Talking to People who are Dying

Eileen Reilly / Senior Social Worker
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Active Listening

• Before talking comes listening
• Careful listening is key to engaging successfully
• Responding to silence
• Allows us to check that the patient’s understanding is correct and up-to-date
• Not the same as agreement
• Skills include restating, paraphrasing, reflecting back, responding to feelings, summarizing and allowing for silence. (Fraser)
Body Language and Touch

• Difficulties in communication and emotion may be expressed in body language rather than words.

• Body language, eye contact, gestures and tone of voice are important. (Research suggests that between 55 - 80% of communication is non-verbal)
Tips for Non-verbal Communication

**SOLER**

- **S** Sit Squarely to communicate presence and availability
- **O** Open Posture – communicates your openness – not hiding anything / receptive
- **L** Leaning Forward
- **E** Eye contact – good eye contact but not starring, communicates your interest and desire to hear what the person has to say
- **R** Relaxed – Being relaxed and natural – comfortable with your own body and situation
Emotions

- Many people find it difficult to talk about emotions
- Emotions are complex
- People who fear dying may seek to avoid communicating about it.
- Anger – common at the end of life
- Can be targeted at something or someone specific, or it may be generalised and unfocused.
- It is helpful if the anger is acknowledged and allowed
- It is often care-givers rather than patients who express anger
- Patients may show a disproportionate response to what seems to be a simple event
Denial

• Denial can be an important defence as well as an adaptive strategy
• “The principle of autonomy permits the dying person to choose to remain in ignorance, or with a limited explanation” (Sheldon, 1997)
• Helpful communication techniques
• Useful to ask ‘Who’s problem is it?’
• Open-ended listening, neutral, empathic responses, silence, developing trust
• Patients can move in and out of denial
Symptom Talk

• Some people who know they are dying avoid talking about it completely, or until close to death.
• They may, however, wish to speak about symptoms, such as pain, shortness of breath or nausea.
• Helpful to acknowledge that these concerns must be worrisome.
• You might say “Tell me more about what you are experiencing”, or ask “What do you think is happening?”
Barriers

• The disease process itself may prevent open communication
• Language barriers can cause misunderstandings, misdiagnosis and treatment difficulties
• Cultural, religious and language difficulties
• Communication Tips...
• communication aids / Check with patient / family about relevant cultural norms
Intrapersonal factors

• The HSCP may lack confidence in their ability to engage with the patient
• May be dealing with painful / unresolved issues of personal loss
• The patient needs to feel the HSCP has time to listen and engage
A 'hospital minute' is a highly contentious issue

...err... excuse me... I was wondering if I could have a...

101 things to do

Of course... in a minute...

You ALWAYS say that... but it can take ages
Questions to keep in mind

• Permission should be sought from the patient before opening up issues for discussion.
• Some questions should be asked in a timely manner.
• Use open and closed questions as appropriate.
• Open-ended questions can allow for deeper conversation, creating openings for exploration of thoughts, feelings, behaviour and relationships.
• These questions are asked tentatively, giving space for time to think and reply.
Examples of open-ended questions

- What is your understanding of your illness?
- What kind of impact has the illness had on you and your family?
- How have roles and relationships changed within your family?
- How would you describe your communication style?
- What do you fear most?
- Who do you rely on to help you?
• Who should be involved in decision making?
• What is most important to you?
• What would be most helpful to you at this time? (Fraser)
But I’ve already answered that...

• There is usually a series of phases as the patient’s awareness grows, rather than one clear moment of communication (Glaser & Strauss, 1965)

• As the patient begins to understand the consequences of the news they have been given, they may ask questions of anybody.

• People may need information repeated or highlighted over the course of their illness.

• Written information and contact details may be helpful
Impact of deaths of other residents / patients

• LTC patients develop meaningful bonds with other patients / residents (Kovach & Robinson, 1996)
• Death rate estimated to be 331 times higher than community rates – high death exposure (Maranzan & Stone, 2005)
• Residents may experience a desire to connect better with staff at an emotional level
• Residents need avenues to share personal experiences, speak about previous losses and participate in community remembrance and ritual for person who died.
Humour

• Research findings consistently identify the importance of humour as a means of enabling communication, fostering relationships and managing emotions. (Dean and Gregory, 2005)
• Humour contributes to quality of life (Shanagher, D. 2014)
• Tips for using humour include:
  • Observation of patient / family
  • Assess receptivity (patient’s mood, comfort, cognition)
  • Put the humour on yourself
Little things can make a HUGE difference

Like simply taking a bit of time to smile and chat

That ‘friendly moment’ is SO important to, and FOR me!
References

• Dean & Gregory / Cancer Nursing, Vol 28, no 4, 2005 More than Trivial: Strategies for Using Humor in Palliative Care
• Lugton, J, McIntyre, R. Palliative Care: The Nursing Role. Pub Elsevier, 2005
• Shanagher, D. The Experience of Healthcare Assistants in Providing End of Life Care in a Continuing Care Unit. hospicefoundation.ie