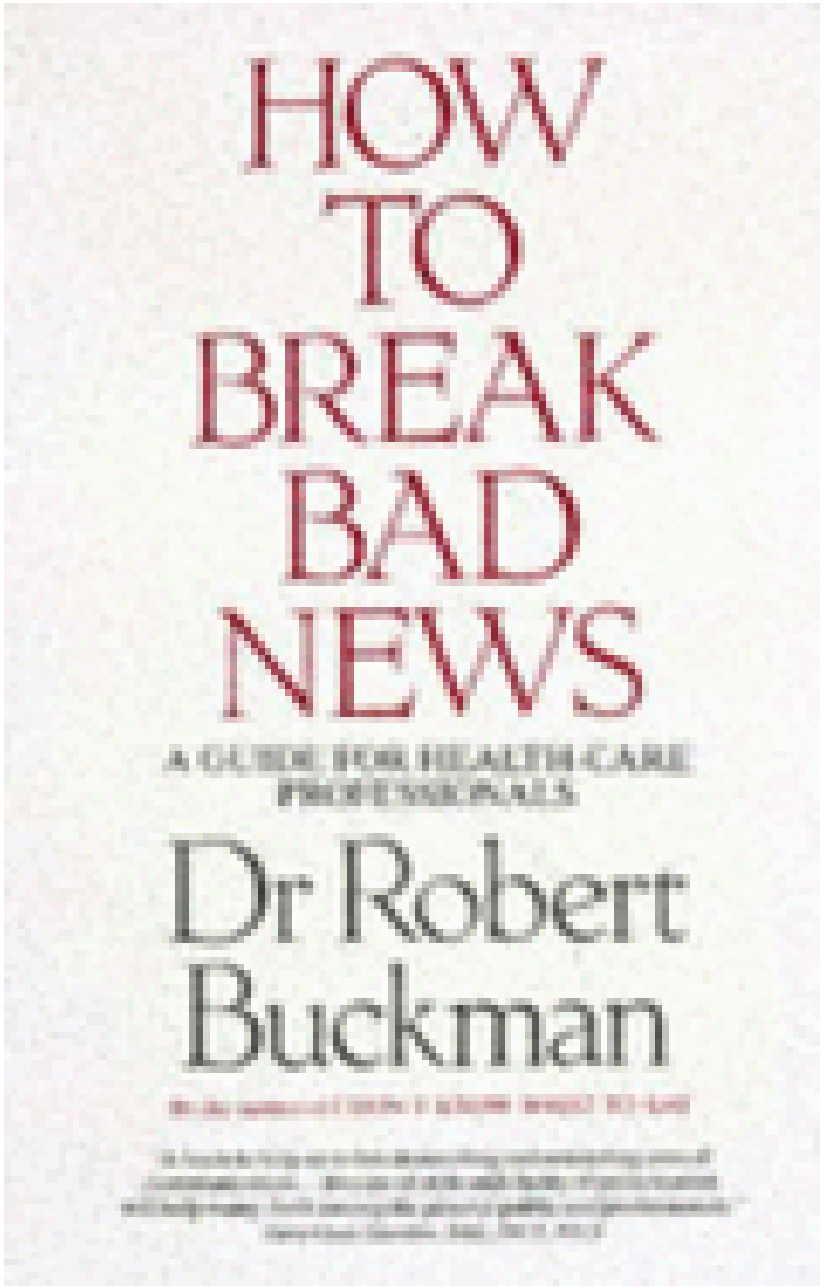
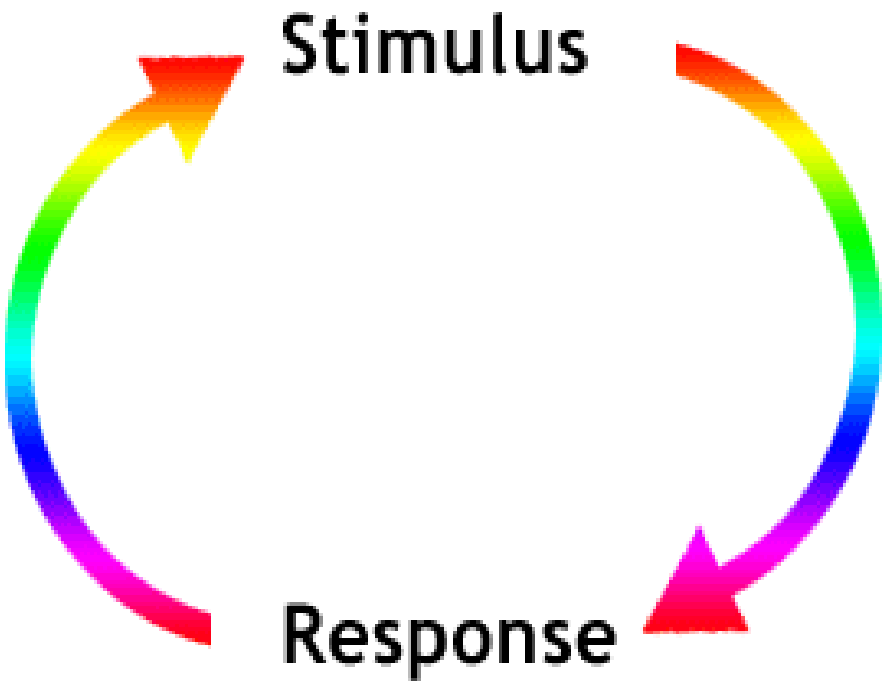


Robert Buckman (with contributions by Yvonne Kason). Baltimore: Johns Hopkins University Press, 1992. ISBN 0-8018-4491-6

Emotionally painful conversations are…

- Inevitable in health care
- Awkward because health professionals are often not trained to conduct them
- 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

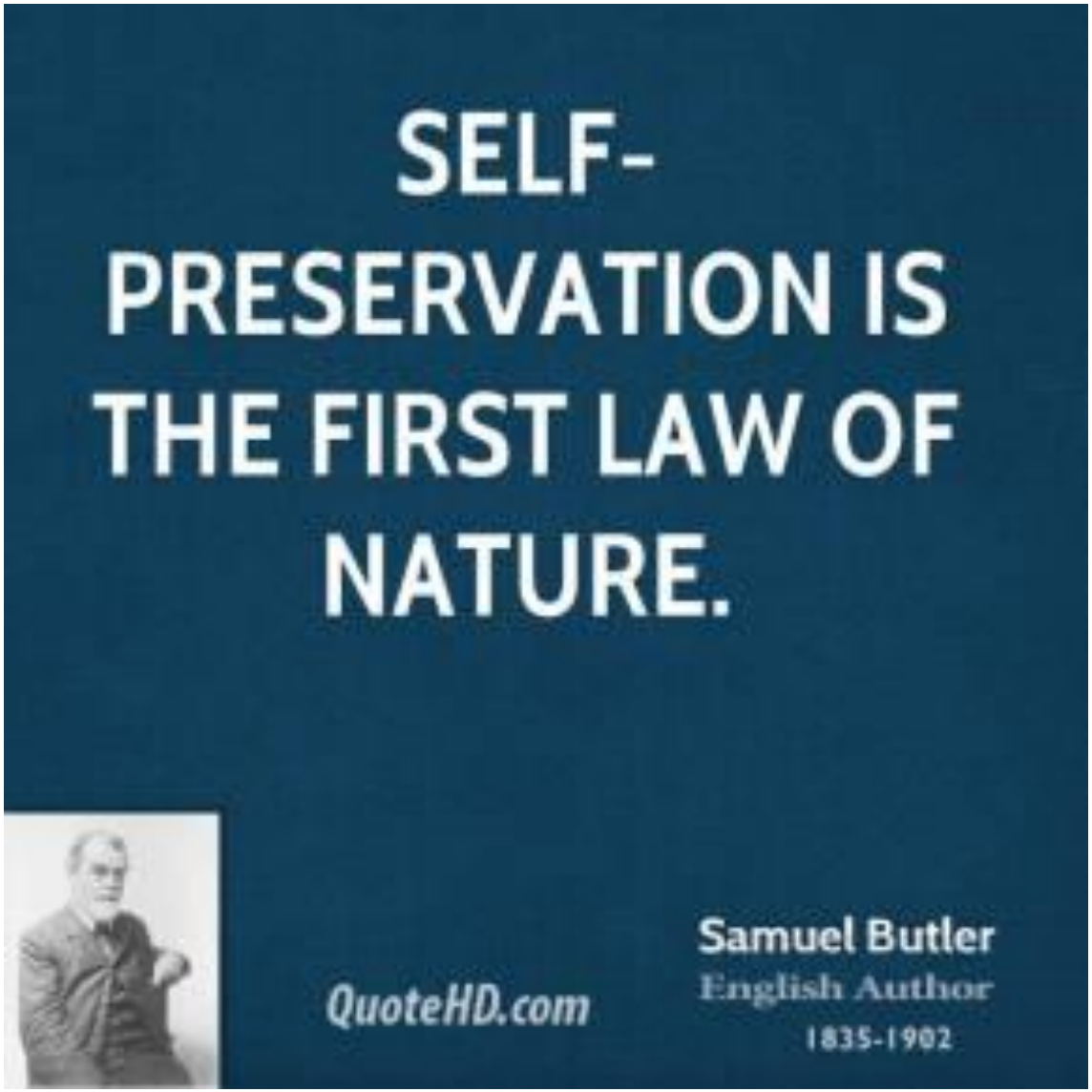
When the conversation goes poorly, it's often because some element of our psychical formation has been triggered in a way that compromises our response's being artful, caring, or empathic/therapeutic.

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?”

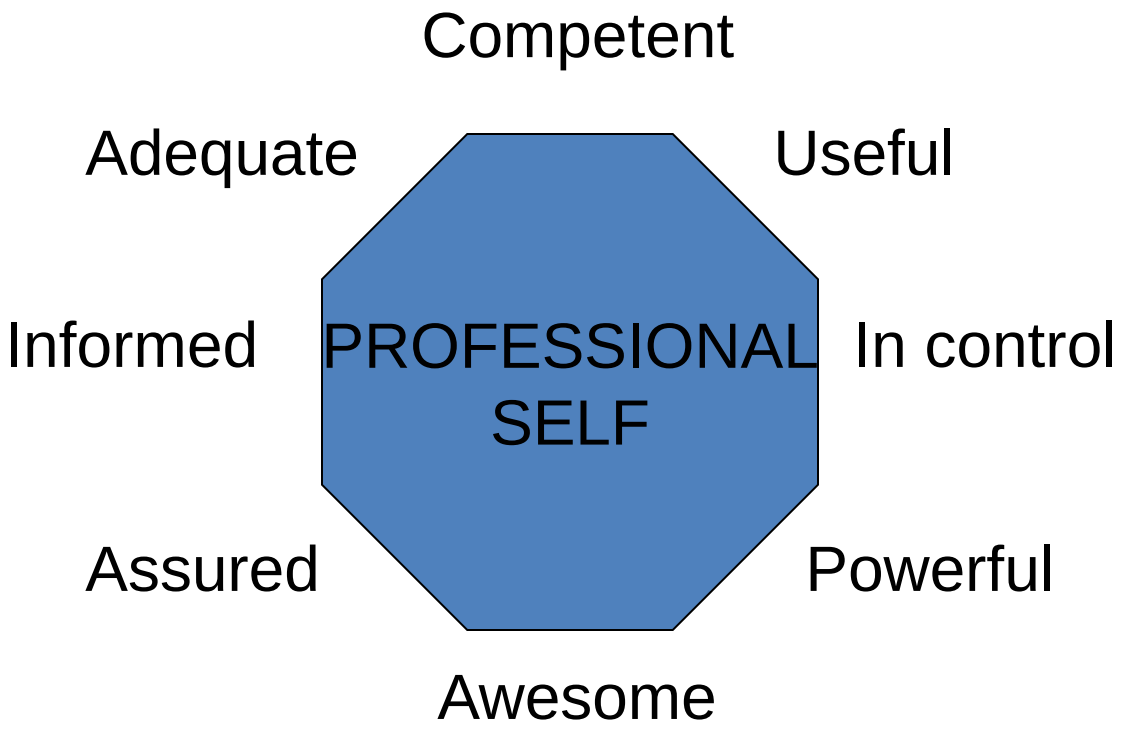
In any situation, it is natural to be inclined to preserve one's self



"We do not see things the way they are. We see things the way we are."

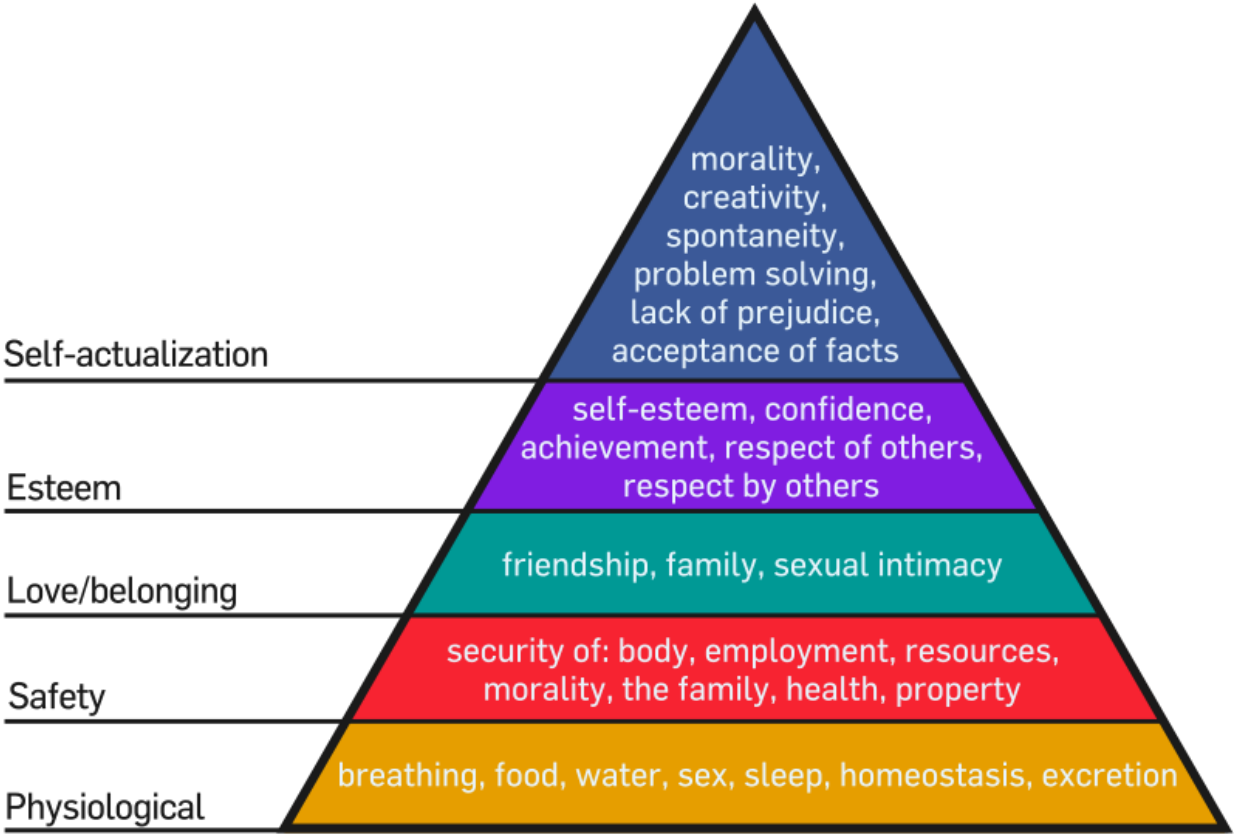
Anais Nin

The Professional Self

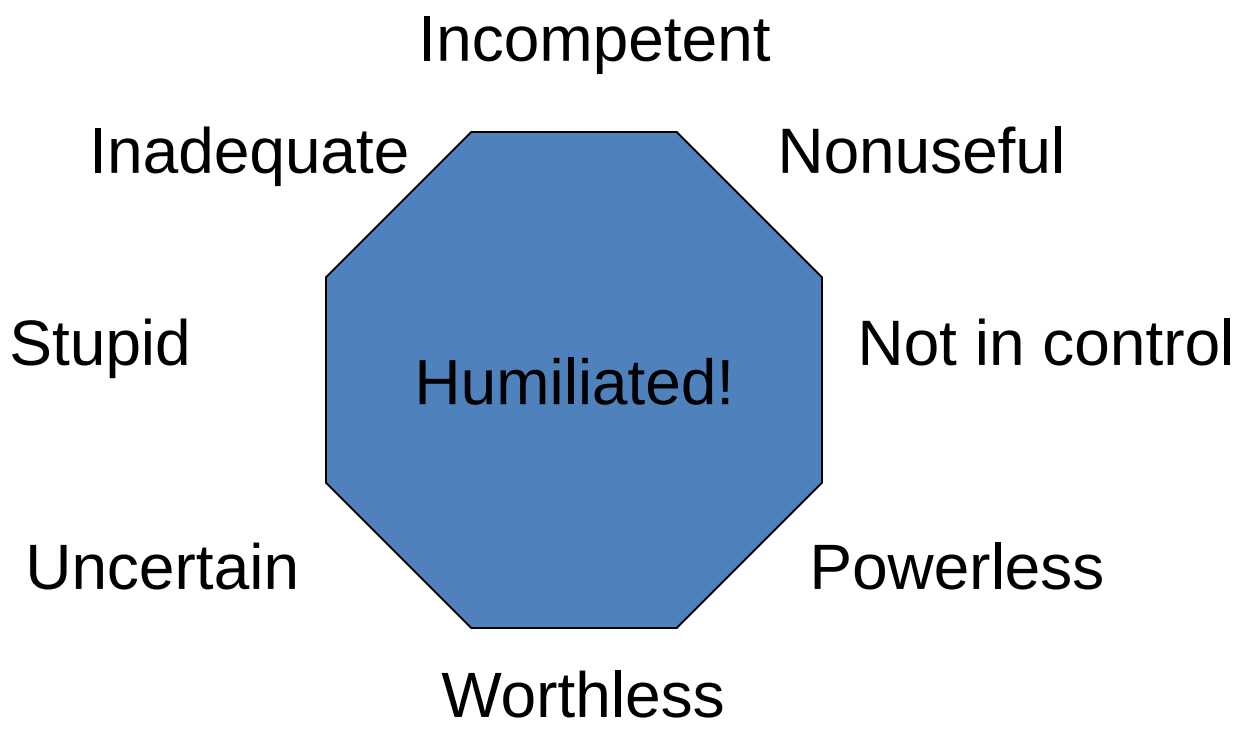


Maslow's Hierarchy of Needs

Abraham Maslow



The Professional Self Is Assaulted by the Difficult Conversation!



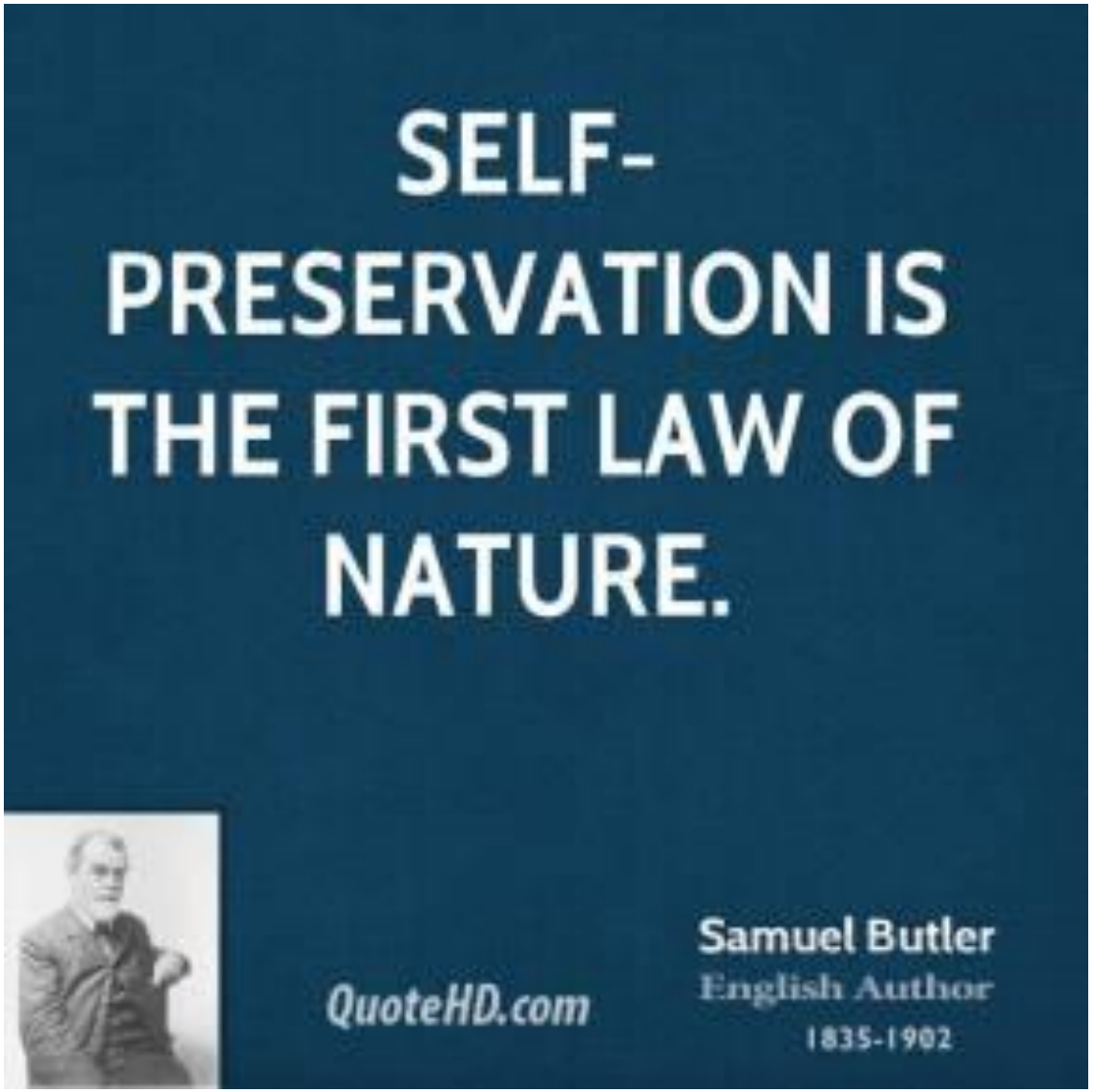
- The difficult conversation is largely about our feelings and the feelings of others—about respecting, acknowledging and controlling them.
- A key error that health professionals make in difficult conversations is thinking that the conversation <u>is all about information.</u>

The reason why is that …

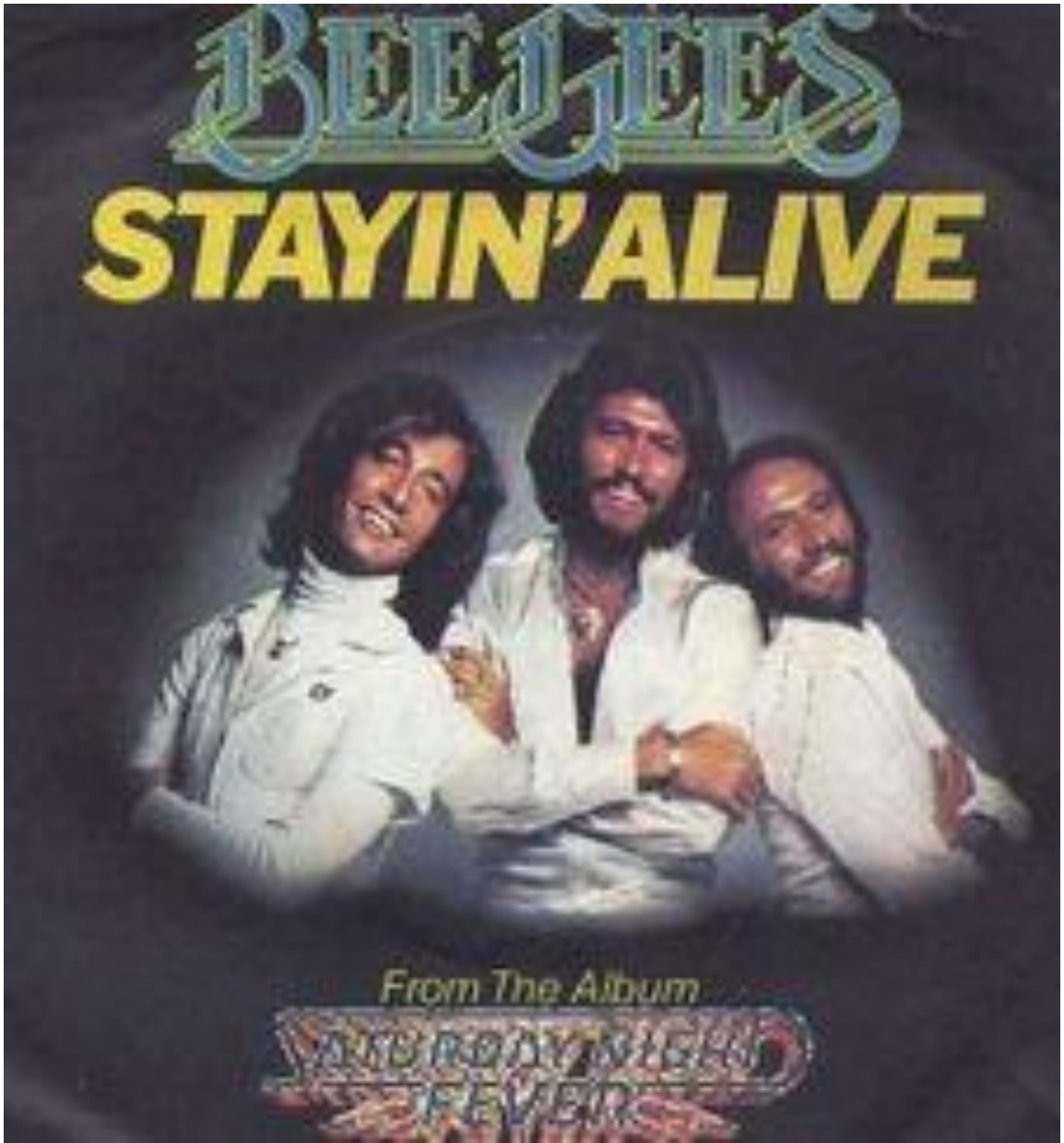
- HEALTHCARE PROFESSIONALS ARE MASTERS OF INFORMATION. THEIR PROFESSIONALISM AND SELF-ESTEEM CONSISTS IN THEIR DEMONSTRATING WHAT THEY KNOW.
- SO, IN DIFFICULT CONVERSATIONS, THEY NATURALLY RESORT TO THEIR STRONG SUIT--WHAT THEY KNOW--TO KEEP THEIR SENSE OF SELF ON TRACK.

What is going on?
Feelings, Interests, Values, Desires, Anxieties, Fears, Beliefs, Knowledge
SELF

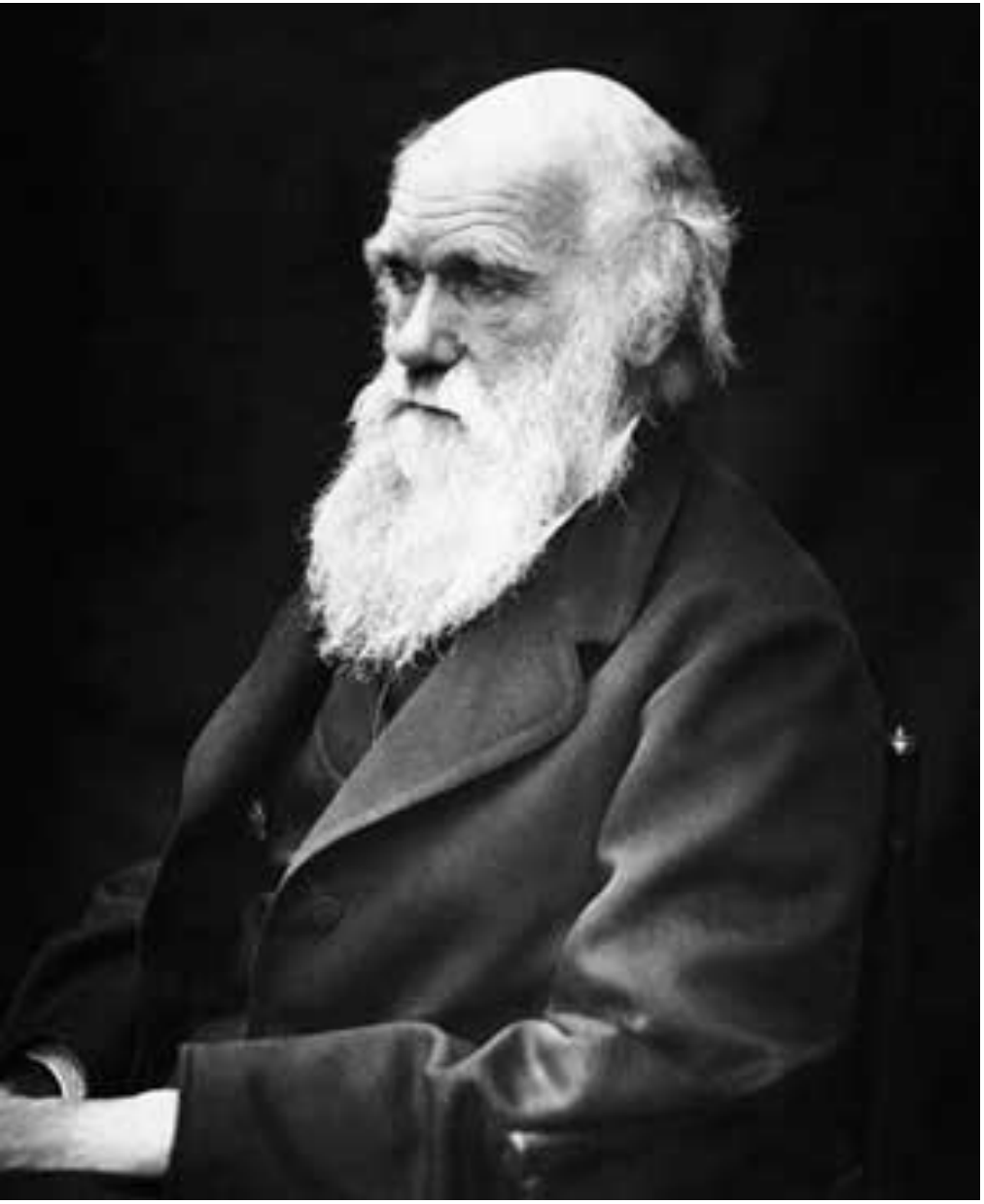
So, if self-preservation is the first law of nature, then the primary job of the self....



Self protection and <u>warding off threats</u>!

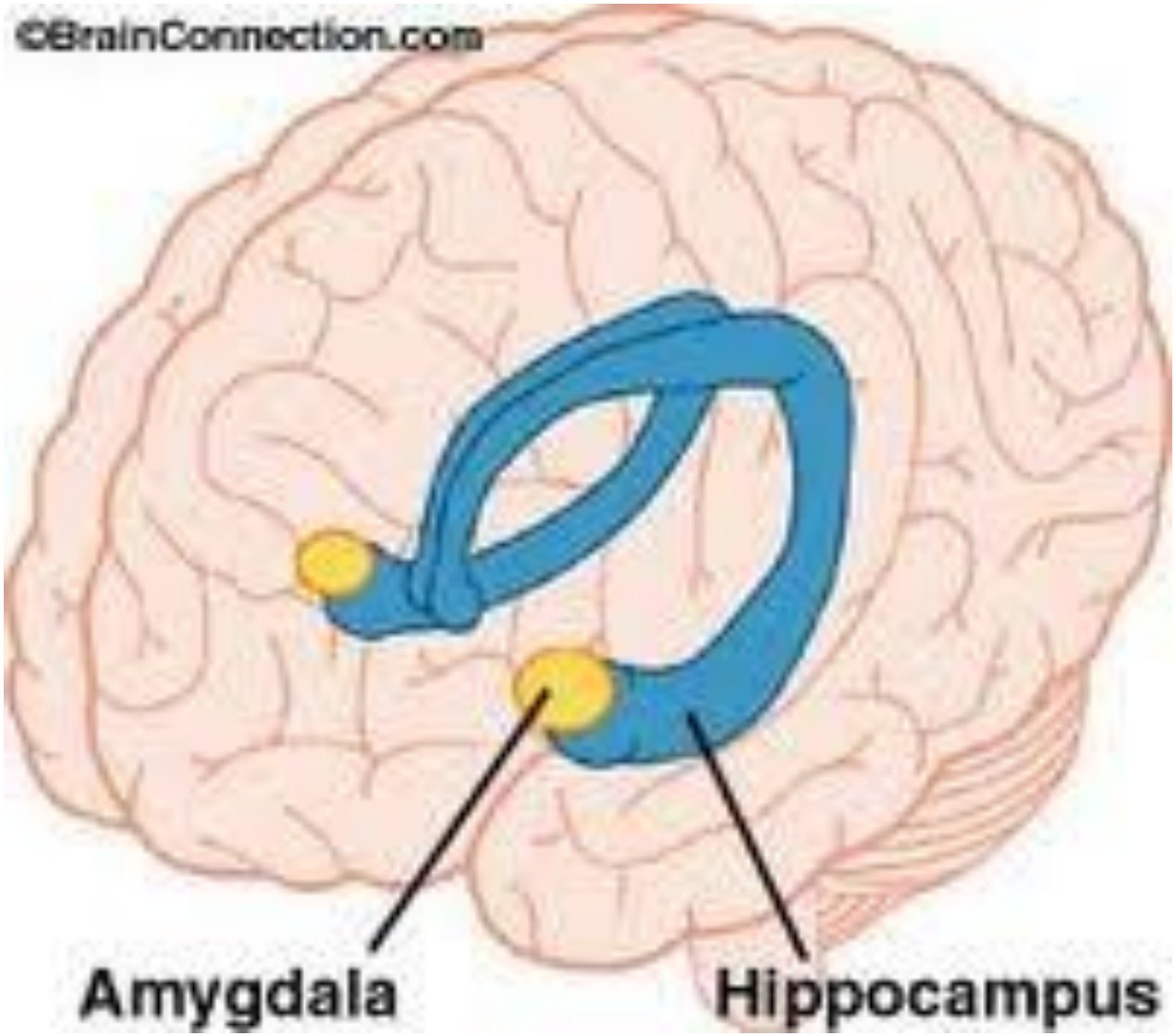


Physical or Psychological Threat? Doesn't matter…..



OUR FEELING CIRCUITS ARE ALWAYS TURNED ON AND THEY ARE ESPECIALLY ALERT AND INFORMATIVE IN INSTANCES OF THREAT.

The Extraordinary Amygdalae



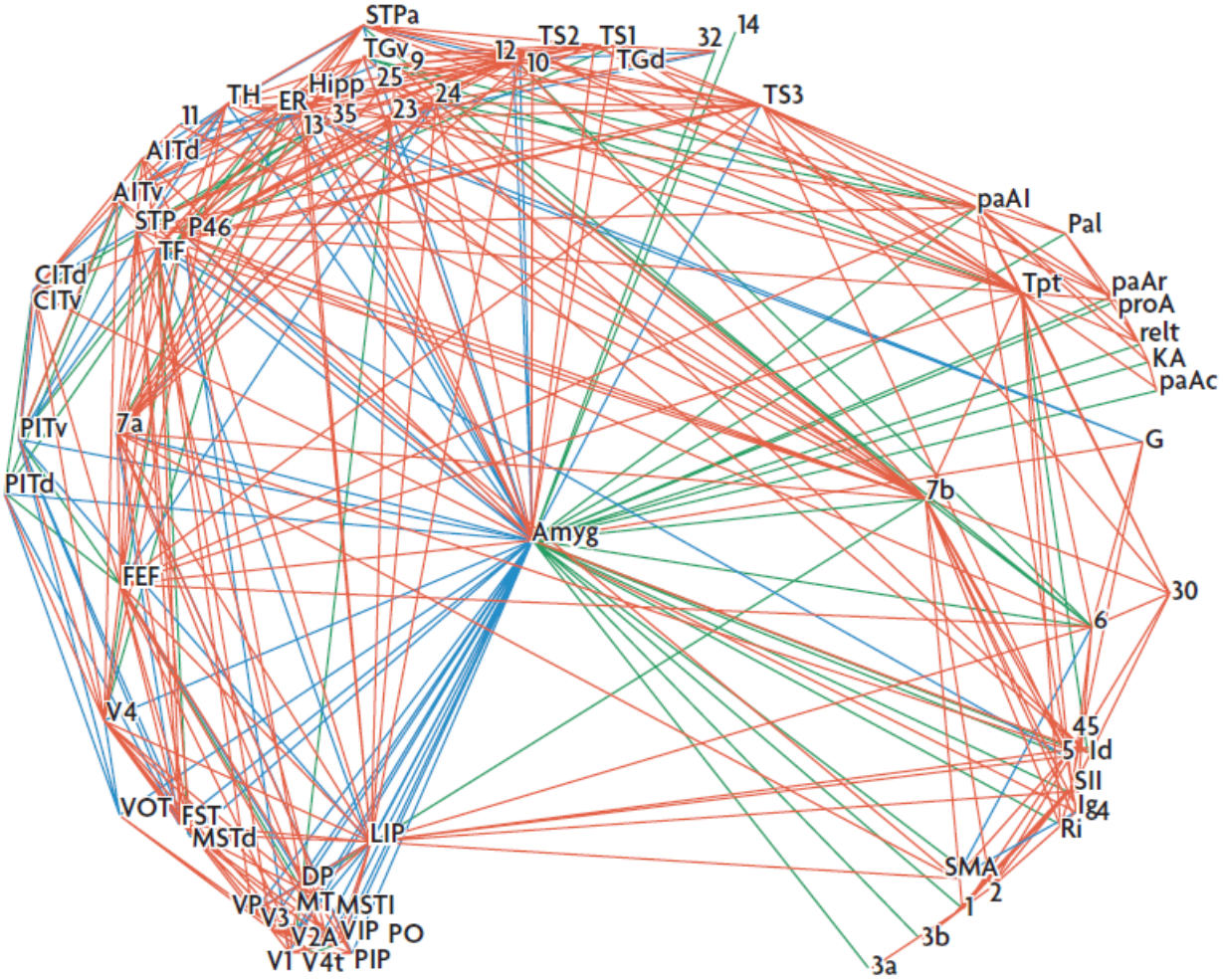


Figure 1 | **Brain connectivity graph.** Quantitative analysis of brain connectivity reveals several clusters of highly interconnected regions (represented by different colours). In this analysis by Young and collaborators[89], the amygdala (Amyg, centre of figure) was connected to all but 8 cortical areas. These connections involved multiple region clusters, suggesting that the amygdala is not only highly connected, but that its connectivity topology might be consistent with that of a connector hub that links multiple provincial hubs, each of which links regions within separate functional clusters. In this manner, the amygdala is hypothesized to be a strong candidate for integrating cognitive and emotional information. Figure labels represent different cortical areas with the exception of Hipp (hippocampus) and Amyg, which represent subcortical areas. Figure reproduced, with permission, from REF. 82 © (1994) Freund Publishing.

I've learned
that people will
forget
what you said,
people will
forget
what you did,
but people will
never forget
how you made them
feel.

[Maya Angelou]

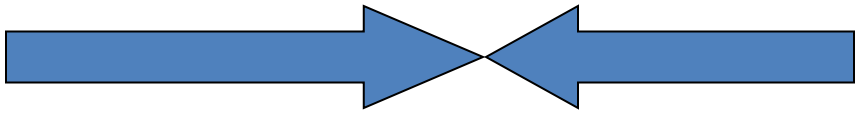
How is John doing?

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.

Our stories, narratives, explanations of what's going on are the compasses we use to make sense out of the world, to steer clear of danger, to keep us safe, to identify threats, and to manage them. If you lose your story, or interpretation, or your narrative of what's going on, you will feel…..

LOST

Difficult Conversations/Experiences

MY STORY  YOUR STORY

- THE FACTS/WHAT'S IMPORTANT
- THE FEELINGS
- THE CONCLUSION: "What this means…" "What you have to do…"
- REMEMBER: Your story is your navigational compass!

You want their story to STOP!

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

Is there another way?

Alternative: An Empathic Approach

The Empathic Approach

The empathist is ready to make entry, through his or her curiosity and imagination, into the way the other uses his or her feelings to bestow meaning on his or her world.

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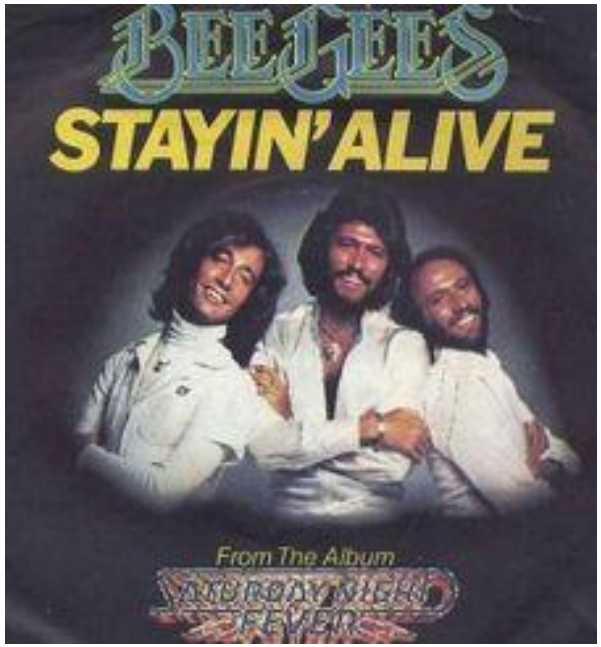
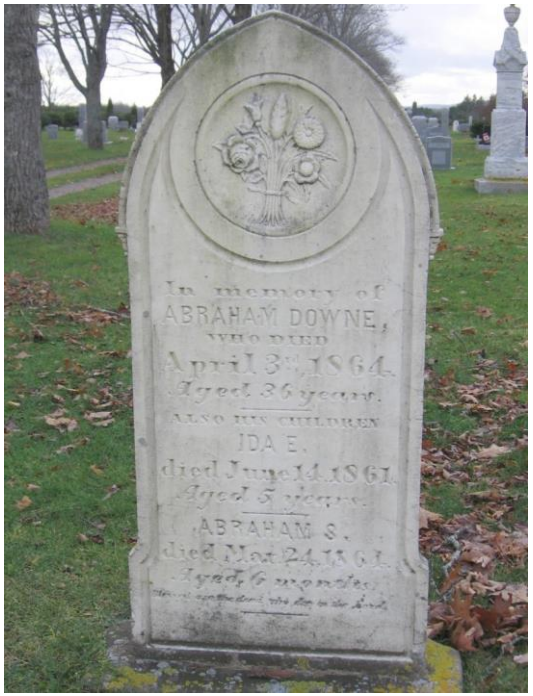
[Maya Angelou]

Which would you rather hear from your doctor?

"The one-month survival rate following this operation is 90%."



"There is a 10% mortality in the first month."



When emotions are expressed in the difficult conversation

- 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 you to hear."

Remember: Patients—AND EVERYBODY ELSE– want to feel …

- Understood
- Respected
- Cared about
- Vitalized
- Safe
- In control

Characteristics of the Empathic Personality

- Curiosity and humility
- Body Language
- Checking and verifying the other's feelings and meanings: attunement and resonance
- Unconditional regard(?)
- Creating a safe place for the client

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

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

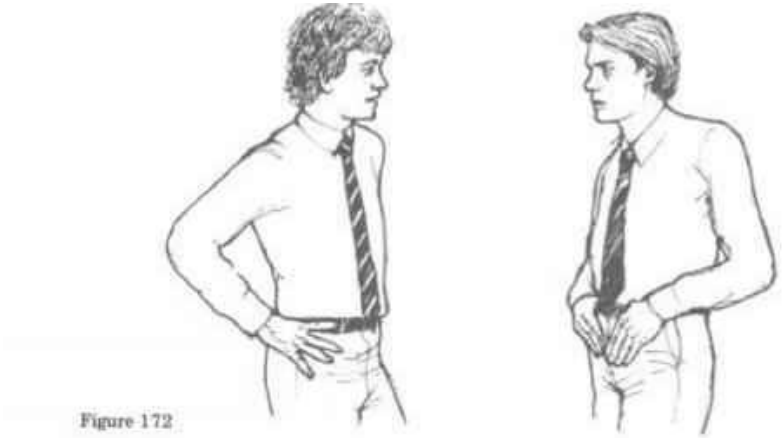


Figure 172

Figure 173

- Sitting posture, handshake (?) smile(?)
- Eye contact
- Touch shoulder, forearm, hand--never below the waist
- Talk slowly;
- If the patient looks away, stop talking and wait

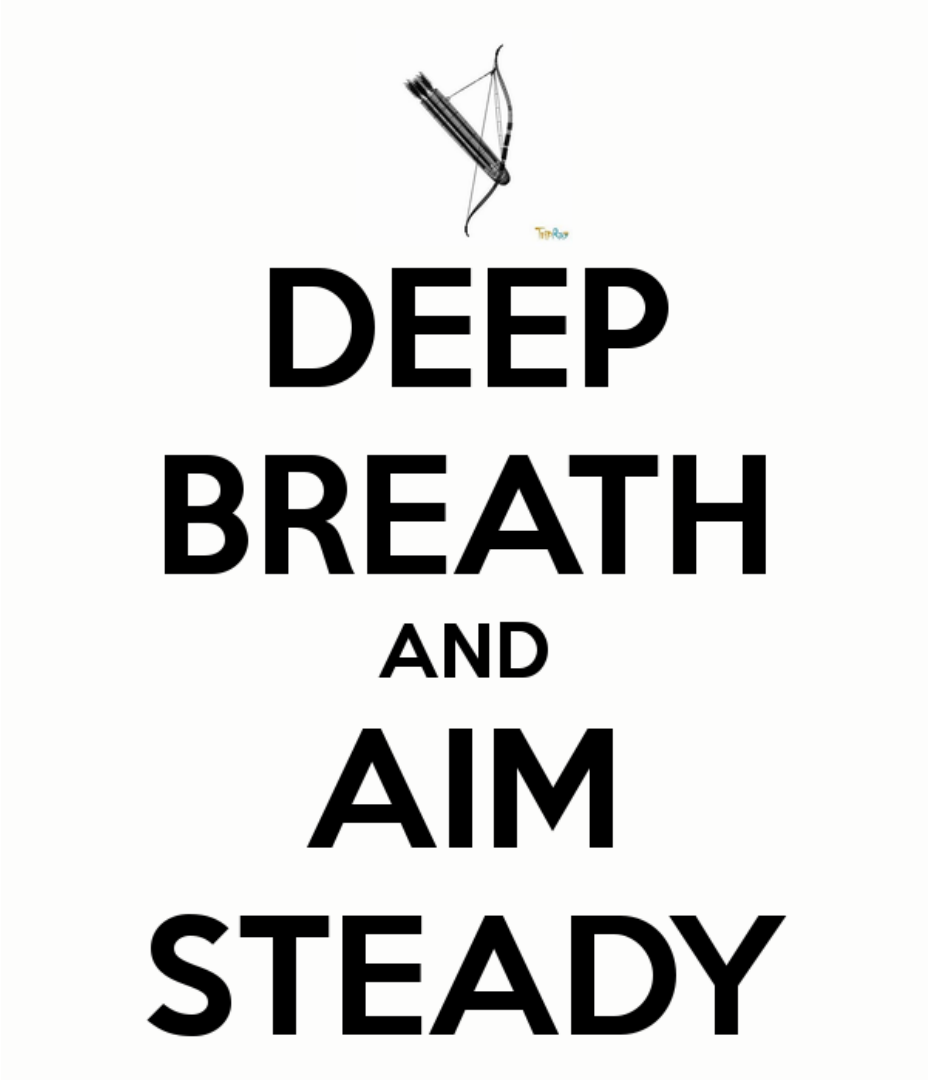
II. Extent of Patient's Knowledge

- "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"

III. How much does the patient want to know? How would you like me to communicate with you?

- “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 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

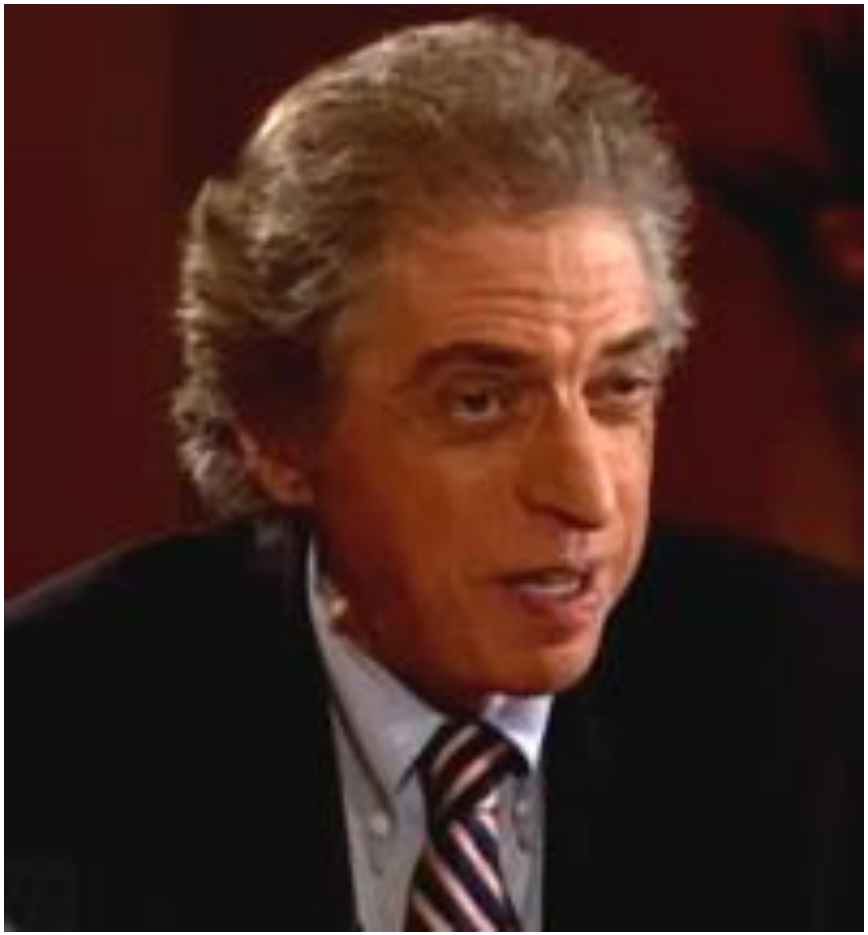
- “I wonder what you’re feeling right now.”
- “What is it about that that ... (worries, upsets) .... you?”
- “What is it about talking about that ... (you don’t like? Makes you anxious? Makes you want to talk about something else?”)
- “What would you like to have happen from this?”
- “Anything else?”

More…

- “We need to decide together where we go from here.”
- 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.

V. Responding to the patient's feelings and reactions

The Empathist's tools

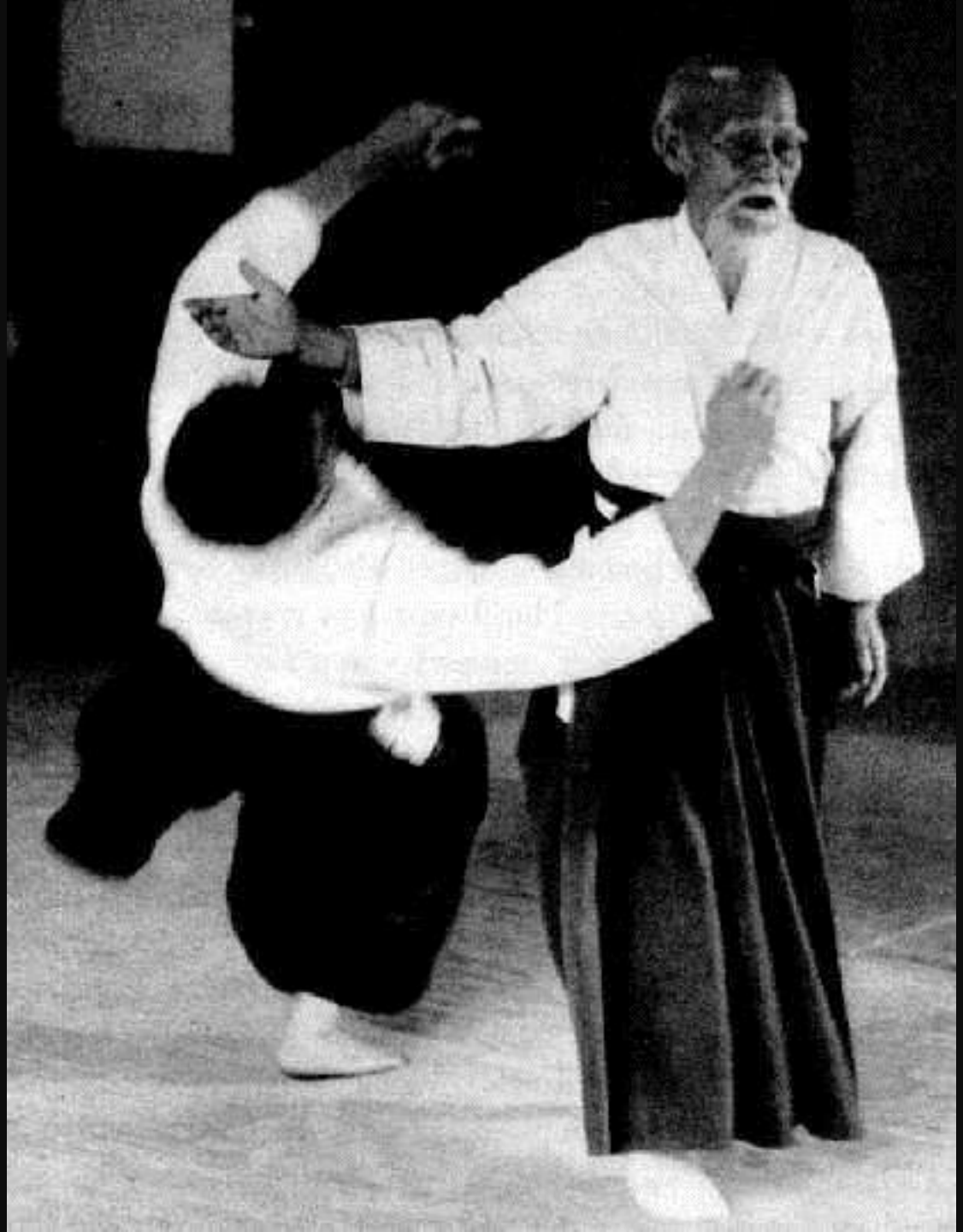


Robert Buckman, MD

- Probing
- Listening
- Re-stating and re-checking
- Normalizing
- Supporting, respecting and being nonjudgmental
- Self-esteeming

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



Thanks very much.