Faculty role play I and II: Difficult Conversations - Recommendations

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Scene 1: Patient in acute withdrawal

Discussion highlighted:

- Value of focusing on treating withdrawal and pain as initial engagement point.
- Giving patient choice about methadone vs. bup-nx (and sharing potential benefits of one vs. other)
- Put patient in the driver's seat as much as possible. Patients in acute withdrawal and with acute illness likely feel loss of control, sick, judged. When there are opportunities to give them agency and choice, this can be critically important to supporting them, aligning the care plan to their goals, and building trust
- Assessing patient's understanding of why they are in the hospital can be helpful engagement point
- Be as transparent and accountable as possible

  "I will do my best to come back today, but if I can't, I will definitely come tomorrow morning."

Scene 2: Patient escalated after pain medication were withheld overnight with cross-covering team

Discussion highlighted:

- Acknowledging/ validating patient's experience and frustration
- MD assuming responsibility for care and the unexpected change to the plan by the overnight team
- If patient is angry, listening, acknowledging, avoiding explaining too much or making excuses
- Ensure strong communication and handoffs between care teams regarding treatment of OUD and pain; set up overnight teams for success
- Acknowledge that the patient not leaving AMA is a success.
- Often if OUD or pain are not fully treated, a patient will self-medicate.
- OK to leave the room to deescalate. If you have the information to treat the acute issues, then that is fine. Acknowledge your intent to provide supportive care, and that you will return (and then do return) the goal of care as to support pt and help with their needs.
  - Make sure you do it in a clear way to respect both of your comfort levels
- Wonderful cup throw by Susannah!
- Important to address OUD and pain; patients with OUD may need higher doses of pain meds
- Case raises questions about our tolerance for certain challenging behaviors. How do we interact if behaviors feel inappropriate/unsafe?
  - General approach may be to communicate the importance of patient safety and staff safety generally
    - Depends on severity of situation and specific behavior. What was the intent? What other factors are at play (e.g intoxication, acute withdrawal, mental health crises, acute stress, past negative experiences in hospital or with healthcare/ authority; racism). Doing best to support and honor patients, setting clear boundaries around safety when needed, giving patients choices when you can.
  - Importance of reliability, accountability – doing what you say you are going to do (part of trauma informed care)

Scene 3: Repair

Discussion highlighted:

- Hospitalist will promise what is within her control— make sure orders are right and communicates with nursing staff and night shift doc for appropriate pain meds available.
- Goal to create space where repair, partnership can happen
    - Often patients apologize
    - Irritability is a symptom of withdrawal. People can feel a lot of remorse and relief if there is a repair there.
- Ask patient to use respectful language to best be heard by care team.

Additional thoughts & reflections:

- Peer recovery mentor own reflection on her experience as a patient in a similar scenario:
    - Make sure the patient feels like they are a person.
    - Taking the time and engaging directly with effective communication can help a patient feel heard
        - In peers own words: "I felt like I was already judging myself before them coming in. I would project my own insecurities on myself on whomever walked into the room. I was combative in this. All the aggressive behavior was out of defense— ashamed I was in the position, hurt, afraid, and actually in pain! All these would snap me."
        - "It took someone coming down, physically to my level, made hand contact, and tried to communicate effectively and directly."
        - "As soon as I felt heard, I was able to try and work with that team. It is hard to navigate the hospital as someone in that position."
- Providers often feel the need to take control if things are escalating. It is important to have safe boundaries; AND, the need to exert control can escalate, so relinquish it when you can (with clear boundaries about what you can't).
    - Patients feel it when staff is afraid of them or trying to control them, and this can be triggering
    - Whether or not it is acceptable to search pt belongings is a whole can of worms we are currently in the thick of.
        - It's often less about if she has drugs on her person, and more about how to manage if there's verbal or abusive issues with staff. Make sure there aren't needles around (sharps box in room)
- Avoid judging the patient for not wanting to talk about use
    - Most people not coming to the hospital looking for SUD treatment.
    - There is a very good reason why someone might not trust us! Many have had bad experiences in hospitals/ healthcare/ institutions.