

The Art of Tough Conversations

Communication as a clinical competency — not a personality trait

🕒 Listen time: ~55 minutes • 👥 Audience: RNs, APRNs, nurse leaders, nursing faculty • 🎧 elitelearning.com/ce-podcasts

🎙️ Featured Voices

HOST	GUEST
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📖 What You'll Learn

- Why communication is a learned clinical competency — not a personality trait — and how to develop it like any other skill
- How to respond when a patient asks 'Am I dying?' or 'How much time do I have?' — without having all the answers
- How to reframe hope during serious illness conversations without giving false reassurance
- Practical strategies for managing denial, anger, and family conflict at the bedside
- The difference between primary palliative care (every nurse's responsibility) and specialty palliative care
- Three communication habits nurses can start using immediately: pause, listen, and close the loop
- How to protect your own emotional wellbeing after difficult conversations — and why self-care is a professional skill

💡 Key Takeaways

- **Communication is a competency, not a personality trait:** Nurses are not born knowing how to have difficult conversations — and that's the point. Like starting an IV, this is a skill that must be taught, practiced, and regularly reinforced. Framing it as a competency removes the shame and opens the door to improvement.
- **You don't have to have all the answers — you have to be present:** When a patient asks 'Am I dying?', the most powerful response is not a clinical answer. It is sitting down, making eye contact, and taking the time to truly hear what is behind the question. Presence communicates more than any perfect script.

- **Hope can be reframed, not removed:** Honest conversations do not take away hope — they reset what hope looks like. A patient who hoped to live 20 more years may find new meaning in hoping to see a grandchild graduate. Eliciting what matters most is how nurses help patients find that new anchor.
- **Denial means 'we have more work to do':** When a patient or family appears to be in denial, the clinical instinct is to fix it. The better frame: they are just not there yet. Most families do get there — on their own timeline, not ours. Persistence and patience are the tools, not frustration.
- **Anger is not personal — and it has an endpoint:** When families lash out, it is almost never about the nurse. It is fear, grief, and loss of control finding an outlet. Stay calm, slow your pace, remove distractions, and ask: 'What do you need from me right now?' Set respectful limits if safety becomes a concern.
- **Primary palliative care belongs to every nurse:** Specialty palliative care teams exist for the most complex cases — but every nurse should be able to have basic conversations about what matters to a patient, what they understand about their illness, and what their goals are. Waiting for a specialist to have these conversations is a missed opportunity.
- **Simulation is the safest place to build this skill:** Some of the strongest evidence in simulation research is around communication — not just clinical procedures. Annual team simulations focused on difficult conversations build comfort, clarify roles, and reveal who on the team communicates best (often the chaplain).
- **Three habits to start today — pause, listen, close the loop:** Pause and sit down when a hard question is asked. Listen to understand what is really being asked before responding. Close the loop by summarizing what you heard and naming the next steps. These three moves, done consistently, transform the quality of every difficult conversation.
- **Nurses need outlets too:** Difficult conversations take a toll. Recognizing that — and knowing what self-care looks like for you specifically — is not optional. Whether it is a team debrief, a run, or a quiet moment, practitioners who care for themselves stay in practice longer and show up more fully for patients.
- **Body language and silence are clinical tools:** In a generation that has grown up communicating through screens, eye contact, intentional silence, and open body language are skills that must be actively taught and practiced. Sitting down, looking up from the computer, and pausing before responding are not soft skills — they are clinical ones.

Do This Next

- ☐ **The next time a patient or family asks a hard question, practice the pause:** sit down, make eye contact, and take a breath before responding. Notice what changes.
- ☐ **Audit your own communication habits:** Are you holding your computer or chart during difficult conversations? Try stepping away from it entirely for the next one.
- ☐ **Practice the three-step framework:** pause → listen to clarify → close the loop. Use it in your next patient interaction, even a routine one.
- ☐ **Ask your unit or practice:** 'When did we last do a simulation focused on difficult conversations?' If the answer is 'never' or 'I don't know,' bring it to your nurse manager.
- ☐ **Search 'serious illness communication' + your specialty area on PubMed or Google:** Evidence-based frameworks exist for oncology, heart failure, pediatrics, and more — and most are free.
- ☐ **Identify your self-care outlet after difficult conversations:** Name it specifically. A team debrief? A walk? A call to a colleague? Having a plan before you need it makes it more likely you'll use it.
- ☐ **Reflect on a recent conversation where a patient or family seemed 'in denial':** Reframe it — what would it look like to approach that family with 'we have more work to do' instead of frustration?

? 3 Quick Reflection Questions

Use these to reflect individually — or to open a team conversation about communication culture in your practice setting:

- 1. Competency check:** "Think about the last difficult conversation you had with a patient or family. Did you feel prepared — or did you feel like you were improvising? What specific skill would have made that conversation go better?"
- 2. Hope and honesty:** "Have you ever avoided a difficult conversation because you were afraid of taking away hope? What would it look like to reframe that conversation as resetting hope rather than removing it?"
- 3. Team culture:** "Does your unit or practice treat difficult conversations as a shared team competency — or as something individual nurses are expected to figure out on their own? What would change if you practiced these conversations together annually?"

► Red Flags & Cautions

- **A nurse avoids a patient's direct question about dying or prognosis** — leaving the patient without acknowledgment, support, or a plan for follow-up.
- **A team frames a family's denial as a failure or a personal affront** — rather than recognizing it as a signal that more time, patience, and communication are needed.
- **Difficult conversations are treated as one-and-done events** — rather than as an ongoing series of interactions that build understanding over time.
- **A nurse or unit has never practiced difficult conversations through simulation or structured team training** — leaving staff to improvise in the highest-stakes moments of a patient's life.
- **A practitioner has no identified outlet or self-care strategy after emotionally demanding conversations** — increasing the risk of burnout, compassion fatigue, and disengagement from patients.

📖 Clinical Spotlight

- ★ **The LVAD Destination Therapy Scenario:** Dr. Kitko describes a defining case from her early career: patients with advanced heart failure deciding whether to accept a left ventricular assist device (LVAD) as destination therapy — meaning they would live and die with the device. The team learned that presenting it as 'this can help you live longer' was not enough. They developed a structured, multi-conversation approach that included zooming in extended family members to ensure everyone understood the patient's wishes before a crisis. When the terminal admission came, families were prepared — and could be present and at peace.
- ★ **Health Literacy Is Not a Safe Assumption:** Dr. Kitko emphasizes that nurses cannot assume patients and families understand their diagnosis, prognosis, or care plan. Before continuing any difficult conversation, assess what the patient actually understands — not what you think was communicated. Incongruence between what is said and what is heard is one of the most common drivers of prolonged denial and family conflict.

- ★ **Simulation Evidence for Communication:** Some of the strongest evidence in simulation research is not about clinical procedures — it is about communication. Structured simulation scenarios focused on difficult conversations help teams clarify roles, build comfort, and identify who communicates most effectively (often, Dr. Kitko notes, it is the chaplain). Annual team-based communication simulations are a high-value, low-cost competency investment.
- ★ **AI and the Return to Human Connection:** Dr. Kitko notes that one of the most promising benefits of AI in healthcare — ambient listening and documentation support — may actually free nurses to do what they do best: communicate. If AI handles the charting burden, nurses can look up from the screen and be fully present with patients and families.

Conversation Starter

 *"Think about the last time a patient or family member asked you a question you didn't know how to answer. What did you do? What would you do differently now — and what does that tell you about where you are in developing this competency?"*

Nurse Leaders & Educators: Consider hosting a team or faculty conversation around: "When did we last practice difficult conversations as a team? What would it look like to make communication simulation a regular part of our annual competency calendar?"

Resources & Links

- Serious Illness Conversation Guide (Ariadne Labs): ariadnelabs.org
- PubMed search: 'serious illness communication nursing'
- Hospice & Palliative Nurses Association: advancingexpertcare.org
- University of Rochester School of Nursing: son.rochester.edu
- Episode page: elitelearning.com/ce-podcasts
- Apple Podcasts • Spotify
- CE courses: EliteLearning.com
- YouTube • EliteLearning.com

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