

# Communication: beyond non-verbal

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# Topic overview: good communication

When  
(right time)

Who  
(right people)

Where  
(right place)

What & Why  
(right content)

How  
(right structure, right delivery)

Accuracy

Brevity

Clarity

Delivery

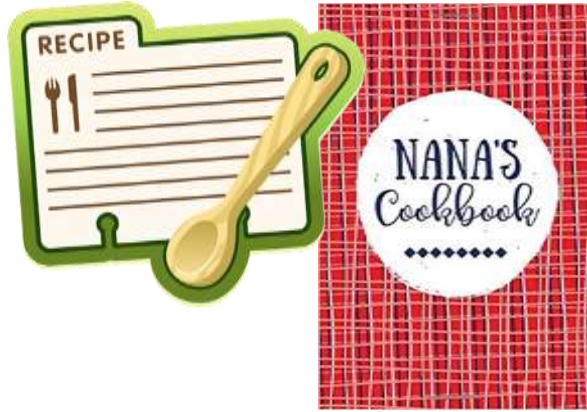
Empathy

Common Pitfalls  
Written Communication  
Conflict



**Breaking bad news as a  
Shakespearean tragedy  
(a structured approach)**

# Good communication



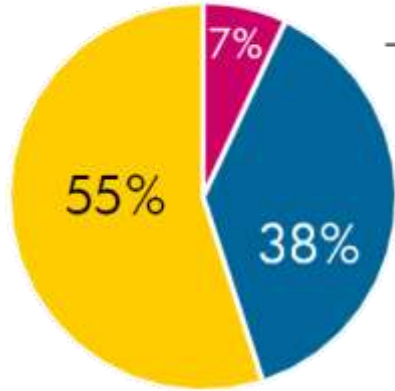
*"Knowing yourself is the beginning of all wisdom."*

~Aristotle



1. All HCPs are good at communication.
2. Medical/nursing school communication teaching was helpful (history taking, 1<sup>st</sup> person).
3. Non-technical skills aren't technical.
4. The communication stops when the doctor leaves.
5. Communication is 93% non-verbal.

# Is non verbal enough?

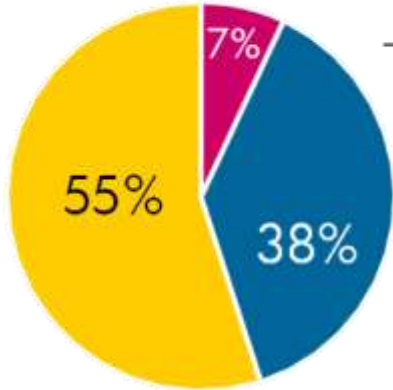


Dr. Albert Mehrabian's 7-38-55% Rule

## Elements of Personal Communication

- 7% spoken words
- 38% voice, tone
- 55% body language

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## Elements of Personal Communication

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Mehrabian had an experimenter read words to an audience of college students, single words like 'love', in different tones and with different expressions. Then, he asked the audience how it knew what the speaker really meant.

The 'silent messages' – how people communicate implicitly their emotions and attitudes.

His big insight was that when words and non-verbal messages were in conflict, people believe the non-verbal every time.

When  
(right time)



Convenient time  
No interruptions  
No rushing

- Why now?
- The **golden** first conversation?
- Where are the family on their journey / story?
- Will you be noise or signal?



Who  
(right people)

Big or small?  
Decision makers  
Family support

Doctor + Nurse  
SNOD  
Trainees  
Bereavement  
Spiritual  
(Skill set)



Quiet  
Comfortable  
Private



Where  
(right place)

Room layout  
Seating position

# Good Communication: beyond non-verbals

## Right message

What & Why  
(right content)

How  
(right structure, right delivery)



**We generally have an agenda.**

- What is it?
- Why are you speaking to the family / parent team?
- Lends itself to a narrative structure.

### Speaking to Family

- Prognosis (understand, trust)
- Build / maintain rapport (trust)
- Rx plan (understand, agree, choose)
- Rx limitations (agree / veto)
- DNACPR (agree / veto)
- Withdrawal (agree / veto)
- Brainstem testing (understand / veto)

### Speaking to Parent Team

- Negotiation (advise, decide, agree)



## Admission ICU / Major Surgery

- signals the **fragility of human life**; shifts from day-to-day life, and planning the future, to **survival** and the corresponding **desire for things to be 'as they were'**.
- family members experience high levels of **anxiety** and feelings of **disorganisation** in response to critical illness - not only during the experience but also for months after the event. **Financial tension.**
- **Dysfunctional** families thrown back together.
- **Lack of control.**

Nursing Times (2003)

## Dying and Family Grief

- 90% of people used to die at home (lost sense of societal continuity with death)
- People must be seen to fight against disease
- Sudden death: unreality, guilt, helplessness, need to understand
- WE provide explanatory language and narrative for the family



"No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning, I keep on swallowing. At other times it feels like being mildly drunk or concussed. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says...."

CS Lewis

Why is breaking bad news so hard (for us)?

Fear of causing pain.  
Fear of being blamed.  
Fear of therapeutic failure.  
Fear of saying I don't know.  
We have a tendency to try and fix the unfixable – we can't!

Own fear of illness or death.  
Fear of elucidating a reaction.  
Fear of exposing own emotion.  
Conjure up feelings of inadequacy and awkwardness.  
Fear of the untaught.

J DAVIES (SNOD)  
GRIEF TALK



# Good Communication: beyond non-verbals

## Right message

How  
(right structure)



### Breaking bad news: A review of the literature

Ptacek, J T; Eberhardt, Tara L *JAMA*; Aug 14, 1996; 276, 6

#### What is said

Preparation: give a warning shot

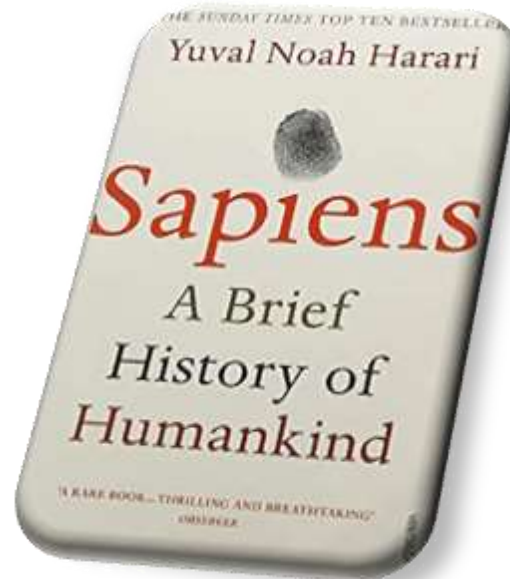
Find out what patient already knows

Convey some measure of hope

Acknowledge and explore patient's reaction and allow for emotional expression

Allow for questions

Summarize the discussion: verbally and/or in written form, audiotape consultation



# Breaking bad news as a Shakespearean tragedy (a structured approach)



Human beings are story tellers. What story are you telling?



# Breaking bad news as a Shakespearean tragedy (a structured approach)

## Prologue

Ensure we are all  
in the right play.

- Ask the family to explain their current understanding.
- Consider a warning shot.

It's a tragedy, not an action rescue or a crime drama.

*“I know you have been through a great deal in the last few days, but can you briefly tell me what your understanding of what the situation is and what has happened to Michael up until now?”*

*“I’m afraid the news isn’t good.” ... be prepared to hurry on*



# Breaking bad news as a Shakespearean tragedy (a structured approach)

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- Consider a warning shot.

## ACT I

Re-tell the story, taking care to highlight the facts that make this a tragedy.

- Build off what the family have told you.

*"As you said, Margaret suffered a very bad bleed in her brain. As you saw, she lost consciousness almost immediately and the paramedics had to put the breathing tube in because she was no longer breathing for herself. Since coming to hospital we have not seen her breathe and many of her brain functions appear to have ceased. We've been very worried."*



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## ACT II

Build toward and say the TELEGRAPHED REVEAL

- Be prepared to repeat and explain.

*“The scan of Margaret’s brain is very abnormal and devastating. My fear is that the damage Margaret has sustained to her brain, is so severe, that she may have already died.”*

Followed by SILENCE



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Build toward and say the TELEGRAPHED REVEAL

“What happens now?”

*“Now, I suggest you go and spend some time with Michael. Then we will come back and talk some more [and we can plan his end of life care together].”*

## I N T E R V A L

Decouple. Guide the family toward accepting a break and agree a second conversation to plan next steps or end of life care.



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Build toward and say the TELEGRAPHED REVEAL

I  
N  
T  
E  
R  
V  
A  
L

## ACT III

Resolve the 'story'.

Discussing end of life care (donation)

Guide the family toward accepting a break.

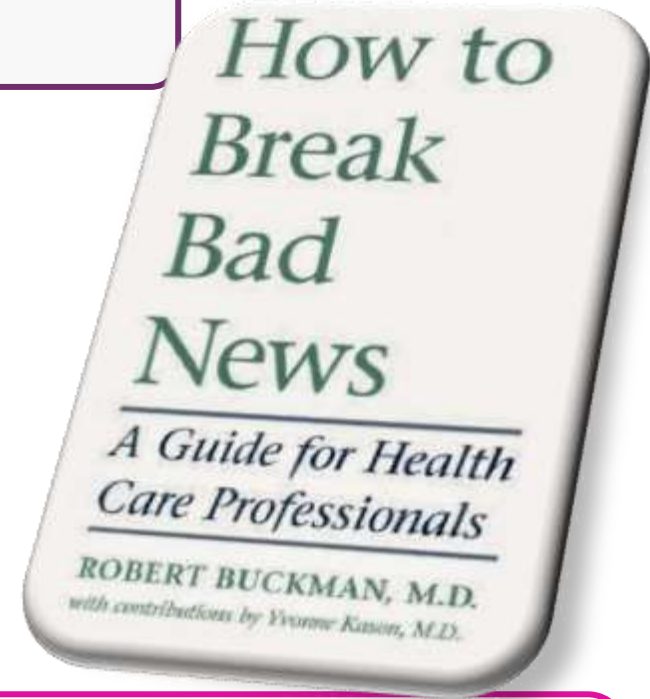
How  
(right delivery)

I've learned that people  
will forget what you  
said, people will forget  
what you did, but  
people will never forget  
how you made them  
feel.

Maya Angelou



**Maya Angelou (1928-2014)**



If we do it badly, our patients and families will never forgive us, if we do it well they will never forget us."

Robert Buckman 1992

# A,B,C,D,E: won't let you down

- A**ccuracy – say truth, admit what you don't know
- B**revity – don't fill the silence with your voice
- C**larity – use unambiguous language
- D**elivery – use appropriate non-verbal techniques
- E**mpathy – explicitly state your sympathy



# Good Communication: COMMON PITFALLS

INADEQUATE  
PLANNING

When  
(right time)

Who  
(right people)

Where  
(right place)

What  
(right content)

How  
(right structure, right delivery)

Misreading  
CHOICE  
POINTS

Stopping

Backtracking

A family challenge can be your greatest opportunity  
to build rapport and understanding

# Good Communication: WRITTEN

Usually best to avoid a story / narrative structure

Slow

Probably inaccurate

Much is redundant



USE Ethical framework as your WRITTEN framework

Date

Time

Location

Brian, a 68 year old morbidly obese male with a past medical history of smoking, hypertension and diabetes has a ruptured AAA.

### ICU consultant in resus

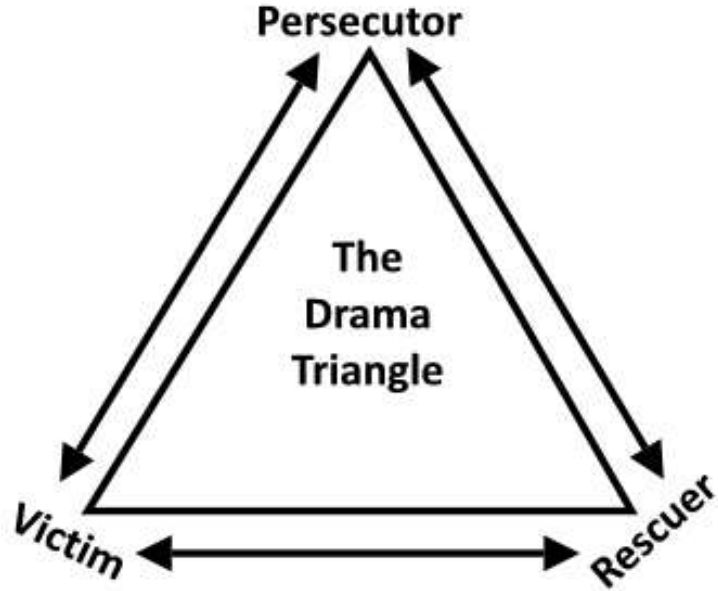
**Brian has a ruptured AAA on a background of life-limiting comorbidities. Even if surgically amendable to EVAR the prognosis is extremely grave.**

**I have spoken to Brian and his son. Brian would like to attempt surgery and is fully aware of the risks. He values his independence (strongly against requiring nursing home care and also vehemently opposed to amputation). Were these negative outcomes all that could be achieved Brian understands and agrees we should move toward a comfort care approach. His son was also in agreement.**

**Having discussed with Miss [Vascular surgeon] and the ICU team we will plan to do the surgery urgently with the aim of admitting to Level 2 care post-op. Deterioration from that point would likely represent an unsurvivable state or a situation that would only result in the outcomes not in accordance to Brian's values, wishes and beliefs. Consideration for palliative care in that circumstance would be appropriate.**

facts  
prognostication  
Patient and  
family  
outcomes  
of  
relevance  
decision

# Good Communication: CONFLICT (families)

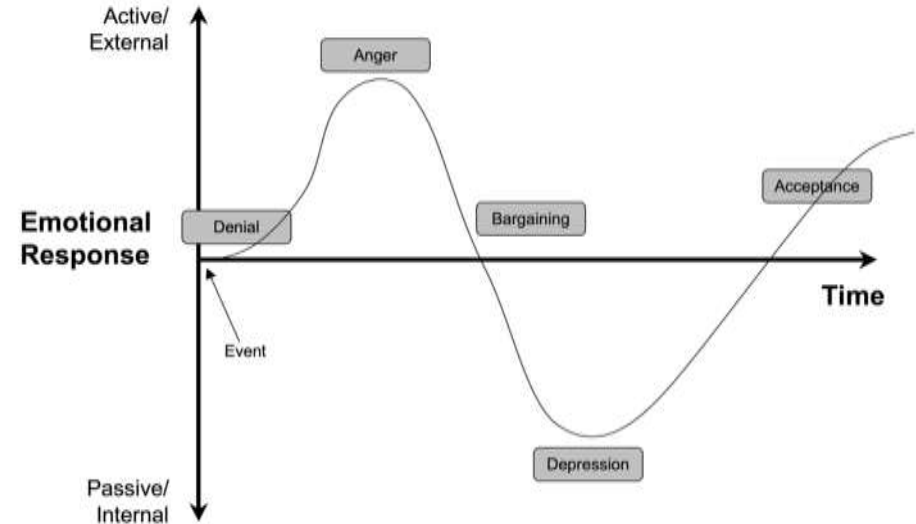
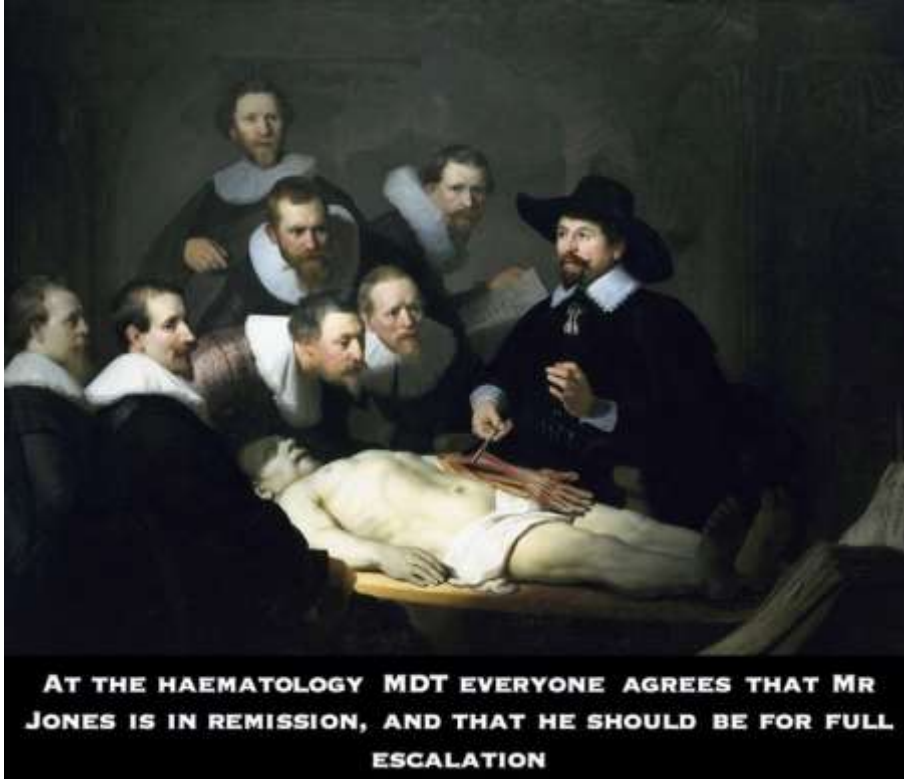


From Transactional Analysis  
by Steve Karpman

**Breaking free of the drama triangle.**

**If you feel you have entered the drama triangle try and occupy the middle of the triangle.**

# Good Communication: CONFLICT (parent team)



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