Raising the Bar on Clinical Communication in Medicine

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Kurtz S, Silverman J, Draper J (2005) *Teaching and Learning Communication Skills in Medicine, 2nd Ed.* Radcliffe Publ: Oxford & San Francisco

Silverman J, Kurtz S, Draper J (2005) *Skills for Communicating with Patients, 2nd Ed*. Radcliffe Publ: Oxford & San Francisco

Kurtz S, Silverman J, Benson J, Draper J (2003) Marrying content and process in clinical method teaching: Enhancing the Calgary-Cambridge guides. *Academic Medicine.* **78**(8): 802-809

TEACH/LEARN COMMUNICATION SKILLS?

AARRGGHH!!!

Look who's endorsing communication teaching and learning now

Royal College of Physicians and Surgeons of Canada

College of Family Physicians of Canada

Association of American Medical Colleges

American Board of Pediatrics

World Federation for Medical Education

Commission for Grads of Foreign Medical Colleges

Licensing bodies

Accreditation boards

Who's endorsing conti

Funding agencies & Pharmaceutical companies
Health Insurers
Patient advocacy groups
Researchers

Medical educators
Learners at all levels of medical education
Health care providers

And many more internationally!

COMPONENTS OF CLINICAL COMPETENCE

- Knowledge base
- Diagnostic skills, problem solving
- Physical examination skills
- Communication skills

What happened?

Evidence Based Rationale

- Enhancing communication leads to better outcomes:
  - ↑ understanding & recall
  - ↑ adherence
  - ↑ symptom relief
  - ↑ physiological outcomes
  - ↑ patient safety
  - ↑ patient satisfaction
  - ↑ doctor satisfaction

  - ↓ costs
  - ↓ complaints and malpractice litigation

Evidence-based Rationale

- Enhancing communication leads to more effective consultations for Dr & patient:
  - Accuracy
  - Efficiency
  - Supportiveness
  - Relationships characterized by partnership
- Improving communication leads to better coordination of care (within practice team, with patient/pt's family, etc)

Global Phenomenon

- Responding to these developments clinicians around the globe express enthusiasm for:
  - Enhancing their own communication skills
  - Enhancing their ability to teach those skills

PURPOSE

To offer medical practitioners and educators a practical, evidence-based conceptual framework for enhancing communication in medicine

3-Part Framework:

- Underlying assumptions
- Contexts, goals, paradigms,1st principles
- One approach for delineating specific skills that make a difference to outcomes of care

To begin…

- Revisiting how we think about communication, because the way we think has a significant impact on what we do

1st Common Assumption

- Communication is a “soft” social skill, an optional add-on extra with no scientific backing
  - *“Hey, I don’t need communication training – I learned to talk years ago…”*

Common assumptions

Myth 1: Communication is an optional add-on, an extra and anyway there's no science behind it

- Communication is a core clinical skill and there's considerable science behind it

2nd Common Assumption

- Communication is a personality trait, either you have it or you don't

Common assumptions

Myth 2: Communication is a personality trait, either you have it or you don't

- Communication is a series of learned skills
  - Not a personality trait
  - Anyone can learn who wants to

For the Doubters:
A Review that quality graded 180 articles

Internal reliability

Precision

External Validity

Only high to medium quality studies included in analysis

81 studies qualified:

- 31 randomized trials
- 38 open effect studies
- 12 descriptive studies

Aspegren, 1999

Results of the Lit Review

- Overwhelming evidence for positive effect of communication skills training
- Only 1 of 81 studies didn't report positive effects
- Med students, residents, junior drs, senior drs all improved
- Specialists as likely to benefit as primary care drs

Aspegren, 1999

3rd Common Assumption

- Experience is an effective teacher of communication skills
  - *“All I need is a little more practice...”*
  - *“I’ll get this later, on my own…”*

Common assumptions

MYTH 3: Experience is an effective teacher of communication skills

- Experience alone tends to be a poor teacher of communication skills
  - It is a great reinforcer of habit - just doesn't discern well between good and bad habits

TAUGHT SKILL RETENTION VS DEVELOPMENT WITH EXPERIENCE ALONE

- Doctors 5 years out of medical school still strong in information gathering (taught) but weak in explanation and planning skills (experience only)
  - discovering pt's views/expectations - 70% no attempt
  - encouraging questions - 70% no attempt
  - repetition of advice - 63% no attempt
  - checking understanding - 89% no attempt
  - categorizing information - 90% no attempt

Maguire et al 1986

Self perception can be inaccurate

- Drs. interrupt patients within
  - 18 seconds (Beckman & Frankel 1984)
  - 23 seconds (Marvel et al 1999)
  - 12 seconds (Rhoads et al 2001)
- Actual time patients take to tell story
  - Primary care: Up to 150 seconds, most < 60 secs (Beckman & Frankel 1984)
  - Tertiary care: Mean time 92 seconds, 78% within 2 min (Langewitz et al, 2002)

Problems with Self Perception conti

- Doctors overestimate time spent on patient education by up to 900%

  (Waitzkin 1984)

- Picking up and responding to patient cues *shortens* rather than lengthens interviews

  (Levinson et al 2000)

Does patient centered care take more time?

- 7.8 min = average consultation for Drs who don't use patient centered skills
- 8.5 min = average consultation for Drs who have mastered patient centered skills
- 10.9 min = average consultation for Drs who are learning patient centered skills

Stewart 1985

Missed Opportunities for Empathy

- Analysis of 20 transcribed audio-recorded consultations
- 384 opportunities for empathy
- Physicians responded empathically to 39 of them (otherwise provided little emotional support)
- 50% of these occurred in last 1/3 of interview despite even distribution of opportunity throughout interview

Morse et al 2008

3-Part Framework

- Underlying assumptions
- Historical contexts, goals, shifting paradigms, 1st principles
- Skills that make a difference

Approaches to Communication

- Shot-Put Approach
  - well-conceived, well-delivered message is all that matters
  - emphasis on telling, feedback not in picture
- Frisbee Approach
  - 2 central concepts
    - confirmation = to recognize, acknowledge or endorse another
    - mutually understood common ground
  - emphasis on interaction, feedback, relationship

Goals of Communication

- Ensuring increased:
  - Accuracy
  - Efficiency
  - Supportiveness
- Enhancing satisfaction for everyone
- Improving outcomes
- Collaboration and partnership

Forging a relationship is CENTRAL to the success of every encounter, whatever the context, however short or long the relationship

Paradigm Progression

- Doctor centered care
- Patient centered care
- Relationship centered care

Same paradigm progression pertains to education

Relationship-Centered Care

- *….the privileges of the healer are founded on meaningful relationships in health care, not just technically appropriate transactions.*

Beach and Inui, 2005

Comparative study of 9 urban hospitals

- Some invested heavily in hiring and training for *relational competence*
- Others looked for highly qualified individuals
- Significant differences were found between hospitals regarding levels of coordination among care providers

Hoffer Gittel J 2003, Hoffer-Gittel et al 2000

9 hospital comparative study conti

- Higher coordination between care providers significantly improved patient care
- Eg, increase in relational coordination enabled:
  - 31% reduction in length of stay
  - 22% increase in perceived quality of care
  - 7% increase in post-op freedom from pain
  - 5% increase in post-op mobility

9 hospital comparative study conti

Conclusions

- "…those in positions that require high levels of functional expertise also tend to need high levels of relational competence to integrate their work with others."

- "It's not just individual brilliance that matters anymore. It's coordinated effort"

Hoffer-Gittel et al 2000

1st Principles of Effective Communication

- Ensures interaction not just transmission
- Reduces unnecessary uncertainty
- Requires planning, thinking in terms of outcomes
- Demonstrates dynamism (engagement, flexibility, responsiveness)
- Follows helical vs linear modeling

Same principles apply to effective teaching & learning

3-Part Framework

- Underlying assumptions
- Historical contexts, goals, shifting paradigms, 1st principles
- Skills that make a difference

WHAT IT TAKES TO LEARN COMMUNICATION

- Knowledge of skills is important – but does not translate directly into performance
- Essentials needed to learn skills, change:
  - Systematic, evidence-based delineation & definition of skills
  - observation of learners with patients (video)
  - well-intentioned, detailed, descriptive feedback
  - practice and rehearsal of skills
  - planned reiteration/review and deepening of skills

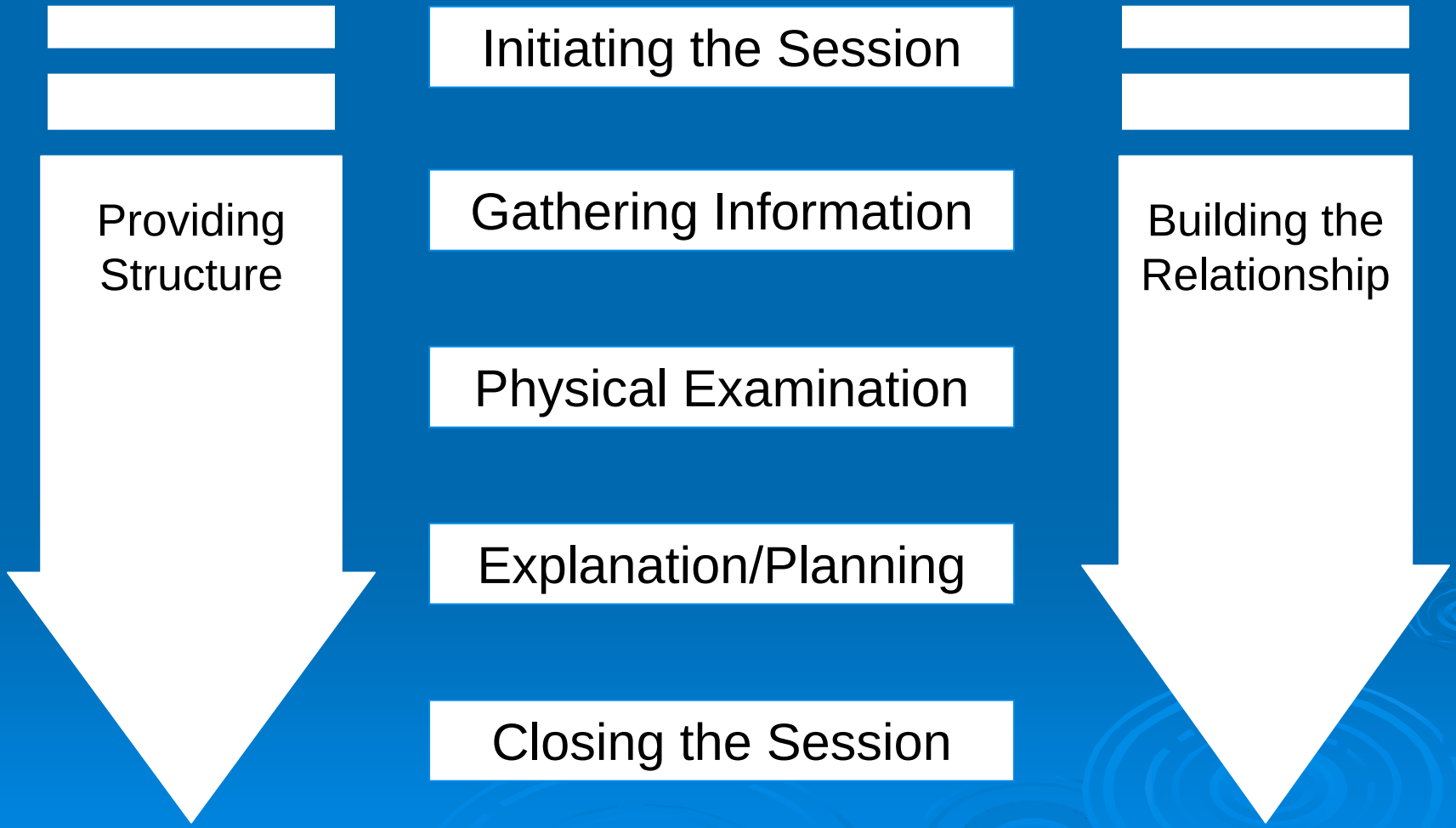
Small group or one-to-one teaching format

What communication skills are important?

TYPES OF COMMUNICATION SKILLS

- *Content skills* - what you say
- *Process skills* - how you communicate
  - how you structure interaction
  - how you relate to patients
  - nonverbal skills/behavior
- *Perceptual skills* - what you are thinking & feeling
  - clinical reasoning
  - attitudes, biases, assumptions, intentions
  - emotions
  - Capacities: compassion, mindfulness, integrity, respect,etc)

CALGARY-CAMBRIDGE GUIDES FRAMEWORK FOR THE MEDICAL CONSULTATION



Kurtz, Silverman, Draper (2005)

Calgary-Cambridge Guides Communication Process Skills

- 56 process skills organized around framework (plus 15 process & content skills: *Options in Expl & Pl* section)
- 30+ years in the making so far
  - Used in all medical specialties
  - Used across contexts and disciplines
  - Used from year 1 through advanced CME
  - Used across cultures; translated into over many languages

ADVANTAGES OF C-C GUIDES

- Accessible summary of skills and of the research evidence (3rd lit review in progress)
- Memory aid to keep skills in mind, organized
- Guidance with considerable latitude
- Framework for systematic skill development

- Common foundation for programs at all levels
- Basis for comprehensive feedback (no hit and miss)
- Core content for faculty training, creating consistency across preceptors

2 ESSENTIAL CONTEXTS FOR COMMUNICATION TEACHING

- Formal curriculum
  - Dedicated communication sessions, modules
- Informal curriculum
  - In-the-moment' teaching (follow-through in clinic, hospital, and other real world contexts)
  - Modelling (intentional and unintentional)
  - 'Hidden' curriculum of how students are treated and see us treating others

WHAT ARE WE MODELLING?

- How we use communication skills and relational competencies with patients
- How we treat the learners themselves
- How we interact with other professionals and support staff
- What we choose to focus on and discuss with learners during rounds & in clinical settings

Examples of Postgraduate Modeling to Advantage

- During surgical rounds senior surgeon asked for 2 additional pieces of information after learner's presentation of patient:
  - *'What questions will this patient want me to answer?'*
  - *'What concerns does this patient have that I need to address?'*
- When a consultation was not going well, a senior oncology surgeon read through the C-C pocket guide to review what he might have missed re communication skill

More Examples of Modeling to Advantage

- Endocrinologist focused attention on what he wanted junior doctors to emulate
  - Asked questions about communication just as he did about PE or medical problem solving or medical technical knowledge
  - Reflected out loud on what he was doing often
  - Talked about his own errors or mistakes and how he handled them
- Nephrologist invited junior doctors to observe him (live and on video) and give him feedback on his communication skills with a patient
- Director of Orthopaedic Surgery did the same

More Examples

- Director of Anesthesiology Residency Program developed a version of the Calgary-Cambridge Guides for pre-op interaction with patients and included it in the daily faculty evaluation protocol for residents; as a result, she saw changes in both faculty and residents

- Family medicine doctor initiated monthly ‘communication rounds’ for cross specialty training

OVERALL GOAL

- Improving communication *in practice* to a *professional* level of competence

  - Behavior = what we do anyway

    vs

  - Professional competence =

    ↑awareness & attention

    ↑intentionality

    ↑ability to reflect on & articulate

    and it's evidence based

WE KNOW THERE ARE PERSISTENT PROBLEMS WITH PATIENT ADHERENCE

Patients do not adhere to medication plans: on average 50% do not take their meds at all or take them incorrectly (Meichenbaum and Turk 1987, Butler et al 1996)

The cost of nonadherence is enormous:

In Canada $5 billion yearly on wasted meds, further related costs of 7 to 9 billion, eg, extra visits to doctors, lab tests, additional meds, hospital and nursing home admissions, lost productivity, premature death (Coambs et al 1995)

RELATED PROBLEMS
eg, RECALL & UNDERSTANDING

There are significant problems with patients' recall and understanding of the information that doctors impart (Tuckett et al 1985, Dunn et al 1993)

Physicians give sparse information to their patients, with most patients wanting their doctors to provide more information than they do (Waitzkin 1984, Pinder 1990, Beisecker and Beisecker 1990, Jenkins et al 2001, Richard and Lussier 2003)

Doctors consistently use jargon that patients do not understand (Svarstad 1974, Hadlow and Pitts 1991)

Doctors overestimate the time they give to explanation and planning by up to 900% (Waitzkin et al 1984, Makoul et al 1995)

WE KNOW THAT IMPROVING SPECIFIC COMMUNICATION SKILLS IMPROVES ADHERENCE AND HEALTH OUTCOMES

RECALL AND UNDERSTANDING

Asking patients to repeat in their own words what they understand of the information they have just been given increases their retention of that information by 30% (Bertakis 1977)

Patient recall is increased by categorisation, signposting, summarising, repetition, clarity and use of diagrams (Ley 1988)

There is decreased understanding of information given if the patient´s and doctor´s explanatory frameworks are at odds and if this is not discovered and addressed during the interview (Tuckett et al 1985)

ADHERENCE AND OUTCOMES

Patients who are viewed as partners, informed of treatment rationales and helped in understanding their disease are more adherent to plans made (Schulman 1979)

Doctors can increase adherence to treatment regimens by explicitly asking patients about knowledge, beliefs, concerns and attitudes to their own illness (Inui et al 1976, Maiman et al 1988)

Discovering patients' expectations leads to greater patient adherence to plans made whether or not those expectations are met by the doctor (Eisenthal and Lazare 1976, Eisenthal et al 1990)

ADHERENCE AND OUTCOMES (CONTI)

Giving pts opportunity to discuss their concerns rather than simply answer closed questions leads to better control of hypertension (Orth et al 1987)

Patients coached in asking questions of and negotiating with their doctor not only obtain more information but actually have better BP control in hypertension and better blood sugar control in diabetes (Kaplan et al 1989, Rost et al 1991)

In a 2 hour tutorial, doctors working with hypertensive patients were taught to focus more on considering their patient's ideas and on patient education. Their patients understanding of their condition improved, compliance increased, and hypertension control remained better 6 months after the tutorial (Inui 1976)

ADHERENCE AND OUTCOMES (CONTI)

When the dr-pt relationship is a negotiated process, in which there is increased understanding of and agreement upon a proposed treatment, higher levels of compliance and improved health can be achieved (Coambs et al, 1995)

Consultations using a structured exploration of patients' beliefs about their illness and medication and specifically addressing understanding, acceptance, level of personal control and motivation leads to improved clinical control or medication use even three months after the intervention ceased (Dowell et al 2002)

SYMPTOMS

- Resolution of symptoms of chronic headache is more related to the patient´s feeling that they were able to discuss their headache and problems fully at the initial visit with their doctor than to diagnosis, investigation, prescription of referral (The Headache Study Group 1986)
- A decreased need or analgysia after myocardial infarction is related to information giving and discussion with the patient (Mumford et al 1982)

Definition conti

- RCC recognizes that communication takes places within organizational contexts and is influenced by organizational or practice policies and processes and by how people within the organization or practice treat each other

Suchman 2001

COMPARATIVE STUDY OF 9 URBAN HOSPITALS RE JOINT REPLACEMENT SURGERY

- Some invested heavily in hiring and training for relational competence (ie, ability to interact with others to accomplish goals)
- Others looked for most highly qualified individuals (neglect of relational competence most pronounced in physician hiring)

- Significant differences were found between hospitals re levels of coordination among care providers

Hoffer Gittel J 2003, Hoffer-Gittel et al 2000

9 HOSPITAL COMPARATIVE STUDY (CONT)

- Higher coordination between care providers significantly improved patient care.
- Eg, increase in coordination enabled:
  - 31% reduction in length of stay
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  - 7% increase in postoperative freedom from pain
  - 5% increase in postoperative mobility

Hoffer Gittel 2003, Hoffer-Gittel et al, 2000

9 HOSPITAL COMPARATIVE STUDY CONT

Conclusion:

"…those in positions that require high levels of functional expertise also tend to need high levels of relational competence to integrate their work with others."

Hoffer-Gittel et al 2000

"It's not just individual brilliance that matters anymore. It's coordinated effort."

Participant in Hoffer-Gittel et al 2000 study

RESEARCH FINDINGS (conti)

- The medical perspective and patient's perspective are different - they require different management
- Including patient perspective improves care
- Patients who are *active* partners have better outcomes

Relationship-centered care (partnership) makes sense

YES, BUT…

Can you teach/learn communication skills?

FOR THE DOUBTERS

Aspegren K (1999) Teaching and Learning Communication Skills in Medicine: A review with Quality Grading of Articles. Medical Teacher 21(6)

DEFINITIONS OF RCC cont

...the social role and privileges of the healer seem to be founded on meaningful *relationships* in health care, not just technically appropriate transactions within these relationships.

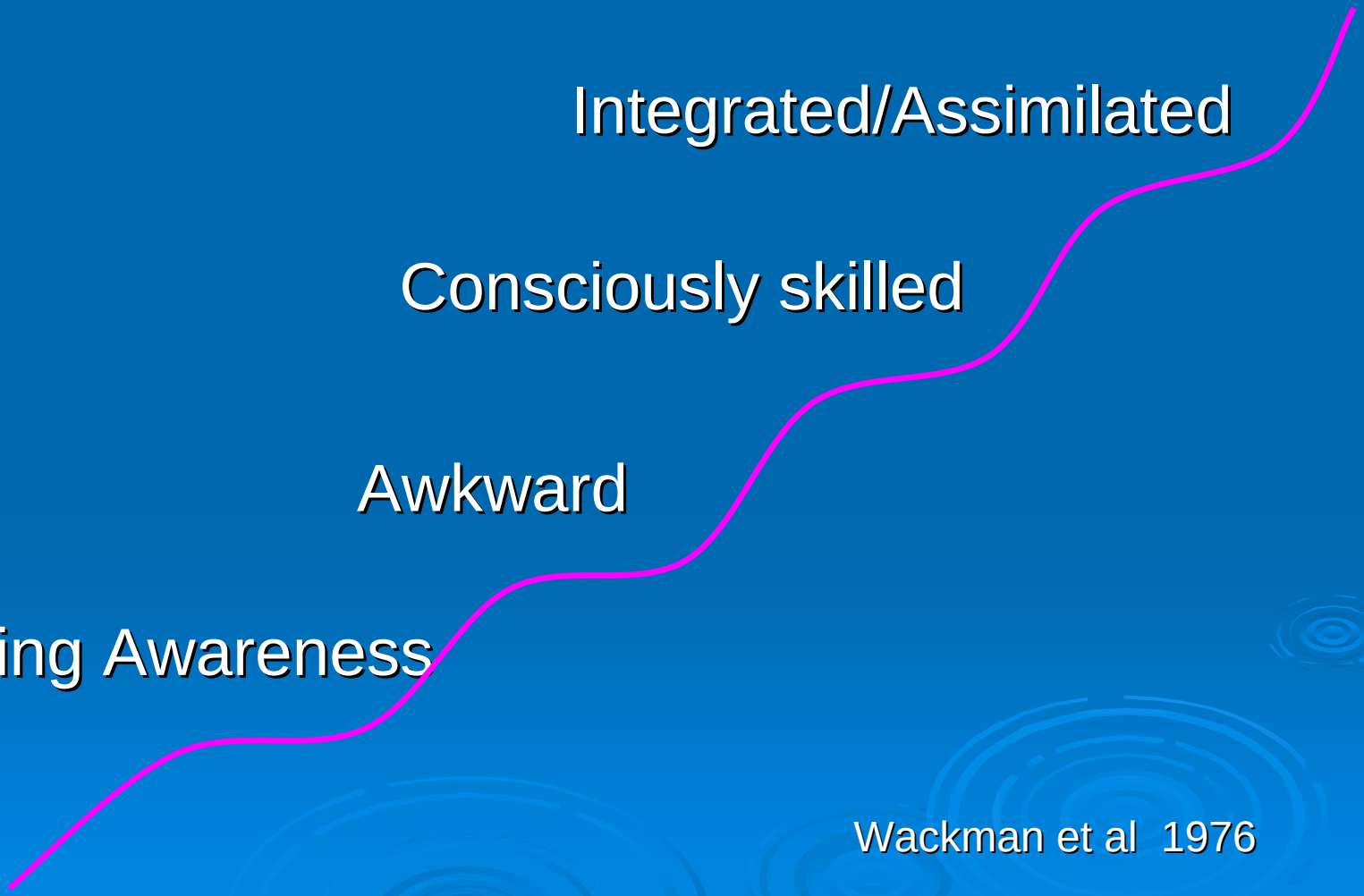
Beach & Inui with The Relationship-Centered Care Research Network. Relationship-Centered Care: A Constructive Reframing. 2005

COMMUNICATION SKILLS TEACHING & LEARNING IS DIFFERENT

- Closely bound to self concept, self esteem, personality
- More complex than simpler procedural skills
- No achievement ceiling
- Don’t start from scratch

- Faculty with limited formal communication training

STAGES IN SKILLS LEARNING/CHANGE
helical process, not linear progression



Wackman et al 1976

WHAT IT TAKES TO LEARN COMMUNICATION

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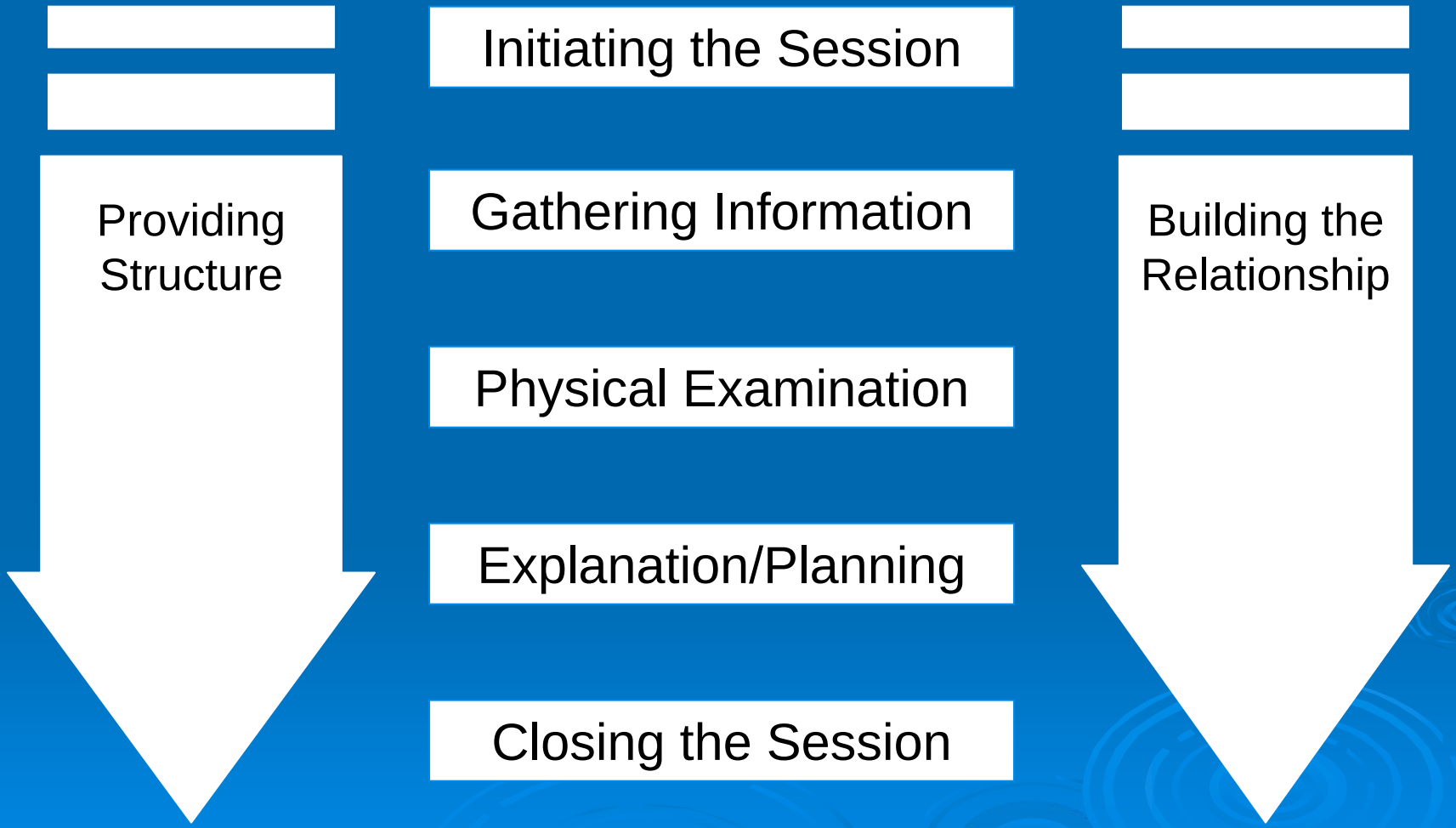
  - observation of learners with clients (video)
  - well-intentioned, detailed, descriptive feedback
  - practice and rehearsal of skills
  - planned reiteration and deepening of skills
  - evaluation of skills

What communication skills are important?

CALGARY-CAMBRIDGE GUIDES FRAMEWORK FOR THE MEDICAL CONSULTATION



Kurtz, Silverman, Draper (2005)

Initiating the Session

preparation
establishing initial rapport
identifying the reason(s) for the consultation

Gathering information

exploration of the patientÕs problems to discover the:

- biomedical perspective
- the patientÕs perspective
- background information- context

Physical examination

Explanation and planning

providing the correct amount and type of information
aiding accurate recall and understanding
achieving a shared understanding: incorporating the patientÕs illness framework
planning: shared decision making

Closing the Session

ensuring appropriate point of closure
forward planning

Providing Structure

making organisation overt

attending to flow

Building the relationship

using appropriate non-verbal behaviour

developing rapport

involving the patient

ADVANTAGES OF GUIDES

- Accessible summary of skills - validated
- Framework for systematic skill development
- Memory aid to keep skills in mind, organized
- Guidance with considerable latitude

SAME PROCESS SKILLS NEEDED FOR ALL THESE COMMUNICATION ISSUES

- Cultural & socioeconomic differences
- Explaining risk & benefits
- Special needs clients (elderly, young, challenged, low literacy)
- Prevention, health promotion
- Giving bad news, death and dying
- Gender differences
- Ethics

WHY ARE COMMUNICATION PROCESS SKILLS SO ADAPTABLE?

Context changes

Content changes

Levels of intensity, intention, & awareness shift

BUT

Communication process skills remain the same

2 ESSENTIAL CONTEXTS FOR COMMUNICATION TEACHING

- Formal curriculum
  - Dedicated communication sessions, modules
- Informal curriculum
  - In-the-moment' teaching (follow-through in clinic, hospital, and other real world contexts)
  - Modelling (intentional and unintentional)
  - 'Hidden' curriculum of how students are treated and see us treating others

INFORMAL CURRICULUM PROVIDES FOLLOW THROUGH IN REAL LIFE (or not)

- To reinforce and deepen previous learning
- To validate applicability in the ‘real world’
- To learn new skills
- To learn to apply skills & capacities in increasingly complex situations
- To move toward professional level of competence

Evidence-based Rationale Patient-Centered Care

- The medical perspective and patient's perspective are different - they require different management
- Including patient perspective improves care
- Patients who are *active* partners have better outcomes

Yes, but is this practical? The question of time…

Also depends on how you view time

- Patient-centered communication is associated with:
  - Better recovery from discomfort and concern
  - Better emotional health 2 months later
  - Fewer diagnostic tests
  - Fewer referrals
  - Fewer return visits

If learners are going to integrate and propagate patterns of relating that they experience in medical training, then it is incumbent upon each of us (as faculty, fellows, or junior doctors) to become more mindful of our own behavior - to become more explicitly aware of and intentional about the values and skills we enact in our day-to-day work… In other words, to help our learners learn and change their behavior, we must commit ourselves to our own continuous learning and behavior change.

Suchman & Williamson 2003

Definition conti

- Four sets of relationships are foundational in health care and healing:
  - Clinician with patient, client, significant others
  - Clinician with other care givers (colleagues, team)
  - Clinician with community (practice, hospital, town)
  - Clinician with self (thought processes; emotional intelligence; intentions, biases, beliefs, values; attitudes and capacities; self concept)

Adapted from Beach & Inui & the Relationship Centered Care Research Network, 2005