

Certificate in Integrative Palliative Care – 3
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Week-01

Lecture 08: Communication Skills in Palliative Care PART: II

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Hello, friends. Namaste. In the last lecture about communication, we saw what the characteristics of good communication are, including communication in PC. And again, we saw the importance of empathy in communication. That was basically about the communication, how it should be spoken to. How it should be heard, too.

Now, we are just in this particular lecture, part two of the communication skills; we will see the methods of communication. Basically, there are two; we will just see.

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These things we saw in communication in the medical field are very, very important because of all these seven points I have written. Communication is very important when you break the bad news.

Your aim shouldn't be to shock the patient. How do you break the bad news? It's a process in itself. You have to break the denial. You have to break the collusion. You have to answer difficult questions.

Patients are going to answer; patients are going to ask very, very difficult questions when they know that they have to face death. There are lots of ethical and spiritual issues that need clarification regarding the patient's emotional reactions and bereavement. So all these issues where communication plays an important role.

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I just said that in this part of the lecture, we are going to learn about methodology. How communication can be done easily.

So, in part three, actually it is part one of this lecture, but I am going in order that in part one of communication, this is part two of communication. So, this is Part Three. We are going to discuss a six-point toolkit. This particular tool, if we use our communication can be improved.

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And in the last part, we will talk about the CLASS protocol, which consists of the six points that need to be addressed with real and very precise attention.

If you attend to all these six points, your communication with the patient will be of superb standard. First are comfort, language, question style, active listening, reflecting, and summarizing. Let's see it in detail.

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Be Prepared...

- To stop the interview at any stage
- For repetition of questions
- For silence
- For denial
- For emotional reactions



In communicating with the patient, you should be prepared to stop the interview at any stage. When you are talking to the patient, a stage may come when you might have to end it abruptly.

Repetitions of questions will be there for silence, denial, and emotional reactions. The patient or family members are going to show all these things.

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1. COMFORT

- Preparation
- Physical environment
- Sitting – perception of time spent
- Height of Chairs, eye contact



Therefore, from the very beginning, a doctor needs to be prepared for such situations: comfort, first point preparation, physical environment, sitting—perception of time spent, height of chairs, eye contact—all these things. That is total arrangement. It must have privacy.

It should be in a room. Communication with the patient cannot take place in the corridor. The physical environment should be present. A doctor is sitting while the patient is standing and asking questions.

No. Nothing is doing. This cannot happen. A patient must also sit. If family members are there, they should be given proper stools or chairs; that whole environment should be comfortable. The patient should be looking into the eyes of the doctor, and the doctor should be answering them.

Therefore, the height of the chairs should be arranged in such a way that there is proper eye contact.

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Getting started...

- Make time for unhurried conversation w/o interruption
- Privacy is important
- Introduce self by name and shake hands
- Sit down to indicate you have time to listen
- Make eye contact
- Avoid medical jargon

When you start the conversation with the patient, make sure that the conversation carries on without any interruption; particularly, mobile phones and other things, if possible, should be kept in silent mode. Privacy is very important because most patients feel shy; if I have to talk about my weaknesses, I will feel shy. Therefore, it is important that the patient is given proper privacy. The interview should be conducted in the room itself, and the doctor must introduce himself or herself, shake hands, sit down, make eye contact, and avoid medical jargon.

So this is the initial part of the complete interview. When I say interview, understand that interview means the dialogue between patient and doctor. That is what I call an interview.

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2. LANGUAGE

- Impact- engaging and gently transferring the information
- Avoid
 - Complex words
 - Jollying along
 - Jargon



Second, language. Engagingly and gently transferring the information.

Do not rush the patient. Come on, come on, tell me quickly. I have only two minutes to listen to you. This is not the way a doctor would ask a patient to speak. A patient will take his or her own time.

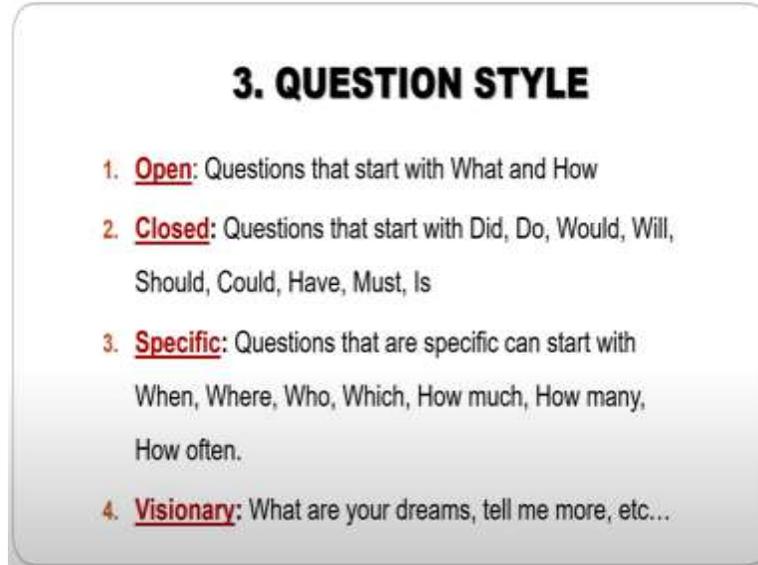
He is a sick person. He is mentally disturbed. He is feeling shy. Therefore, give him enough time to speak. Give enough time.

Avoid complex words. We said in the last lecture that the language was simple. Do not use any medical jargon. Jolly along, yeah, yeah, this will happen, you know. Do not. Let him speak clearly, and the doctor should also speak clearly.

There is no requirement to go along with one another's feelings. Jargon, particularly medical jargon, should not be used. Nobody understands it. Only doctors understand that language. A patient coming from the villages; otherwise, not everybody is a doctor.

So when you talk to a patient, you speak that language; you explain the name of the disease, the symptoms, and everything in simple words that any patient can understand.

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Question style: Questions should be open. An open question means what, how, and that they are answerable questions. Questions that start with did, do, would, will, should, could, have, and must are all closed questions. A closed question means that the answer is either yes or no.

Did you eat your breakfast? The answer will be what? Yes or no. A specific question means one that intends to receive specific information about a particular issue. If the doctor is asking, "Did you have a fever last night?" A specific question. Did you have a fever last night? Yes or no? If yes is there, then the dialogue will continue. Visionary means talking about the future and other things; you know what your dreams are, so tell me more.

Particularly, visionary questions will be asked of the people who are in the last stage of life: what will happen, what will you do, and what should your children do after you die? You know all those things about the future.

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QUESTION STYLE

- **Open Question** (How do you feel now?)
- **Closed Question** (How is pain in your hand?)
- **Focused Question** (For a specific information)
 - If too many – proper interrogation
- **Leading Question:** Never ask.
- **Direct Question:** Eliciting a special symptom
- **Multiple Questions:** First Interview with patient

I have given very simple statements and simple sentences to understand, such as the open question example: how do you feel now? When I ask you how you feel now, a doctor asks the question to the patient, and the patient can answer in any way. He is open and will actually narrate how he feels. He will say, "Okay, I am feeling very well, doctor." I have been taking medicine for two or three days.

I am feeling a little bright. You know, he will give a detailed description of how he feels. Therefore, it is called a open question. To elicit information from anyone, you should always ask open questions. Only then will the person be able to give you the answers.

This is what I have done. If you ask a person another open question, it should be a general one. What did you do last night? Now that person is open. He will ask, "Yes, last night I did a lot of things." 3 o'clock, 4 o'clock, and 5 o'clock.

Everything will say. But if I ask you, "Did you have dinner last night?" The answer will be either "yes" or "no." So, open questions provide many opportunities for giving and receiving information. Particularly in the relationship between the doctor and the patient, the doctor wants to receive more and more information from the patient. Similarly, the patient wants to receive information about his state of health. Closed question: How is the pain in your hand? You will have only two words.

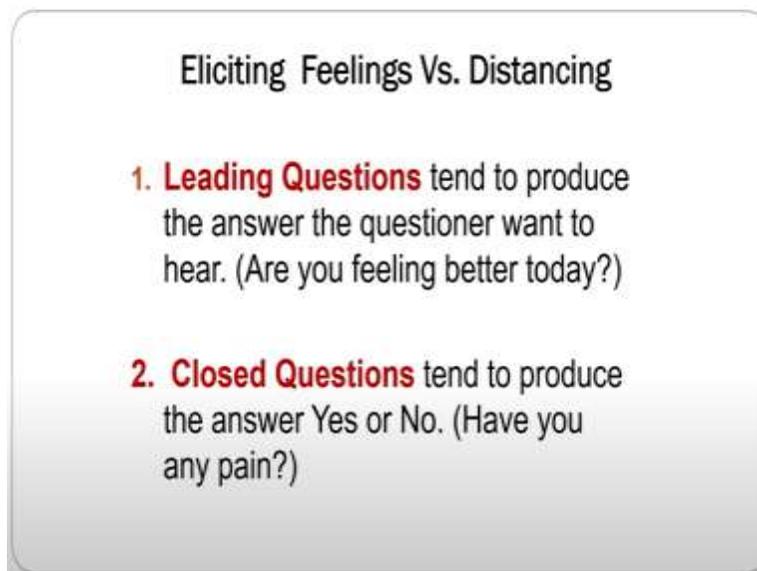
Is it okay? That's a bad pain. One should not ask a closed question. Focus on a specific question for information. Like I said, did you have a fever last night? Did you take the proper medication last night? Leading questions never ask. Direct questions eliciting a specific symptom can be asked because you want particular information about that symptom. Multiple questions will be asked in the first interview because you want to

collect all the information available about the patient's family and the state of the disease.

You want to write down the complete case history. You want to find out what the diagnosis is. And, therefore, many questions will be asked. So, this is all about the question's style. This is what we have generally been using in your social life.

When a college friend asks another college friend, they will generally be asking open questions. What happened? What did you do last night? How was the movie last night? This is all because they want to collect a lot of information. They want to stay in touch with one another.

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Eliciting Feelings Vs. Distancing

- 1. Leading Questions** tend to produce the answer the questioner want to hear. (Are you feeling better today?)
- 2. Closed Questions** tend to produce the answer Yes or No. (Have you any pain?)

Eliciting feelings and distancing oneself. Eliciting means asking for information, distancing means I don't want your information.

Leading questions tend to produce what the questionnaire wants to hear: "Are you feeling better today?" Leading questions might prompt some patients to say, "Yes, I'm feeling better." Closed questions, such as "Do you have any pain, yes or no?" are also used.

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Common ways of distancing oneself are. Distancing means getting away; you don't like him. It's a sort of behavior characterized by apathy, you know.

Non-verbal messages, labeling, paying selective attention to safe physical aspects, and never asking beyond the physical are important. Never asking beyond the physical, that is called be of this. Why? Doctors are supposed to be a little social and also psychological. We are talking about palliative care; we are talking about holistic care.

Physical, mental, social, and spiritual. So it is not only about the pain and the disease; the doctor needs to ask questions. Doctors need to ask about the family. What is going to happen in detail? Premature normalization and false reassurance. Doctors are not supposed to give false reassurance.

Yes, things will be okay. No, a doctor is not a god. But he has to be hopeful. If he completes this particular course of medication, yes, it's possible. We'll see better results.

You should not use inappropriate humor. And by disappearing from stressful situations, sometimes you can avoid discussions not conducted by the doctor.

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CASE HISTORY

- **History is His/Her story !**
- We need to know his issues in order to help him
- **LISTEN to the story**
- **Active listening** is the key to effective communication

An illustration showing a doctor in a white coat and glasses listening to a patient. The patient is sitting and talking, while the doctor is leaning forward, looking at the patient. The scene is set in a clinical environment.

I said that case history is a very important step in the medical process, and it is the first step. History means it is his story or her story; therefore, in writing case history, communication will play an important part. We need to know his issues in order to help him.

Listen to the story therefore. Active listening is the key to effective communication.

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4. ACTIVE LISTENING

- Open questions, encourage talking
- Accept silence
 - Allow assimilation of news
 - Patient feels listened to
 - Time to react, ask questions, talk
- Avoid unnecessary interruption
- Respond through verbal and non-verbal means
- Summarize & prioritize the agenda
- Empathize & give realistic hope

How do you carry out active listening? Open questions are important because with open questions you receive a lot of information, including silence. Silence is also part of

communication; when a doctor asks two or three questions and the patient or family members do not speak, their silence means yes—they are trying to assimilate the questions, they want to give proper answers, and they need some time to react, so accept silence in such interviews. Avoid unnecessary interruptions; respond through verbal and non-verbal means.

Make use of verbal as well as non-verbal means. Do not close your eyes; discuss, summarize, prioritize the agenda, and empathize. A summary is to be given to the patient once the whole communication between the patient and doctor is over. This is what has happened: you are suffering from this and this, the probable diagnosis is this, and this is the plan of treatment: this is what we are going to do—one, two, three, and four. So, the whole summary should be given to the patient, and then hope should be provided. In such cases, you know, I have treated many cases and have been successful, the doctor will say.

So, we will go accordingly, and things will be okay, you know.

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Listen, listen, and listen.

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Active Listening!

- Active listening is a skill that can be acquired and developed with practice. However, active listening can be difficult to master and will, therefore, take time and patience to develop.
- '*Active listening*' means, as its name suggests, actively listening. That is **fully concentrating on what is being said rather than just passively 'hearing' the message of the speaker.**
- Active listening not only means focusing fully on the speaker but also actively showing verbal and non-verbal signs of listening. Generally speakers want listeners to demonstrate '*active listening*' by responding appropriately to what they are saying. Appropriate responses to listening can be both verbal and non-verbal.

In active listening, you concentrate fully on what is being said rather than just passively hearing the speaker's message. Yes, you do hear the message; those words are part of it. But what is being said, what is the psychology behind it, and what are the feelings behind it should also be understood.

And that can be understood, provided that you listen actively.

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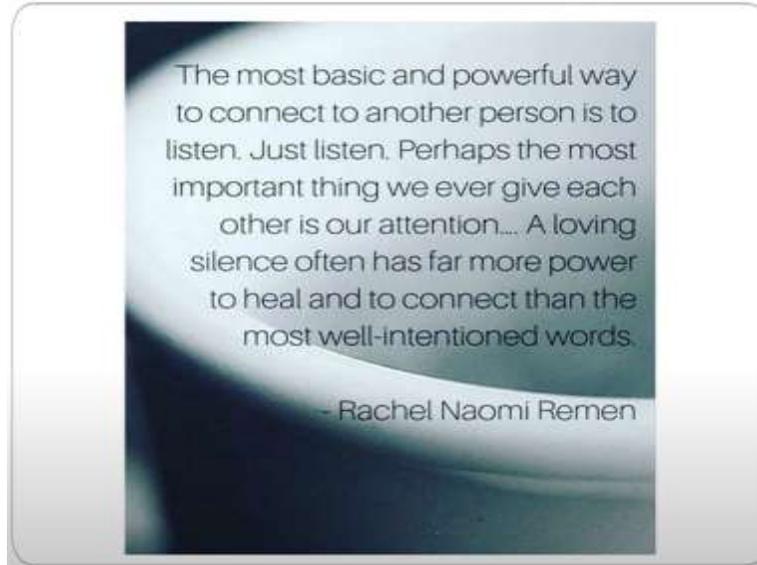
Signs of Active Listening Non-Verbal Signs

This is a generic list of non-verbal signs of listening, in other words people who are listening are more likely to display at least some of these signs. However these signs may not be appropriate in all situations and across all cultures.

- Smile
- Eye Contact:
- Posture
- Mirroring
- Distraction

Active listening signs include smiling, making eye contact, maintaining good posture, mirroring, and minimizing distractions.

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The most basic and powerful way to connect with another person is to listen.

Listen and listen. Just listen. Perhaps the most important thing we ever give to each other is our attention. When you listen to someone, you give your attention to them. A loving silence often has far more power to heal and to connect than the most well-intentioned words; even if you just listen, maintain silence, and be there in the room with the patient. Maybe you take the patient's hand in your own; that is all a patient requires.

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5. Reflecting on Answers

- For example, 'What have you been told about your illness so far?' or 'What is your understanding of the reasons we did the scan?'
- The responses to such questions will indicate the patient's understanding of his or her illness to date, will allow for the **correction of misinformation** and can also help to determine whether or not the patient has, for example, unrealistic expectations, illness denial or gaps in information about his or her illness.

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6. Summarizing

- Present treatment or palliative care options, being sure to align your information with what you ascertained (during the assessment of the patient's perceptions) to be the patient's knowledge, expectations, and hopes.
- Providing a clear strategy will lessen the patient's anxiety and uncertainty.

Reflecting on the answer, think, "Yes, you said this, I understood, but what should we do now?" Correction of misinformation should be provided, and I said that it is very, very important so that both parties, the doctor and the patient, know where they stand and what is to be done next.

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Communication problems

palliative care

- **Bad News:** Any information that drastically alters a person's view of their future for the worse.
- **Denial:** The psychological shock-breaker that allows us to suppress mentally what we can not accept emotionally.
- **Collusion:** Collusion implies information (diagnosis, prognosis and medical details about patient) being withheld by some and not shared with significant stakeholders.
- **Anger Management:** Appropriate short-term reaction to diagnosis of serious illness. Encourage expression of Anger.
- **Difficult Question by Patient:** Show interest, empathize and explore reasons behind it.

Communication problems, bad news, denial, and collusion are what we are going to face.

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Now, there is a class protocol in the last part of the communication process.

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Communication Protocol

- A communication protocol is a system of rules that allows two or more entities of a communications system to transmit information via any variation of a physical quantity. The protocol defines the rules, syntax, semantics, and synchronization of communication and possible error recovery methods. Protocols may be implemented by hardware, software, or a combination of both.
- Communicating systems use well-defined formats for exchanging various messages. Each message has an exact meaning intended to elicit a response from a range of possible responses pre-determined for that particular situation. The specified behaviour is typically independent of how it is to be implemented.

First, let's understand what a protocol is. What is a communication protocol? A communication protocol is a system of rules that allows two or more entities in a communication system to transmit information via any variation of a physical quantity. When two entities, in this case a doctor and a patient, are transmitting information.

Sometimes doctors speak; sometimes patients speak. How should they talk so that the

necessary physical information can be conveyed and not left out? There is a well-formatted protocol; this is how, if you follow it, that communication will be complete.

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The CLASS Protocol

- As stated earlier, communication in palliative care is important from the moment that the patient first meets a palliative care professional until the last moment of life.
- Most significant conversations in palliative care comprise two major elements: one in which medical information is transmitted to the patient (bearing the news), and the other in which the dialogue centers on the patient's feelings and emotions and in which the dialogue itself is a therapeutic action (therapeutic or supportive dialogue).
- In practice, most conversations are a mixture of the two, although commonly there is more medical information transmitted in the earlier conversations shortly after starting palliative care, and there is usually a greater need for therapeutic dialogue in the later stages.

Here we have a CLASS protocol: the patient first meets a palliative care professional until the last moment of life. When such communication takes place for the first time, it has two types of meanings. Any communication between a doctor and a patient has two meanings.

First, communication bears the news that this is what happened. It is basically about the person, the patient, and a little bit about the disease. And the second part of that communication is a supportive dialogue. Therapeutic, yes, this is what has happened to you in the last six or seven days.

Dysentery, diarrhea, this, or that. And this is what you have done. Fine. Second stage: now what should we do? It should be supportive and therapeutic. What is the treatment plan? So, such communication has two meanings. Bearing the news and engaging in therapeutic or supportive dialogue is important.

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The CLASS Protocol

- C: Physical **CONTEXT** or setting
- L: **LISTENING** skills
- A: **ACKNOWLEDGE** emotions
and explore them
- S: Management **STRATEGY**
- S: **SUMMARY** and closure



CLASS is an acronym. C stands for context. "Context," I said. The setting. What is the setting? How and where is the interview taking place? Which room? L means active listening. A means to acknowledge and explore the emotions of the patient. Management means what the strategy is, what the treatment plan is, how that particular disease needs to be treated, and lastly, S means summary. This is the CLASS protocol when you carry out the first interview with the patient; then this is the methodology you will follow.

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Take Home Message

- Genuineness
- Best learned through experience
- Identify your skills and try to refine them
- Identify your shortcomings and try to overcome them
- There are no rigid guidelines
- Should be person centered and context oriented
- Do not try to imitate someone else!

The take-home message is genuineness, best learned through experience: identify your skills and try to refine them, identify your shortcomings, and try to overcome them. In communication, there are no rigid guidelines. It basically depends on the doctor, the patient, and the circumstances; it should be person-centered and context-oriented. Do not try to imitate someone else.

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Apply two parallel principles...



- 1. Never lie to a patient**
- 2. Avoid thoughtless candour**

There are only two parallel principles. Never lie to patients. If there is bad news to be given to the patient, deliver it properly. Do not cause shock or numbness. There is a proper procedure for breaking the bad news.

And, second, avoid thoughtless candor. Be very gentle. Do not be foolish with him. Do not rush the matters. So whenever you talk to the patient, always talk with empathy as if you are feeling the same pain that he is experiencing.

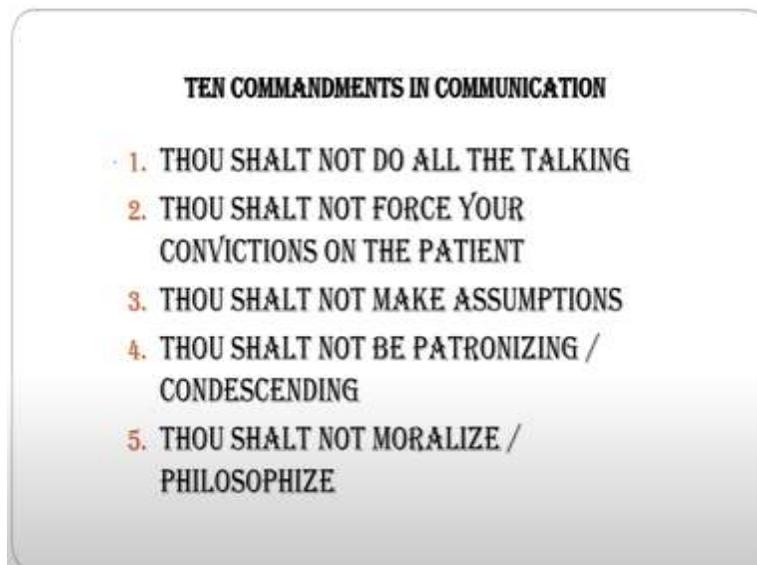
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Ten Commandments. A good communicator is not someone who is perfect and therefore never commits mistakes.

There is nothing like perfection anywhere. Nobody is perfect. There are no perfect communicators. So, he is someone who tries to get it right as often as he can. But who is a good communicator? He finds out where and how he committed the mistake and how he is going to improve on it.

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In a normal interview, both the patient and the doctor will speak, not only the doctor. Thou shalt not force your convictions on the patient, whatever you may know about that particular disease; do not force your views on the patient.

The patient also has the right to say something about it. Do not make assumptions that this could have happened. No. Medicine is a science. There is no place for assumptions. If you think that something has happened, then there are lots of medical tests—this or that.

Thou shalt not be patronizing. You should not patronize others. Patronize means no, no, no, I am there with you; I look after you; no, nobody looks after anyone. Just be very, very frank with him, be gentle. Yes, this is the situation, and we'll do it like this: thou shalt not moralize; do not give moral lectures. Don't worry, you are not the only one suffering from this; there are so many people who have suffered, so many people who have had heart attacks, no.

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Never draw comparisons, particularly about the disease and other things; everything is different.

Every patient is an individual, and the disease he is experiencing is also totally different from any other disease. No sympathy. I'm sorry; you know, I'm really very sorry. This is what has happened.

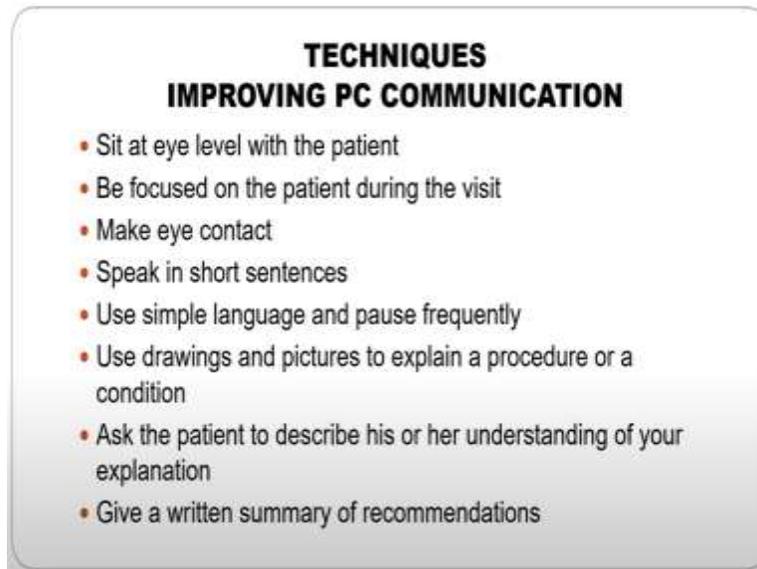
As a doctor, you know you have seen so many patients for so many years. So, you have to be sympathetic, but there is no requirement to show it too much. No use of medical

language. Whatever is required, provide it in simple language that the patient and family members can understand.

Award lies. Don't tell lies. Be frank with him. Be honest. And lastly, do not make use of inappropriate humor. Humor is very good. He should be jovial. But wherever there is a serious situation, particularly sickness, it is serious.

Sickness is a serious situation for the patient and their family members. So there is no place for inappropriate humor.

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Techniques for improving palliative communication. Sit at eye level. If I am the doctor, then the patient should also be sitting at the same eye level so that I can look into his eyes and he can look into mine.

Focus on the patient. When the patient comes, he is the only person to whom you are supposed to talk. He is the only person. Total concentration on the patient.

Make eye contact. Speak in short sentences; do not speak in long sentences. Use simple language, and use drawings and pictures. You have many models and other things to explain. For example, if you go to a dentist, the dentist will just take out the models of dentures. This has happened to your upper and lower teeth, you know. So, if possible, the doctor should keep some models and charts and must explain them to the patient.

Ask the patient to describe their understanding of your explanation. And let the patient describe so that, as a doctor, you will come to know how much understanding he has and,

whenever you decide on the treatment plan, how much understanding he will require. Give a written summary of the recommendations.

That is, of course, part of medicine. You must provide the written summary. This is what happened. This is the case history. This is the probable diagnosis if more tests are required, and all those things must come out correctly. Gentlemen, dear friends, here we have come to the end of the first week. The first week is very important because we are trying to introduce this new subject to you, which is about integrative palliative care.

Very important subject. As we said earlier, it is for everyone. It is for a layperson as well. It's not that any nurse or doctor can do it and understand it. We have made this particular course in such a way that anybody who is interested and can understand English can take this course and understand it properly, digest what we are going to speak about, and what we are going to say. And I'm certain that it will be useful to them, to the family members, and in their lives.

In this particular week, we had several lectures. We started with what palliative care was. Dr. Geeta Joshi explained all of those things. And thereafter, we came to the main subject: integrative palliative care. What is integrative palliative care? And then we explained everything about CAM: complementary and alternative medicine. After that, the two most important aspects of palliative care were present. First was community participation because without community participation, we cannot practice palliative care at all.

We need the support of the patients and their families. In palliative care, the patient is at the center, not the disease. And when the patient is at the center, we need the family and the whole community to be part of palliative care. So we spoke about community participation, and then we came to communication.

If there is no communication, we can't do anything about it. In any other medical field, it's fine. Doctors may not do it. But in palliative care, particularly when you are dealing with communities, your communication skills should be impeccable. So, we take sufficient time to tell you what the characteristics of communication are, along with the methodology by which we provide you with a six-point toolkit, and finally, we discuss the CLASS protocol. Thanks.