Raising the Bar
on Clinical Communication in Medicine

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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
2\textsuperscript{nd} 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

A Barbour 2000
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
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
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

- Initiating the Session
- Gathering Information
- Physical Examination
- Explanation/Planning
- Closing the Session

Providing Structure

Building the Relationship

Kurtz, Silverman, Draper (2005)
56 process skills organized around framework
(plus 15 process & content skills: Options in Expl & PI 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)
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).
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)
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)
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
Higher coordination between care providers significantly improved patient care.

Eg, increase in coordination enabled:
- 31% reduction in length of stay
- 22% increase in quality of service pts perceived
- 7% increase in postoperative freedom from pain
- 5% increase in postoperative mobility

Hoffer Gittel 2003, Hoffer-Gittel et al, 2000
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

...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

Integrated/Assimilated
Consciously skilled
Awkward
Beginning Awareness

Wackman et al 1976
WHAT IT TAKES TO LEARN COMMUNICATION

- Knowledge of skills – but does not translate directly into performance
- Essentials needed to learn skills, change:
  - systematic delineation & definition of skills
  - 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

Initiating the Session
Gathering Information
Physical Examination
Explanation/Planning
Closing the Session

Providing Structure
Building the Relationship

Kurtz, Silverman, Draper (2005)
Providing Structure
making organisation overt
attending to flow

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

Gathering information
exploration of the patient's problems to discover the:
- biomedical perspective
- the patient's 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 patient's illness framework
planning: shared decision making

Closing the Session
ensuring appropriate point of closure
forward planning

Building the relationship
using appropriate non-verbal behaviour
developing rapport
involving the patient

Exploration of the patient's problems to discover the:
- biomedical perspective
- the patient's perspective
- background information - context
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
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