Ep #119: Empathy and Clarity: A Nurse Practitioner's Guide to Supporting Patients Through Tough Times

Full Episode Transcript

With Your Hosts

Sarah Michelle and Anna

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Welcome to the *Real Deal NP Club*. Whether you're hoping to become a real deal nurse practitioner or you already are one, this is the place for you to get the resources you need as you tackle this massive transition into practice. We're your hosts, Sarah Michelle, Chief Nursing Officer of Blueprint Test Prep, and Anna Miller, Director of Nursing Content. And we're here to hang out with you each week like your best friends in the NP space. Let's dive in.

Sarah: Hi, friends. We are so excited for what we're going to be talking about today. As an educator and an NP, I know that students often don't really get the chance to have a lot of those significant conversations with patients, especially when it comes to the topic of delivering bad news.

And I think that we can understand too that because preceptors are the ones with the overall responsibility and that liability for patient care, and if you were a patient would you really want a student delivering that tough news, or would you rather have your established clinician that you already have that rapport and relationship with giving you that news?

And so today we're just going to talk about the basics of having difficult conversations with patients so that way in hopes you will be better prepared for your clinical practice.

And of course, Anna is here with me today and she's going to be giving her guidance as well.

Anna: Yeah, absolutely. And I totally agree with what you said about being an NP student, a lot of times you don't get that experience. Now, I did have a few opportunities to watch my preceptors have tough conversations, but watching and doing, totally different things.

And I specifically remember a couple of really tough situations in my women's health rotation that my preceptor had me stay in the patient visit for, but depending on where you work, this may or may not be something that you have to do often. But every time you have to deliver bad news, you

are going to learn a little bit more about just better ways to deliver it and have those conversations.

Sarah: Yeah, and it's one of those things that will just kind of evolve over time and you'll get better and better. I felt like I had a lot of experience, at least watching bad news be delivered. Sometimes I was the one giving bad news inadvertently because I was an oncology nurse. That was just kind of a name of the game, it feels like everything is bad news in oncology. But the more you do it, the easier it will get.

And to just kind of start off, let's just picture together that you just got a report back, there's some test results and they are less than favorable for one of your patients. So you of course are sad for what this means for your patient, but you're also really nervous about how you're going to tell them. And so Anna, how would you kind of prepare?

Anna: Well, first, always, always just double check the interpretation, right? And with that, are there any other tests that we should be looking at or anything else we need to order? For example, some tests are done as a screening and then reflex confirmatory testing is done. So we have to ask ourselves, do we have all of the information we need to have this informed conversation with the patient in the first place?

Sarah: Absolutely, because that patient is going to have questions about what needs to be done and kind of what the next step is. And so after you make sure that you yourself understand the results fully, you then need to make sure that you know those next steps and all the options that you can present to your patient.

One example that I'll always remember is thinking about giving news that a painless lymph node was suspicious for cancer on an ultrasound. And so the patient was an otherwise totally healthy 40 something year old who came to see me for a lump that was not going away. And we had to give him the news that the ultrasound that I ordered showed some malignant characteristics.

Anna: Yeah, I absolutely hate those situations. So how did you approach this conversation?

Sarah: Well, even though I knew his care was kind of out of my hands now, he was going to need that referral for an ENT or the ear, nose and throat specialist. I still needed to know what his next steps were going to be, right? Because I knew he was going to ask me, which he did, “Well, what is that doctor going to order instead?”

And so even if you aren’t going to be the one managing the next steps for your patient or ordering that next thing, you should be able to explain to them what those next steps actually will look like.

Anna: Yeah, absolutely. And just thinking with my clinical hat on here, I imagine you had to explain that he needed the referral to ENT and there they would likely do some type of biopsy and other advanced imaging.

Sarah: Exactly. But of course, it took some time for me to educate myself before I was prepared and ready to have that conversation with him. And so once you understand the results and you know the plan of care and what the options are going to be for your patient, you can bring the patient in for that conversation.

Anna: Yeah, and this is something we’ve actually talked about in our free class webinars over lab review, if any of you have joined us for those. But just to recap in case you didn’t, you never give abnormal results over the phone, right? Significant results should not be told over the phone, they definitely should not be left on a voicemail message.

A lot of times patients can be sent a letter with non-urgent results or sent a message to view in their electronic health record. But for any results that require a treatment or a change in treatment, the patient really should be brought in for an appointment to discuss these.

Sarah: And important too, I know this seems tiny, but once the patient is there for their appointment, you should select a quiet room to bring them to.

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The exam room closest to the busy waiting room is probably not going to be the best place, but rather the exam room at the end of the hall where it's quieter and more private.

I remember when I was pregnant and we were about to find out that my daughter had a heart defect. And obviously I'm having a lot of emotions, I know I just had this abnormal ultrasound. I could hear a patient in the next room getting bad news and that only escalated me and my already super high emotions and everything else.

So just be really cognizant of the placement of your patients too and what they might be overhearing because they've already got a lot going on if something is wrong.

Anna: Yeah, I had a few situations in the women's health clinicals where this happened. And I remember having these in quiet rooms by back doors where there were actually alternative exits too so patients didn't have to walk through a busy lobby after.

And then to make these just a little more comfortable, hopefully, like you mentioned at the beginning, as the clinician you already have that established rapport with the patient in your other interactions with them.

And we're going to talk about nonverbal communication coming up, but you want to be welcoming and friendly to the patient to help them be a little more at ease and just really, really pay attention to your communication strategies as you talk with them.

Sarah: Yeah, I think you definitely want to be aware of that nonverbal communication. Sometimes that talks just as loud as your verbal communication. You know, we just talked about using that rapport that you've established with the patient and that's important.

So to take that to the next step, you want to be eye level with your patient. This means if your patient is sitting in a chair, so are you. And if the patient is sitting down, you don't want to be standing because then you're literally,

like quite literally talking down to them, which subconsciously, whether we like it or not, is very intimidating and automatically puts them on the defense.

Anna: Yeah, that's a great point to bring up. And along those same lines, try not to have your arms crossed or folded because that may also subconsciously come across to the patient as stress or rudeness or just otherwise discomforting.

And then of course, with your actual words, try to avoid using too much medical jargon, right? You may have an occasional patient who also works in the medical field, but as a general rule, explain things in simple terms.

Sarah: And that one can really be a hard one sometimes because we just kind of get in the groove and like this is our knowledge base and our expertise and we know all the things, and so we really get accustomed to speaking in a certain way. But when you're looking at the patient, do they seem responsive to what you're saying? That's what you should be analyzing for yourself because as much as you want to avoid medical jargon, you also want to make sure that you're speaking slowly and clearly and in a way they can understand.

And obviously you're probably going to be a little anxious yourself because nobody wants to be the bearer of bad news. That really stinks. But don't rush through it either because the patient deserves to have a conversation with their clinician that gives them more answers than questions. If they're leaving with tons of questions, then we haven't done our jobs appropriately.

Anna: Yeah, absolutely. And it always brings me back to learning in nursing school all about that therapeutic communication. But a great way to gauge the conversation is to ask the patient about their own understanding of this illness or condition, right?

Maybe you are talking about complications from a disease that they've had for a really long time. So it's possible the patient understands more than

you think. Or on the flip side, this could be a totally new diagnosis, but the patient may have a general knowledge of anatomy and physiology that you could use to then help further explain things.

Sarah: Yeah, do you think you have any examples of that?

Anna: Yeah, so I can think of times where let's say a patient wanted to be evaluated for possible dementia. And the patient and their partner had been noticing some signs of memory loss and cognitive delay for about a year. So we did some screening tests in the office, referred them for more lab work and a brain MRI. And the MRI did show some atrophy in the hippocampus, which is consistent with Alzheimer's dementia.

So when I brought the patient and their partner in to deliver the news, I asked what they knew about Alzheimer's dementia and treatment. And they'd actually already done quite a bit of research on their own, and so that made it a lot easier to guide the conversation to what they needed to know instead of wasting time on things they already knew.

Sarah: Ooh, yeah, I really like that advice. And I think that kind of goes well too with something else I was thinking of, which is kind of summarizing the conversation at the end. Because even on a good day, when you're not giving bad news, patients rarely remember most of what they were told.

And so at the end of an important conversation, give them a summary. You can phrase it like, okay, so we talked about a lot today. Your lab showed this, which can mean a few things. And we're going to set you up for further testing with so-and-so. We might give you a referral to see a specialist, whatever that plan is.

And then remind them too, you know, I will continue to oversee your care and don't hesitate to reach the office if there are more questions you might think of. And another thing I love to do too is, in this day and age everyone has a cell phone. So ask them to pull out their cell phone and write down that summary that you just gave them. So that way when they go home and

they want to speak to a loved one or a friend or whoever about it, they have all that information right there.

Anna: Oh, I love that idea.

And similar to studying, like we talk about a lot, people tend to remember the first and the last things they either read or they're told. So if we can end with that summary of what we talked about, that will hopefully set that patient up for success with a solid plan for follow-up care. And if they have it written on their phone or anything like that, they always have something they can refer back to as well.

But there is one other side of this we haven't talked about yet. What should we do if a patient becomes really, really emotional? Because that can feel pretty uncomfortable in the moment.

Sarah: Well, I've definitely been on the flip side of that and been that really emotional patient. Just remember that patients are free to feel their feelings. Being emotional is a perfectly normal, expected part of the process when you're getting unanticipated news. And you just want to acknowledge whatever it is that they are feeling.

So it would be like, Mr. so-and-so, I can see this is upsetting you. And I understand this is not news that you wanted to hear today. And this just really helps to kind of normalize the reaction, helps them ground back down a little bit and makes them see too, like you really see them, you really care for them.

And remember too, if that patient reacts with sadness, anxiety, or frustration, that has nothing to do with you. I mean, I know at Meadow's ultrasound appointment, I mean, I literally had a panic attack on the ultrasound table and I was all over the place. And that had nothing to do with the ultrasound tech. It had nothing to do with my OB. I just had to be able to feel my own feelings and then we could work through like what the game plan is.

And I think alongside that, if you have someone that's having a big emotional reaction, maybe we don't give them the game plan in that moment. Like I know we're busy, I know we have other patients to see, but you've kind of got to let them come back down a little bit before you're delivering more news.

Anna: Yeah, absolutely. And I've even seen people react the opposite of that. So also expect silence as a natural response too, right? You have just delivered very unexpected news and maybe the patient's response is silence as they are just trying to process everything. So do not try to fill that silence with your own talking. Just be quiet, wait for the patient and just listen.

If there is a very, very prolonged silence, you can say something like, I know this is a lot to take in, tell me what you're thinking. And that can just be enough to acknowledge how they're feeling right now and get that communication flowing again.

And now we always like to touch on any legal considerations here, so when it comes to delivering bad news, are there legal considerations here, Sarah?

Sarah: I think the biggest things we need to consider are just patient privacy and the right to informed consent. So the cornerstone of this is, of course, always HIPAA. We've heard about HIPAA a million times, but maintaining patient confidentiality, especially with abnormal results, is absolutely essential.

Now, if the patient brings someone in with them to the appointment, you still want to ask the patient, is it okay to speak in front of this person about your health before we start this conversation?

And then Anna, what do we want to keep in mind about adolescents too?

Anna: Yeah, adolescents are a special population that when it comes to certain conditions, some things, right, you can treat them confidentially

without notifying their parents. And this really applies mainly to reproductive rights. So you can confidentially treat them for any STIs and pregnancy prevention and care, among a few other exceptions.

Sarah: And of course, just always remember too, informed consent, that principle means giving the patient the information that they need to be able to make that informed decision about their care. So we cannot withhold necessary information because we feel the need to. We cannot withhold bad news or information about a diagnosis because we think we want to protect that patient.

Our job as nurse practitioners is to provide care to our patients. And to be able to do that well, we have to be honest and transparent. And we do have that legal obligation to tell our patients the whole truth every time.

And so to kind of sum everything up, we did talk about a lot today, and it's definitely, it's not easy giving bad news to patients, but hopefully you feel just a little bit more prepared for when that day comes because it will.

And remember too, be prepared before you walk in the room of what those next steps are going to be. Speak slowly, listen, make sure they're understanding, avoid that medical jargon, and just be really open and honest with your patients and give yourself some grace and self-compassion as well as you kind of figure it out and you kind of evolve in how you deliver bad news.

Anna: Yeah, you absolutely have to take care of yourself. Like we know your first priority is your patients, but delivering this kind of news can really take a toll on you too. So be sure to just take care of yourself, debrief with colleagues and seek support for yourself if you need it.

Sarah: And that wraps up this week's episode. So we'll be talking to you in a couple of weeks.

As an extra bonus friends, if you're looking for support no matter what phase of your nurse practitioner journey that you're currently in, I have

communities available for both students and new nurse practitioners. In these communities, we work to uplift one another and grow this profession together every single day. Links to join will be included for you in the show notes.

Thanks for listening to the *Real Deal Nurse Practitioner Club*. If you want more information about the different types of support that we offer to students and new nurse practitioners, you can visit npreviews, with an S, dot com. We'll see you next week.