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Tending to everyday and BIG conversations in teaching and practice

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Throughout our professional lives, there will be patients and families whose journeys affect us deeply and shape our development as practitioners and teachers. When recalling our most challenging times in practice, we remember patients and families whose memories have sat quietly undisturbed within us, only to be brought to the surface when prompted.

For us, our memories include difficult discussions held with a conscious ventilator-dependent gentleman unable to be weaned from life supporting therapies and facing stark choices about limited treatment options available, or conversations held with a son struggling to come to terms with the imminent death of his father whilst knowing that the resulting inevitable loss was unconceivable, or speaking with a family who did not know how to say goodbye to their dying child and who simply asked of the clinical team, “What kind of a God would let a child suffer so?”

In reminiscing about patients long passed and their families, it strikes us that there is something that all these situations hold in common. The thoughts that pervade these events are not related to how well the “I’m sorry I’ve got some bad news” talk went with families. They are not even about how well a particular “formulae” worked in discussing treatment planning or in preparation for withdrawal of life support. Rather, the memories recalled speak to the smaller, everyday seemingly inconsequential conversations and acts of kindness shown by and to patients, families and practitioners, and to the resilience and bravery of the human spirit. They speak to the importance of cultivating rapport over a short period of time in time-critical circumstances. And they speak to comfort, presence, humility, and connection in moments of silence and shared sorrow.

These simple yet vital elements of everyday communication are also important to families in intensive care. A consistent finding about the experiences of families in this context is how

important it is for staff to demonstrate compassion, empathy and concern. Families deeply value emotional engagement and commitment on the part of their care providers. When bereaved families recall their time in intensive care, they do not necessarily remember the names of the medications, surgeries, or procedures. Nor do they place prime importance on what was said, but rather in how it was spoken, when it was spoken, and whether they were talked to, talked at, or talked with. Patients and families value opportunities to speak, to be understood, and to be known. Patients and their families are naturally more forthcoming when practitioners speak less and listen more. When practitioners refrain from dominating or interrupting the conversation, patients and families are enabled to tell their stories, utter their questions, and unburden their fears.

Perhaps we have got it wrong. Most communication training programs focus on the dramatic, high-stakes conversations, such as conveying life-altering diagnoses, discussing do-not-resuscitate orders, deciding whether and when to discontinue life-sustaining treatment, or disclosing adverse medical outcomes. Perhaps reflective of the age in which we live, practitioners may expect quick-fix solutions to these dilemmas. The use of particular scripts, mnemonics or elusive toolkits that will solve all the problems – or at least go some way to solving them. However, the exclusive focus on BIG conversations in our training initiatives may unwittingly send the wrong message that these are the only conversations worth learning about, or that matter to patients and their families.

Perhaps communication training needs to encompass not just the BIG conversations but the daily interchanges that lead up to and follow the BIG conversations. This would include introducing and nurturing our learners in the art of everyday quiet conversations and interludes of talking with patients and families at the bedside. This would include tending to conversations that not only prepare the patient and family for test results that could confirm a serious diagnosis whilst listening carefully for yet-to-be-revealed hopes and worries to arise, but also for following up with supportive conversations about the meaning of such news and what to expect over time. To reorient our teaching priorities and expectations of our learners by including everyday as well as BIG conversations, would enable learners to practice and master skills under less stressful, less contrived high-stakes circumstances. To learn to walk before running, so to speak. And in so doing, our learners would more gradually cultivate the solid foundation of communication and relational learning that no script mnemonic, or checklist can truly capture.

Moreover, by privileging such fundamental principles and applying them in the countless, seemingly everyday conversations and not just the BIG conversations, we would all be reminded of the full-range of conversations that matter and are long-remembered.