

Communicating with patients and families in times of stress: Can we do better?

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Physicians have not always thought that this is necessary to break bad news to patients. The Hippocratic writings tell us: "Conceal most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity... revealing nothing of the patient's future or present condition. For many patients... have taken a turn for the worse... by forecast of what is to come."

Times have changed, however, and today patients and families want and expect clinicians to communicate bad news - clearly and compassionately. Over the course of my career, I have been struck by how patients and families remember the moment of hearing bad news for the rest of their lives. Years after their stay in the hospital, they will have forgotten the details of their illness and how it was treated, but they will often remember - word for word - the way that doctors communicated bad news. Sometimes the memories are very positive, and sometimes they are not.

For all the time and effort we spend teaching and learning about the technical aspects of medical practice, it is striking how little time and effort we devote to improving communication skills around breaking bad news. Some physicians simply say they are not good at doing this, and pass these obligations off to someone else, as if this is an optional part of being a doctor. An emerging view, however, is that competence as a physician is a global ideal - encompassing technical skill, clinical knowledge, interpersonal skills, and strength of character. Just as we have very high standards for competence in technical skills and knowledge, so should we have the same high standards for our interpersonal skills.

Simulator technology has a proven track record of enhancing performance in demanding situations. My colleagues and I have explored whether this educational methodology can be adapted to teach clinicians how to communicate better. We have developed a one-day training program called the Program to Enhance Relational and Communication Skills, or PERCS. The day has a number of components, including some short didactic lectures, and well as viewing some videotapes where patients and family members are interviewed about their perspectives on what they value in the relational and communication skills of doctors and nurses. The heart of the program is a series of high-fidelity simulated end-of life discussions with trained actors. These are observed by the other course participants via a live video feed from the simulator room to a nearby conference room. Following the simulation, we review the scenario on video and all of the participants and actors participate in a structured feedback session.

The feedback sessions are perhaps the most valuable part of the day. We emphasize a spirit of collegiality and mutual respect, while recognizing that all of us are a "learning team" with valuable insights to share and to learn. The facilitators are skilled at providing feedback to the trainees in ways that can be heard and that will be useful to them. The most powerful insights often come, however, from the trainees themselves, through the process of insight and self-discovery.

I will share some of the evaluations that we have received from the training during the session, but here I will focus on several of the areas that our trainees have identified as the most valuable. First is the inherent tension between learning skills or techniques versus learning how to engage others in relationship. Skills and techniques are important, but they should not be confused with the ability to build relationship. By analogy, finger exercises are of course an important part of learning how to be a pianist, but no one would mistake playing scales for playing music. As David Browning, one of our founding collaborators, wrote, “Making time available, finding a quiet place to talk, maintaining eye contact, sitting instead of standing, learning to be empathic. All of these are important tools... But our tools will only do their job well if we understand the relational context in which we use them.”

Second is the importance of multidisciplinary approaches to working with families under these types of stressful circumstances. As a pediatric intensivist, I have always made an effort to include the patient’s nurse anytime I sit down with parents. Until my experiences with the PERCS training, however, I felt that the burden of communicating bad news and responding to the cognitive and emotional needs of the family fell entirely upon my shoulders. The work that I have done and observed in this program has shown me, however, that these conversations go immeasurably better when there is a true partnership between the clinicians involved. As I think of it, while I have always seen the value of inviting the nurse into the room, I now see the value of inviting the nurse into the conversation. As one of our trainees put it on an evaluation form, “I’m never going to talk to a family in a tough situation without a nurse again.”

Third, the PERCS program provides a wonderful opportunity to reflect, discuss, and learn about some of the particularly difficult situations that can arise when working with families under difficult situations. One that frequently emerges during our trainings is how to respond to the question, “Doctor, if this were your child, what would you do?” This is a question that has long intrigued me, especially since many pediatricians believe that one of the highest standards we can attain is to treat our patients as if they were our own children. While respecting the high degree of integrity and commitment that lies behind this view, I think that this question raises many different issues and must be considered on several different levels. A few years ago I wrote an article on this topic (see references), so I won’t elaborate here, but my point is that the PERCS training provides a unique opportunity to personally reflect on how to respond to that question, to discuss the issues with fellow clinicians, to practice one’s response in a very realistic but simulated environment, and to observe how others deal with the question. Few other learning modalities have this much potential.

How might this relate to the practice of pediatric anesthesia? For many families, the most frightening aspect of their child needing surgery is not the surgery itself, but the anesthesia. And while the risks of anesthesia are generally low, parents are correct that bad outcomes from anesthesia can be devastating. The anesthesiologist is in a tough position. Many patients are now same-day surgery, and even those who are admitted beforehand are in the hospital only briefly, so the anesthesiologist has almost no opportunity to establish a relationship with the child or the family. Furthermore, the time constraints of the current OR environment mean that any interaction between the anesthesiologist and the child or family must be very brief. How can the anesthesiologist make the best use of this time to establish rapport with the child and family, assess and respond to how much or how little they would like to know, and find the right words to both honestly communicate what needs to be said while still being compassionate and reassuring? This is a tall order, and not something that anyone is likely to learn from attending a lecture on how to do it

better. This is precisely the kind of situation that would be amenable to the learning techniques and methodologies that we have developed in the PERCS program. My colleagues and I hope to be able to expand our program in this direction in the near future.

These are some of the articles in the field that I have found most helpful:

1. Back AL, Arnold RM, Tulskey JA, Baile WF, Fryer-Edwards KA. Teaching communication skills to medical oncology fellows. *J Clin Oncol* 2003; 21(12):2433-2436.
2. Beckman HB, Frankel RM. Training practitioners to communicate effectively in cancer care: it is the relationship that counts. *Patient Education & Counseling* 2003; 50(1):85-89.
3. Buckman R. Breaking bad news: Why is it still so difficult? *Br Med J* 2002; 288:1597-1599.
4. Curtis JR. Communicating about end-of-life care with patients and families in the intensive care unit. *Crit Care Clin* 2004; 20(3):363-380.
5. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287(2):226-235.
6. Fallowfield L, Jenkins V. Communicating sad, bad, and difficult news in medicine. *Lancet* 2004; 363(9405):312-319.
7. Groopman J. Dying words: How should doctors deliver bad news? *New Yorker* 2002;62-70.
8. Harms C, Young JR, Amsler F, Zettler C, Scheidegger D, Kindler CH. Improving anaesthetists' communication skills. *Anaesthesia* 2004; 59(2):166-172.
9. Truog RD. "Doctor, if this were your child, what would you do?". *Pediatrics* 1999; 103(1):153-154.
10. Zoppi K, Epstein RM. Is communication a skill? Communication behaviors and being in relation. *Fam Med* 2002; 34(5):319-324.