Pocket Cards for Compassion-Based Patient Conversations

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The Art of Difficult Conversations

Courtesy of Laura Heesacker, LCSW

1. **Beliefs and Confidence-**Find the confidence in yourself to walk this path with your patient. Hold the belief that your patient can make the change.
2. **Value Identification-**Ask yourself what will this "difficult" conversation be in the service of (e.g. safety, etc.) and then stand firm in that value.
3. **Realistic Expectations-**Your patient might leave upset, if you are holding the line in a compassionate and supportive way…this is still a win.
4. **Relationship as a Resource-**Leverage the relationship you have with your patient, e.g. "I know you don't want to do ____, will you do it for me this time, I won't abandon you, I will stand by your side as you make this change.

5. **Willingness to Feel Uncomfortable-**Consider modeling for your patient: relaxing your hands, softening your jaw, deepening your breath, etc. Mirror neurons are real and effective!

Keys to Successful Conversations

Courtesy of Laura Heesacker, LCSW

1. **Time Management-**have a plan e.g. "We have 10 min. left together, I have 3 important things I want to discuss and I am sure you have some things, who shall go first?
2. **Set an "exam room goal"-**an outcome you hope to achieve when you walk out of the exam room e.g. introduce the topic of needing to change medications in the near future.

3. **Think in Micro Increments-**as long as patient/others are not in eminent danger changes can unfold over time, chuck it up and plant seeds for future change. E.g. Say to the patient "No changes need to be made today"-it might keep the patient/family in their frontal lobes vs. brain stem survival mode.
4. **Deliver the message** by speaking slowly and keeping the messages simple
5. **Validate patient/family fears,** check for understanding, clear up any misunderstandings, and give patient choices if possible

S.O.A.R through Difficult Conversations

Courtesy of Laura Heesacker and E. Krebs

S: Shared Decision Making when safety allows, avoid backing patients into a corner.

Lower Risk = Higher Shared Decision Making

O: Outcomes- Focus on what the patient cares about:

- Improved quality of life
- Protection from opioid-related harm
- Staying under the care of the team

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A: Assurance and Validation

- All pain is real
- Make eye contact
- Observe behavior
- Physical exam at every visit

R: Risk and Redirect

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- Risk belongs to the Drug
- Use universal precautions (UDS, PDMP, etc.)
- Redirect conversation from pain to function

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V.E.M.A-Validate, Educate, Motivate, Activate

Courtesy of Anthony J. Mariano, PhD

V: VALIDATE THE PATIENT'S EXPERIENCE:

Verbally acknowledge you understand what the patient is saying and feeling.

You do not need to agree with a patient to validate their experience.

Ex: *"I see/hear that you are feeling (upset, anxious, angry, scared, betrayed, etc.)."*

E: EDUCATE THE PATIENT ABOUT BEST PRACTICE/SAFETY:

Use educational handouts about safety and non-opiate evidence based options

Discuss what you now know about safe opioid use and prescribing

Consider using "validation" statements before "education" statements

Ex: *" I understand that making changes to your current opioid prescription feels scary to you, and we now know that non-opioid treatments are not only safer for you, but can help increase your functioning and improve your quality of life."*

M: MOTIVATE THE PATIENT TO ENGAGE IN CHANGE:

Use motivational interviewing to assist your patient in moving toward self-management strategies. Ask open-ended questions to identify areas where a patient is open to making lifestyle change.

Ex: "Given the way you are living your life now, do you see any room where you would like to do it differently, or are you basically satisfied with the way things are going?"

A: ACTIVATE CHANGE PLAN:

Whenever possible, give the patient choices about how to move forward within the safety parameters you are upholding.

Collaboratively set goals with your patient.

Ex: *"Let's work together to develop a taper plan that will work best for you. We have ______ amount of time to get you to a _______ dose. The recommendations for tapering are______. Which dose during the day would you like to start reducing first?"*

Common Traps and Negotiation Strategies

Courtesy of Brad Anderson, MD, Kaiser NW

1. Compassion Traps:

Patient: "Do you want me to lose my job, do you want me to be on the street?"

Provider: I want you to have safe and effective pain control and it is my medical opinion that your current medicine won't give you that.

2. All or Nothing Traps:

Patient: "So you're going to do nothing for me then?"

Provider: "I am confident that together we will find safe and effective options"

3. Addiction Labeling Traps:

Patient: "Are you accusing me of being an addict?"

Provider: I have never accused anyone of diabetes but I've diagnosed him or her with it and that is what I am trying to now, diagnose.

4. Desperate and Threatening Traps:

Patient: “Don’t bother with any other meds, I’ll just kill myself.”

Provider: I need to ask you some more questions about your thoughts about suicide.

5. Endgame:

Patient: Behavior is angry, despondent, avoidant…

Provider: “At this point, I suggest we agree to disagree, what I have laid out is what I believe to be the safest and most effective course of action right now. Now, how do you want to spend the rest of our time?”

General Recommendations:

- **Stay in the medical expert roll**

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- **Emphasize concern and CONDITION**
- **Speak to what is behind a patient's comment, not to the comment itself**
- **Speak to what you know to be true, trust your science**

5 Step Navigation Process

Courtesy of Barry Egener, MD

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1. **Navigate the Emotional Landscape** by showing willingness to feel uncomfortable, and offering reflection, validation and support. You are not condoning the patient's behavior when you reflect, validate, and support the patient's experience.

2. **Elicit the Patient's Perspective** by asking the patient how pain management, quality of life, functioning, etc. is going for them? Or what does the patient know about the safety of opioids, etc.

3. **Present your Perspective** by asking the patient if they are interested in hearing about, safety concerns, effectiveness of

opioids, other modalities, etc. if yes, continue with offering information slowly and checking for understanding as you go

4. **Agree on Common Goals** even if it is agreeing to disagree. Goals should be specific, measurable, agreed upon, realistic, and time-based (SMART)

5. **Set Limits** by understanding where you will stand firm (e.g. at least one Rx will be tapered) and where you are willing/able to share control (e.g. which Rx taper starts first)

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5 A's for Dealing w/Hostile Patients

1. Acknowledge the Problem
2. Allow the Patient to Vent Uninterrupted in a Private Space
3. Agree on What the Problem Is
4. Affirm What Can Be Done
5. Assure Follow-Through

R.U.L.E s- of Motivational Interviewing

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Courtesy of William R. Miller, Stephen Rollnick

R: Resist-the Righting Reflex,

U: Understand the Patient's Motivations

L: Listen to the Patient,

E: Empower the Patient