II

Talking Tools

Putting Communication Skills to Work

Resource Booklet

A Three-Hour Interactive Course for Practising Physicians

Health Canada Santé Canada

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Foreword

Interest in effective patient-physician communication has grown enormously since the Canadian Breast Cancer Initiative (CBCI) published *Talking Tools I — Better Physician-Patient Communication for Better Patient Outcomes* in 1998. In fact, practising physicians, medical schools and patients across Canada are becoming more focused in their efforts to improve patient-physician relationships, and to adopt patient-centred practices.

Talking Tools II — Putting Communication Skills to Work represents a major step in the work of the Professional Education Committee of the CBCI, and in the development of the field of communication training and education for practising physicians. *Talking Tools II* includes two core elements: a ***Resource Booklet***, which presents evidence of the benefits of good communication as well as a detailed discussion of a dozen specific communication skills and how they may be used; and a ***Course Book***, which provides all the information and materials needed to run two separate, three-hour courses, each focusing on different communication skill sets. By providing a "hands-on" learning experience for practising physicians, *Talking Tools II* builds on the awareness-raising focus of *Talking Tools I*.

It is important to note that the development of the *Talking Tools* resources reflects the goal of the Professional Education Strategy, which is to provide physicians with a variety of resources on communication skills and techniques. By working together, we can ensure that physicians across Canada have the communication tools they need to do their job.

Sincere thanks to all members of the Curriculum Working Group. Your recognition of the importance of physician-patient communication issues is reflected in the many hours devoted to developing and reviewing *Talking Tools II*. Special thanks to both Suzanne Inhaber and Dr. Jean Parboosingh of Health Canada for their commitment and hard work in support of this project. I would also like to thank Allium Consulting Group Inc. (Ottawa) for writing and designing *Talking Tools II*.

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Introduction

The medical interview is the most important clinical tool that physicians have at their disposal. Yet, up until recently, the medical profession has largely ignored the substantial impact of communication techniques and approaches on clinical outcomes, patient and physician satisfaction levels, and medical costs.

One of the major barriers to acceptance among physicians has been the belief that communication skills are innate — "you either have them, or you don't." However, a growing body of research has demonstrated that not only is physician-patient communication a core clinical skill, but also that these skills can be taught, learned and retained.

This resource booklet explores the "whys" and "hows" of improving physician communication skills. Intended to be used by physicians as a stand-alone resource, but preferably as part of a facilitated training program, the booklet includes:

- an overview of research supporting the effects of good patient-physician communication on patient outcomes and satisfaction, and on physician satisfaction;
- an overview of two conceptual frameworks for patient-physician communication;
- a "working" explanation of 12 key communication skills;
- a review of four "skill sets" which can be used by physicians to move successfully through the main stages of an interview — including a summary of relevant research, some tips for putting the skill sets into practice and case study examples of how physicians can use them for better clinical results; and
- some suggestions for how physicians can monitor and assess their progress in putting effective communication techniques to work.

1

The Evidence

A substantial body of research supports the view that communication is an essential clinical skill and that the patient-physician interview is one of the most powerful tools available to physicians. The sheer volume of consultations physicians undertake in a professional lifetime (some 200,000) underscores the importance of "getting it right."

There are currently more than 7,500 articles on physician-patient communication listed in the Index Medicus and the Social Science Citation Index. Not only has the "quantity" of research increased in recent years, quality has improved, as well. The use of more sophisticated research designs and the development of audio, film and video technology has enhanced the credibility of communication research.

Overall, research and practice in the area of physician-patient interaction demonstrate that:

- there are major problems in communication between physicians and patients
- communication is a core clinical skill — it can improve patient satisfaction and health outcomes
- communication can have a positive impact on physician satisfaction
- communication can enhance efficiency and save time
- communication skills can be learned and retained; while personality and personal style may give you a head start, everyone can improve

Yes, there is a problem

- More than 54% of all patient complaints and 45% of patient concerns are not brought out by physicians.
- In 50% of visits, patient and physician do not agree on the nature of the problem.
- On average, physicians interrupt patients 18 seconds into the patient's description of the problem; and once interrupted, patients are unlikely to raise additional concerns.
- Most malpractice suits are due to communication errors, not competency errors — patients whose autonomy and means of expression are severely limited by the demands of time and a physician-directed, narrowly focused interviewing style are less satisfied and more likely to bring suit.
- Patients' most common complaint is lack of information from their physicians; 83% of people believe in patients' right to information.

Communication can improve patient outcomes

- Randomized controlled trials demonstrate that patients with diabetes, hypertension and ulcer disease who are trained to be more assertive in physician interviews have significant reductions in glycosolated homoglobin, blood pressure and functional limitations from ulcer disease.
- Patients' perceptions that they had been listened to fully and completely by the physician was the single variable most highly associated with relief of chronic headache symptoms.

- Interviewing style in assessing and educating patients about compliance affects the accuracy of information and the potential for miscommunication — and therefore noncompliance.
- The style of delivering news to patients may determine the acceptability of a diagnosis or recommendation.
- 16 of 21 studies showed positive, significant relationships between communication and patient health outcomes.

Communication affects patient satisfaction

- A patient-centered interviewing style has a strong positive effect on patient satisfaction.
- Communication skills, such as meeting expectations, giving information, and talking about distressing problems, are related to patient satisfaction.
- Including certain communication behaviours (education, stress counselling, negotiation) during visits with primary care patients predicted patient satisfaction whereas technical interventions (examination, tests, medications) did not.

Communication affects physician satisfaction

- A review of 17 studies on physician satisfaction show that the majority of physician dissatisfaction stems from one-to-one communication with patients.
- Communication skills of meeting expectations, giving information and talking about distressing problems are related to physician satisfaction.
- Physicians' overall satisfaction was most closely related to the patient-physician relationship.

It doesn't take any longer

- Physicians who are sensitive to and explore patients' emotional concerns take a mean of one minute longer to complete visits than physicians who do not.
- There was no increase in the length of the interview in primary care following training in the skills of "problem-defining and emotion-handling."
- Physicians who used more appropriate communication skills and involved their patients more actively in their own care did not have longer interviews than their colleagues.

Communication skills can be taught, learned and retained

- Medical students who learned key interviewing skills were diagnostically more efficient and effective in interviewing patients.
- Training internal medical residents and staff physicians to use more appropriate interviewing skills led to significant improvements in the information-gathering process.
- An eight-hour communication course improved primary care physicians' detection and management of psychosocial problems and reduced patients' emotional distress.
- Improvement in the interviewing skills of established general practitioners following an interview training course was maintained over a two-year period.
- Practice and feedback are the only ways of actually learning the skills; feedback may come from "inside" (e.g., critical review) or "outside" (e.g., patient feedback).

2 Conceptual Frameworks

A framework helps to structure communication learning in much the same way physicians use schema in clinical decision making: by helping to access and apply knowledge or skills systematically, by aiding recall, and by imposing coherence and order on what would otherwise be random pieces of information.

Researchers have proposed a variety of frameworks which attempt to broaden the conventional medical approach to include psychosocial aspects of the patient-physician interaction. Following is a brief overview of two conceptual models that have been developed by leading Canadian academics specializing in clinical communication. Both frameworks propose a structure for unifying research, practice and teaching in the field.

The two models presented here are based heavily on the work of two Canadian academics, Dr. Moira Stewart, University of Western Ontario (Patient-Centred Model), and Dr. Suzanne Kurtz, University of Calgary (Calgary-Cambridge Observation Guide).

References for a sampling of other proposed frameworks are also provided below.

Clinical Practice Guidelines

In November 1993, the National Forum on Breast Cancer identified a need for better definition of the limits within which treatment decisions should vary. The Forum also highlighted the need for patients with breast cancer to be empowered to make their own decisions as much as possible.

Clinical Practice Guidelines for the Care and Treatment of Breast Cancer (Supplement to Canadian Medical Association Journal (CMAJ) 1998; 158 (3 Suppl.), Health Canada and Canadian Medical Association) provides health care practitioners and patients with guidelines for the treatment of breast cancer patients. Released in February 1998, the Guidelines are unique in that they have been simultaneously produced in two documents, one as a lay document for women and their families, and the other as a technical document for health care professionals.

The Guidelines reflect a wide consensus about the range of treatment options considered acceptable according to current evidence. They address 10 elements of the care and treatment process, and are intended to enlighten the discussions between patients and physicians during the decision-making process.

Patient-Centred Model

Developed and refined over the past 30 years, the patient-centred model integrates the conventional understanding of disease (medical model) with each patient's unique experience of illness. The traditional notion of the professional being in charge and the patient being passive does not hold in this model. "To be patient-centred, the practitioner must be able to empower the patient, to share the power in the relationship."

The patient-centred model consists of six interconnecting components. The first three components address the process between patient and doctor. The second three components shift the focus to the context of the patient-physician interaction. Ideally, the physician moves among these six components, in response to cues received from the patient. The six components of the patient-centred model are briefly described below.

❶ Exploring both the disease and the illness experience

Effective patient care requires attending as much to patients' personal experiences of illness as to their diseases. The patient-centred method focuses on disease and on four principal dimensions of patients' illness experiences: a) their ideas about what is wrong with them; b) their feelings, especially fears about being ill; c) the impact of their problems on functioning; and d) their expectations about what should be done.

❷ Understanding the whole person

Over time, physicians come to know the context of the patient's life, including family, work, beliefs and life crises. Understanding the whole person can enhance the physician's interaction with the patient — especially when the symptoms do not point to a specific illness. It can also help to deepen the doctor's knowledge of the human condition, especially the nature of suffering.

❸ Finding common ground regarding management

Patients and physicians often have widely divergent views about the nature of the problems and priorities; the goals of treatment; and the roles of the doctor and the patient. Finding common ground involves the physician in incorporating patients' ideas, feelings, expectations and function into treatment planning.

❹ Incorporating prevention and health promotion

This task requires that continuing and comprehensive care be the underlying philosophy of the physician's practice. Within a supportive process, physicians and patients together monitor areas in patients' lives that need strengthening in the interests of long-term emotional and physical health.

❺ Enhancing the patient-doctor relationship

At every visit, physicians strive to build an effective long-term relationship with each patient as a foundation for their work together. They can then use this relationship to help mobilize the strengths of the patient for healing.

❻ Being realistic

Doctors must be able to manage their time effectively, developing skills of priority-setting, resource allocation and teamwork. They must also respect their own limits of emotional energy and not expect too much of themselves.

Calgary-Cambridge Observation Guide

The Calgary-Cambridge Observation Guide uses a simple five-point plan to structure individual communication skills. Based on a sequence of basic tasks that physicians and patients routinely attempt to accomplish in everyday clinical practice, the plan provides a logical organizational schema for both patient-physician interactions and communication skill education. As indicated, each of these five tasks include an expanded framework of skill sets which provide further detail about the goals to be achieved.

Each of the skill sets is further subdivided into individual skills. In all, the framework includes a total of 70 individual skills, each of which is conceptually linked to a skill set and to the functions performed by physicians as part of the logical sequence of a clinical interview session.

In addition to extensive research evidence, the authors cite three immediate **goals** and five **principles** of communication which influenced the selection of individual skills to be included in the framework. Together, they provide a simple and coherent theoretical foundation for the observation guide and for the development of communication curricula in general.

❶ Initiating the session
- establishing initial rapport
- identifying the reason(s) for the consultation

❷ Gathering information
- exploration of problems
- understanding the patient's perspective
- providing structure to the consultation

❸ Building the relationship
- developing rapport
- involving the patient

❹ Explanation and planning
- providing the correct amount and type of information
- aiding accurate recall and understanding
- achieving a shared understanding: incorporating the patient's perspective
- planning: shared decision making
- options in explanation and planning
  - — if discussing opinion and significance of problem
  - — if negotiating mutual plan of action
  - — if discussing investigations and procedures

❺ Closing the session

Goals of Medical Communication

The three immediate goals that physicians attempt to achieve whenever they talk to patients are:

1. Accuracy
2. Efficiency
3. Supportiveness

Effective communication provides the means of accomplishing these goals.

Principles that Characterize Effective Communication

1. Ensures an interaction rather than a direct transmission process.
2. Reduces unnecessary uncertainty.
3. Requires planning and thinking in terms of outcomes.
4. Demonstrates dynamism.
5. Follows the helical model.

Other Models

Other approaches to patient-doctor communication include:

- biopsychosocial model
- three-function model
- family systems approach to patient care
- physician self-awareness

As Stewart et al. (1995) have observed, many of these models "are similar in their attempt to broaden the conventional medical approach to include psychosocial issues, the family and the physician, but they differ in the level at which they work." Some are conceptual models which do not include implementation methods, others focus on methods without a well-developed framework.

3

Breaking It Down — The Skills

The key to learning a complicated skill set — whether it's playing tennis, driving a car or communicating with patients — is to break it down into discrete elements. The process involves identifying individual skills, practising their components and putting them back together into a seamless whole.

Following is a brief overview of 12 selected communication skills, presented in random order.

1 Skill Showing Empathy

Empathy shows one person's appreciation, understanding and acceptance of someone else's emotional situation. In the patient-physician relationship, empathy allows both parties to develop a shared understanding of the illness experience. Demonstrating empathy requires that the physician identify a patient's emotional state accurately and acknowledge it. By doing so, the physician indicates that the patient has been truly heard, that the patient's emotions are acceptable, and that the physician is touched by the patient's experience.

Cohen-Cole and Bird (1991) identified five types of empathic responses:

- reflection — "I can see that you are ..."
- legitimation — "I can understand why you feel ..."
- support — "I want to help."
- partnership — "Let's work together."
- respect — "You're doing great."

Empathy can be expressed verbally or non-verbally. For example:

Verbal

- "I really feel bad for you."
- "That must be very difficult for you to cope with."
- "You seem (sad, angry, stressed) today."
- "This can't be an easy time for you."
- "We'll work together to get through this."
- "Please call me anytime." (If you say this, be sure that you can make yourself available.)

Non-Verbal

- using a sad or sympathetic tone of voice
- expressing concern through your facial expression
- touching a patient's hand

Be Yourself!

Knowing what skills are effective in certain situations isn't enough. You need to practise, trying out phrases and behaviours that fit with your own personality and style. Through a process of repeated practice and feedback, you learn to put your own stamp on each skill.

2 Skill Open and Closed Questions

The way in which physicians phrase questions plays a central role in the quality and quantity of information they obtain from their patients. Most physicians tend to control the interview and, by doing so, impose limits on the patient's responses. While this is appropriate in some circumstances, it does not always achieve the desired end. Using different questioning techniques — such as "open" questions — encourages patients to go into more depth with their answers and helps to elicit information that is crucial to diagnosis and treatment. Kurtz et al. (1998) outline the use of open-ended questions.

One general strategy is to begin the interview with open questions (to get a picture of the problem from the patient's perspective), then to focus the questioning by using increasingly specific though still open questions, and finally using closed questions to obtain additional details that the patient may have omitted.

Open questions and statements introduce an area of inquiry without limiting the response. They suggest to the patient that some elaboration is both appropriate and welcome — for example, "Can you tell me about any pain you're feeling?" "Tell me more about that pain you've been feeling."

More specific but still open questions sharpen the focus, but allow the patient some leeway in answering — for example, "What makes the pain worse or better?"

Closed questions and statements limit the response to a narrow field set by the questioner — usually a "yes" or "no," or a few words — for example, "Are you feeling any pain in your left arm?" "Have you been taking your medication?"

3 Skill Active Listening

Active listening is not just "sitting and doing nothing." It is the sincere attempt to understand what is being communicated. Active listening involves:

- being prepared to listen (i.e., not rushing the patient because of other commitments)
- listening to verbal and non-verbal cues (body language)
- listening in an understanding and supportive way, for example:
  - verbal facilitation: "um," "yes," "go on," "ah ha"
  - non-verbal facilitation: position, posture, eye contact, affect, facial expression, animation
  - wait time: pausing before asking follow-up questions
- respecting the sender
- clarifying the sender's message ("What I hear you saying is ... Is that right?")

4 Skill Non-Verbal Cues

Picking up patients' non-verbal cues and decoding them are essential to understanding patients' emotions and feelings. While patients may not comment verbally on their distress, they may indicate it in their body language. Watch for signs of distress such as:

- avoiding eye contact
- fidgeting
- shifting around in the chair
- holding the body tensely

Don't just assume that you've interpreted a patient's body language correctly. Check it out with them to see if you're right. Take into consideration that there may be cultural issues to consider — for example, in some cultures, it is considered impolite to look someone directly in the eye.

Remember that body language is a two-way street and that patients pick up physicians' non-verbal cues as well. "Good" body language invites communication — for example:

- leaning in to listen to the patient
- maintaining eye contact and attention
- nodding your head

"Distracting" non-verbal cues inhibit communication — for example:

- fidgeting, tapping your pen
- looking at your watch or the clock
- avoiding eye contact

5 Skill Timing

Controlling the rate and amount of information shared is a mistake commonly made by physicians in communicating with patients. By interrupting patients and demonstrating impatience (both verbally and non-verbally), physicians may miss essential information, endanger the "partnership" relationship and even waste time over the long run. Keep in mind the following:

- prepare adequately for the interview by reviewing the patient's chart, history
- announce to the patient how much time is scheduled — this permits patients to decide how much and what information they want to share in the time available
- establish priorities with the patient if there are several issues he/she wishes to discuss
- tell the patient directly when you are under extreme time pressures, and share the reasons for that pressure (e.g., emergency case, late arrivals, etc.)
- schedule another appointment if there is not sufficient time to discuss everything adequately

6 Skill Silence

Because physicians are often under considerable time pressure, they may feel the need to keep the interview moving. However, the use of silence is a helpful communication technique in eliciting the full range of patient concerns. More than just a listening device, it allows patients to take their own time in discussing a problem and leaves them "space" to think. A brief silence or pause encourages the patient to say more; longer periods of silence are appropriate if the patient is having difficulty in expressing him/herself or is becoming emotional. Physicians should be aware that there is "a delicate balance between comfortable and uncomfortable silence, between encouraging communication and interfering with it by creating uncertainty and anxiety." It is therefore important to be attentive to the patient's non-verbal cues.

7 Skill Summarizing

Summarizing what the patient has said is a useful tool for checking if you have an accurate understanding of the patient's perspective. Summarizing involves encapsulating what the patient has said, then inviting him/her to correct your interpretation and to provide further, clarifying information. **Internal summarizing** focuses on a specific part of the interview — it should be used periodically throughout the session to ensure that information has been interpreted accurately. **End summarizing** pulls together the entire interview. Without summarizing to check for completeness and accuracy, physicians must rely on conjecture and assumption, and are susceptible to the distortion/misinterpretation inherent in all communication.

The advantages of summarizing include:

- demonstrates that you have been listening attentively
- demonstrates your interest both in the patient's disease and in her/his "illness framework"
- gives the patient the opportunity to explain further
- ensures accurate information gathering
- permits you to organize your thoughts

Example

Physician: "Let me see if I've got this right. About two months ago, you started getting severe headaches once or twice a week. The headaches would only last about an hour if you took over-the-counter painkillers immediately; otherwise they would last three or four hours. You're now getting the headaches more frequently — three or four times a week — and the painkillers don't seem to work anymore. Is that right?"

Patient: "Yes, and I can't afford to be away from work right now. This is our busiest time of the year and I'm afraid my business will go under if I'm not there."

8 Skill Plain Language

Many physicians forget that "the outside world" doesn't speak the same language as they do. While some medical jargon has come into common parlance, much of it is still mystifying to the average consumer. Often, patients are unwilling to tell the physician that they don't understand, and will leave the consultation with unanswered questions or misinformation. Using concise, easily understood questions and comments, without jargon, is essential to good communication. Plain language helps to ensure that patients understand their treatment plan and what they must do to comply with it.

9 Skill Clarifying Responsibilities

It is important that physician and patient clarify from the outset what their individual roles and responsibilities are in the patient-physician partnership. Since patients will have differing perspectives about how active a role they want to take, and since a patient's perspective may change over time, part of the physician's job will be to determine individual expectations. Physicians can accomplish this by:

- providing opportunities and encouraging the patient to contribute their ideas, suggestions, preferences and beliefs
- offering the patient choices and encouraging him/her to make decisions to the level they wish
- assigning tasks (e.g., further research, consultation with other professionals, lifestyle changes, medication)
- checking with the patient to see if the allocation of tasks is appropriate

10 Skill Action Planning

This involves negotiating a mutual plan of action for addressing the patient's health concerns. For the physician, action planning involves:

- providing clear information about the available options for action or treatment
- eliciting the patient's ideas, understanding, concerns, perceived barriers
- encouraging the patient's involvement in making choices
- taking into account the patient's context (e.g., lifestyle, beliefs, cultural background) and support systems
- checking with the patient to see if the plan is understood and agreeable

11 Skill Checking with the Patient

Much of the misunderstanding in communication comes from assuming that the other person understands what you're saying. However, in many cases, factors such as emotion, and differences in cultural background and education, can blur the message as it passes from "giver" to "receiver." One of the tools physicians can use to determine whether the patient's message has been received correctly is to check frequently with the patient. For example:

- "What I hear you saying is ... Is that correct?"
- "You seem to be saying ... Do I have it right?"
- "If I understand you correctly, ... Do you agree?"

12 Skill Following the Patient's Lead

The skill of following the leader involves allowing the patient to lead the interview, and probing for more information as issues arise. As with other skills such as silence, follow the leader is often difficult for physicians who are used to taking control of the interview. However, when used appropriately, this skill can actually save time by allowing the full range of patients' concerns to be elicited and priority concerns and expectations to be identified.

Example

Patient: "I'm having some pain in my right leg."

Physician: "I see. Can you tell me a little more about the pain?"

Patient: "Well, it's not there all the time, it sort of comes and goes."

Physician: "Can you be more specific about when it's worse or better?"

Patient: "I can't really say, but that's not what I'm most worried about, anyway."

Physician: "Really? Can you tell me about your main concern?"

4

Putting It All Together — Four Skill Sets

Managing physician-patient communication effectively involves more than just applying individual skills in isolation. Through ongoing practice and self-assessment, physicians learn how to link skills together to meet the specific requirements of each interview. Following is an overview of four major "skill sets" — including why they're important, the supporting research, some "how to's," and a case study example illustrating how to put these skills into practice.

A. Drawing Out the Patient

Why Do It?

Skill Sets

- **A. Drawing out the patient**
- B. Handling emotions
- C. Sharing decision making
- D. Getting effective closure

"If physicians are from Mars and patients are from Venus, the missing link is that the logic of clinical decision-making and the patient's experience of illness often do not coincide. The result is that the clinician often elicits the facts but misses the story."

Patients can be ill but have no disease. Consider, for example, the recently bereaved patient complaining of lethargy, insomnia, migraines; or the child with problems at school leading to abdominal pain. A patient-centred approach expands the physician's agenda to take into account both the "disease" (physician's agenda) and the "illness" (patient's agenda). Studies of patient satisfaction, adherence, recall and physiological outcome all support the need for a broader view of history-taking that includes the patient's point of view as well as the physician's biological perspective.

Most physicians assume that a patient is seeking medical advice and care because of a single, primary complaint — and that this complaint will be the first one voiced. Much of the research does not support this assumption. As Frankel (1994, p. 5) observes, "Serial order is not related to the clinical importance of patient concerns and is not a reliable guide to their importance from the patient's perspective."

And just because patients share a variety of concerns with their physician does not mean they want them all acted on. Anecdotal experience suggests that as many as one out of every three problems that a patient brings up involves a desire to be heard by the physician, not to have her/him take clinical action.

"Illness" and "Disease"

Physicians need to explore both disease and illness to determine all the relevant information.

"Disease" — the biomedical cause of sickness; the physician's traditional and central agenda

"Illness" — the patient's unique experience of sickness, including feelings, thoughts, concerns and effect on other aspects of life

Eliciting the full range of relevant information from a patient helps the physician to make a more accurate diagnosis and more appropriate treatment plans. It also encourages the patient to cooperate in the treatment effort.

Some "How To's"

The process of eliciting information from the patient involves establishing their feelings, ideas, function and expectations, then establishing the personal and cultural context.

Using silence

- Start the patient off by inviting her/him to tell the story of the problem from when it first started up until now
  — for example, "Tell me all about it from the beginning."
- Use "continuers" to elicit additional concerns and feelings
  — for example, "Mmh hmn," "I see," "I understand."
- Wait for the patient to continue describing her/his concerns before asking another question.

Timing

- Determine with the patient what the most pressing problem is and negotiate to defer non-essential concerns to a later visit.

Using open questioning style

- Ask questions that will help to draw out how a problem is affecting the patient's day-to-day functioning.
- Ask the patient for her/his ideas about what is causing the problem. This can help to reduce the potential for miscommunication and misunderstanding
  — for example,"What do you think brought this on?"
- Determine patients' expectations about the kind of care they should receive. Because patients come with their own expectations about how these problems should be dealt with, your recommendations may not be followed because the patient disagrees with them or wasn't really interested in them in the first place.
- "What do you want me to do in order to help?"
- Find out about the patient's personal and cultural context. The actions and actors participating in a patient's experience of illness — the patient's perspective — can help you to hone in on a clinical decision — more quickly, less expensively and with minimum frustration for both parties
  — for example, "What else is going on in your life right now?"

Summarizing

- Summarize what you understand to be the patient's key concerns as well as their expectations about what is causing the problem and what should be done about it. Invite the patient to add additional relevant information and/or correct anything that you have said.

A Case in Point

Physician: Hello, Mrs. Wright. What brings you here today?

Patient: Well, I'm having some trouble with the medication you gave me for my arthritis.

Physician: Mm-hm.

Patient: Yes, well, I'm not sleeping very well. I'm sure it's got something to do with the medication. Maybe I shouldn't be taking so much or maybe I should be taking something different.

Physician: Okay, let's talk about that. But first, is there anything else bothering you? Are you having any other problems physically? Or are there any special stresses in your life right now?

Patient: Well, actually, there is something else.

Physician: Go on. Tell me more.

Patient: I'm sure it's nothing important.

Physician: (Silence)

Patient: I have a small lump in my breast.

Physician: I see.

Patient: I'm sure it's nothing, but it is causing me a little bit of worry from time to time.

Physician: Yes, I can see that you're concerned about it. Why don't we talk some more about this and then we'll see what we can do about your medication.

The Research

Following is a sampling of research on "drawing out the patient."

- Organic disease fails to explain many patients' problems: in 50% of cases in which patients presenting to general practitioners with chest pain, the cause was unproven after six months' follow-up.
- When patient and physician agree on the nature of the problem and the proposed solution (i.e., diagnosis and treatment), the outcome is enhanced.
- 40% to 80% of patients who receive recommendations do not follow them; in many cases, the recommendation may not fit the question, need, or priority the patient brings to the encounter.
- Eliciting patients' beliefs about their illness was key in enabling patients to understand and recall information.
- Undiscovered discordance between the health beliefs of patients and physicians can lead to problems in patient satisfaction, adherence, management and outcome.
- The amount of information elicited by physicians was related to the appropriate use of open and closed questions; open questions prompted the revelation of substantially more relevant information than closed questions.

B. Handling Emotions

Skill Sets

A. Drawing out the patient
B. Handling emotions
C. Sharing decision making
D. Getting effective closure

Why Do It?

The link between physician empathy and support, and patient satisfaction has been cited frequently in the literature on patient-physician communication. Researchers have also begun to see a relationship between what patients interpret as lack of caring on the part of physicians and the decision to litigate for malpractice. In addition, many studies have identified significant relationships between the degree of empathy expressed by the physician and the patient's adherence to treatment advice.

Given the convincing evidence that building positive therapeutic relationships makes a difference in the process and outcomes of care, why do many physicians find it so difficult to deal with patients' feelings? Spiro (1992) suggests that up until now, medicine has been driven by the image and value of clinical detachment and neutrality, while empathy is based on passion and relationship, joy and sorrow, and the experience of being in the world.

Some "How To's"

➤ Show that you are receptive to patients' emotions, that it is "OK" for them to bring up and discuss difficult emotional issues. One way to accomplish this is by asking about patients' feelings, for example:

Using open questioning style

— "How are you feeling about that?"
— "What is your biggest worry in all this?"
— "Are things at home or at work bothering you?"

➤ Watch for and recognize the signs of emotional distress in patients. This means staying attuned to both verbal and non-verbal cues, watching for discrepancies between what is said and how it is said, and being sensitive to what is not said. Consider, for example, the patient who says she is feeling fine but nervously clutches her handbag during the interview, or the patient who avoids eye contact and does not mention anything about his wife when asked how things are going at home. Suchman et al. (1996) suggests that often patients will use "neutral statements" as trial balloons to test whether it is safe to talk about emotion. For example, "I haven't seen too much of my husband lately. He's been very busy with work."

Body language

➤ Listen more, talk less. Because physicians are trained to be efficient about their time and to actively solicit information from their patients, it is sometimes difficult for them to listen. The use of active listening techniques often encourages patients to express their emotions. Active listening may involve, for example:

Active listening

— nodding the head
— saying "mm-hmm," "I see," "go on"
— facing the patient directly
— maintaining eye contact
— sitting close to the patient

➤ Respond immediately to verbal and non-verbal cues that indicate distress. It is important to "seize the moment" and not let emotional issues go unaddressed. Branch and Malik (1993) refer to the decision to pursue the expression of emotion as a "window of opportunity." Given the signal to proceed from the physician, patients will generally express their feelings at this point.

Timing

Showing Empathy

- Validate the patient's feelings. Patients often need to be reassured that their feelings are acceptable and normal. Indicate that these kinds of feelings are to be expected under the circumstances and that there is nothing inappropriate in feeling or expressing them. For example, try using one of the following phrases:
  - — "It would be surprising if you didn't feel angry or frightened after hearing that diagnosis."
  - — "I understand completely. Most people in similar circumstances would react just as you are."
  - — "Your reaction is absolutely normal."

Checking with the patient

- Give and ask for feedback. For example:
  - — "It sounds like you're feeling ... Is that right?"
  - — "It seems like you're saying ... Does that sound about right?"
- Show partnership and support to reinforce that you are "on the patient's side" and will help her/him through the medical problems.
  - — "We'll work together to decide what the best course of treatment is."
  - — "I'm available anytime if you have questions or concerns."

A Case in Point

A 47-year-old woman sees her physician about a breast lump. Recognizing the woman's extreme agitation and reluctance to move forward for more tests, the physician provides both non-verbal and verbal cues that she would like to know more about how the patient is feeling. By expressing openness, empathy and support, the physician creates a safe and comfortable atmosphere that encourages the patient to express her feelings and apprehensions. The physician is able to determine the primary source of the woman's fears — that she will require a radical mastectomy and that her new husband will not be able to deal with her disfigurement.

Once these fears are out in the open, the physician is able to address the patient's concerns directly, to provide support and suggest some possible ways of addressing the situation. For example, the physician and the patient may decide that it would be best to include the husband in all stages of diagnosis and decision making about treatment options.

Had the physician not demonstrated empathy and a willingness to listen and understand the patient's emotional concerns, it is unlikely that the patient would have been willing to express her fears openly. In this situation, the result might well have been uncertain or delayed treatment, and substantially increased trauma for the patient.

The Research

Research demonstrates the important influence of physician empathy and support in patient outcomes and satisfaction.

- A classic study of cross-cultural patterns of facial expression showed that Americans were significantly less successful in detecting anger than Brazilians, Chileans, Argentineans and Japanese.
- In a survey of American physicians, half said angry or hostile patients were the most difficult to deal with and more than two thirds believed that medical school did not adequately prepare them for dealing with emotional problems of patients.
- Practitioner empathy and support positively affects patient satisfaction and reduction in concerns.
- Patient dissatisfaction and the perceived absence of caring on the part of physicians led to letters of complaint.
- There is a relationship between physician empathy and malpractice suits.
- Major reviews of the literature found significant relationships between empathy and adherence to treatment advice.

C. Sharing Decision Making

Skill Sets

- A. Drawing out the patient
- B. Handling emotions
- C. Sharing decision making
- D. Getting effective closure

Why Do It?

By allowing patients to understand the decision-making process and involving them to the extent that they wish, physicians can increase patients' commitment to whatever treatment plans are made. "A therapeutic alliance which contains a clear rationale, a sensitive exploration of potential barriers and support for making difficult changes enhances the likelihood of success and satisfaction with a recommended plan." Increasingly, medical researchers, educators and patient groups are advocating negotiation and collaboration between physicians and patients to address the issue of non-adherence. It is also important to remember that patients will vary in the extent that they want to participate in decision making; some feel more comfortable leaving decisions to their doctors.

Some "How To's"

Timing

- Allocate sufficient time in the interview to fully explain the diagnosis and treatment options — bear in mind that most physicians drastically overestimate the actual time spent in explanation and discussion with patients.
- Determine what the patient's expectations are, and how much information he/she wishes to have about the condition, treatment options, etc.

Checking with the patient

- Assess the patient's comprehension of the disease and its treatment options. For example, ask questions such as:
  - "What do you know about this condition?"
  - "What has worked for you in the past? What hasn't?"

Using plain language

- Offer the patient some choices for treatment options.
- Suggest a treatment option and provide a clear rationale for your advice — a key concept in establishing a partnership with patients is ensuring that they understand why you are suggesting that option.

Action planning

- Determine what, if any, are the patient's reservations about a particular approach and address each of them individually — these reservations may be because of the patient's personal circumstances, misinformation or fear.

Clarifying responsibilities

- Decide on a "game plan" and assign mutually agreed-upon responsibilities — for example, you agree to explore homeopathic solutions for the ailment, while the patient agrees to continue with the prescribed medication until more information is available.

Summarizing

- Review your own and the patient's roles and responsibilities, and check to see if the patient understands and agrees with them.

Showing empathy

- Provide support by, for example:
  - acknowledging the difficulty of following a rigorous treatment plan or making lifestyle changes
  - indicating your availability for questions and follow up

A Case in Point

Mrs. Little has been diagnosed with breast cancer and she and her doctor are discussing treatment options. Her doctor has explained the various options and, at Mrs. Little's request, has provided her with additional information explaining the process and expected outcomes for each. Mrs. Little has asked for information about both traditional and non-traditional approaches, such as acupuncture and herbal therapy. From their conversations, the doctor is aware that Mrs. Little is extremely wary of surgery and chemotherapy. Her mother died of breast cancer after a long and very painful treatment process and Mrs. Little does not want to endure the same pain, suffering and diminished quality of life.

Although the physician feels strongly that Mrs. Little's condition is highly treatable through traditional methods, he acknowledges her apprehensions and respects her need to explore other options. At the same time, he presents the facts supporting his preferred method of proceeding. Together, they work towards establishing a mutually acceptable treatment plan. It is agreed that Mrs. Little will continue to research non-traditional treatments, while at the same time she and her physician will take the necessary steps to prepare her for possible surgery and follow-up chemotherapy. They agree on a "decision date," when they will meet to discuss the results of their research and to decide on a future course of action.

The Research

- Patients of physicians who encourage them to participate more actively in the medical encounter and in treatment decisions enjoy more favourable outcomes both physiologically and functionally.
- Patients who were given the prognosis and treatment options before the diagnosis were better able to assimilate and retain information.
- Patients and doctors who agree on the nature of the problem and the follow-up plan achieve better patient outcomes.

D. Getting Effective Closure

Skill Sets

- A. Drawing out the patient
- B. Handling emotions
- C. Sharing decision making
- D. Getting effective closure

Why Do It?

Closing the session effectively involves ensuring that the patient knows, and is in agreement with, the treatment plan. It enables patients to feel comfortable about a mutually agreed plan, to be clear about what will happen next and to move forward with more confidence. It also allows doctors to begin the next session without any unfinished business. Many of the problems related to getting effective closure can be avoided using effective communication techniques during the previous phases of the interview. Getting effective closure also involves using specific skills such as summarizing, clarifying responsibilities and checking with the patient.

Some "How To's"

Summarizing

- Review the session briefly. Touch on the main points of the interview, including what brought the patient in, and the diagnosis and treatment plans. Encourage the patient to take notes.

Clarifying responsibilities

- Contract with the patient about next steps, including patient and physician roles and responsibilities regarding, for example, any lifestyle changes, additional research, further consultation, medication, alternative therapies, etc.
- Explain what to do if things do not go as planned — for example, if there are side effects from the medication prescribed or if the problem persists.

Checking with the patient

- Check with the patient to see if he/she agrees with the proposed plan and ask for additional questions.
- Determine if the patient is satisfied.
- Reassure the patient of ongoing care and encourage him/her to bring a friend or family member to follow-up interviews, if desired.

A Case in Point

Physician: So, let's just see where we are. You do have a small lump in your breast. It may be nothing at all, but we need to know for sure. So the next step is to find out what we're dealing with. We'll do that by getting a needle biopsy, then we'll talk about where to go from there. Does that sound all right to you?

Patient: Yes, I guess so.

Physician: I know this is all pretty frightening for you, but let's take it slowly. I'll get you an appointment for the biopsy and I'll let you know by this Thursday exactly when it will be. That will give you some time to make arrangements for a little time off at work. Okay?

Patient: Yes. I need to go home and talk to my family about all this.

Physician: That's a good idea. And if you or your family have any questions, please give me a call. Is there anything else you can think of now?

Patient: No. I just need some time to think. None of this has really sunk in yet.

Physician: That's completely understandable. But remember, I'm here and we'll work our way through this one step at a time. Are you all right with that?

Patient: Yes. I think so.

The Research

- Women with breast cancer who were seen by surgeons offering patients a choice between mastectomy and lumpectomy suffered less anxiety and less depression than patients seen by surgeons favouring either one or the other.
- A study of primary care physicians in Oregon (White et al., 1994) demonstrated that:
  - 21% of closures revealed new problems not discussed earlier in the meeting
  - the average length of closure was 1.6 minutes
  - physician behaviours in closure include:
    - clarifying the plan (75%)
    - orienting the patient to next steps (56%)
    - providing information about the condition or therapy (53%)

5

Reinforcement and Development

Ongoing feedback and self-assessment is an essential tool for improving your communication skills. As Kurtz et al. (1998) have observed, "learning any skill is greatly helped by self-observation, by being able to see for ourselves how we are doing." There are a variety of assessment strategies available — choose the one that's right for you. Whatever method you use, you may want to keep a workbook to follow your progress. As you do your assessment, jot down skills that you feel you are doing well, some that you are improving on, and others that still need work.

Self-Reflection

Improving your skills may be as simple as taking some time to review an interview in your mind, thinking about how it went and what might have been done better. Take a few minutes to reflect on your performance and make some mental or written notes about your own strengths and weaknesses in, for example, drawing the patient out, dealing with emotions or sharing in the decision-making process. Try doing this self-reflection exercise as close as possible to the time of the interview, otherwise you're likely to forget the "fine points" of the interaction. It must be noted, however, that our perceptions of our own behaviour through reflection are not always accurate. It is often more useful to observe or listen to a recording of the interaction.

Audiotaping and Videotaping

You can assess your interviewing communication skills by recording your interview sessions and reviewing them later. You don't need to have the newest high-tech equipment, but you will need to get the patient's permission before going ahead. "On balance, most people do not mind being observed, discussed or videotaped, but there have to be rules and respect for the individual" (Tate, 1997, p. 60).

Audiotaping is cheap, unobtrusive and easy, the only drawback being that it does not permit you to analyze your body language. Videotaping allows you to catch your expressions and other non-verbal behaviour but it is more difficult to set up and can be more threatening to patients. There are a variety of videotaping formats available: a VHS allows four to eight hours of recording on one tape; camcorders are smaller but have restricted recording times; digital cameras provide perfect copies but can be quite expensive.

Patient Feedback

Patient feedback can be obtained through a questionnaire, issued following the interview session. In order to get feedback that is as honest as possible, take appropriate steps to ensure that the patient is offered the opportunity to respond anonymously — some patients will fear endangering their relationship with a physician by commenting "on the record" about their communication skills. Also take care to ensure that participating (or not) in the survey is the patient's choice.

Peer Review

Another strategy for developing your communication skills is to enlist the help of your colleagues. You might ask for a colleague to sit in on several of your interviews (with the patient's permission, of course) or for a fellow physician to review a videotape or audiotape of a few sessions with you. Set some ground rules for the peer review — for example, that discussion of weaknesses include a strong focus on suggestions for alternative approaches.

Self-Assessment and Feedback Program

This program is designed for practising physicians wishing to assess how well they communicate with their patients and to identify skills that could be improved. It consists of two validated assessment tools (written questionnaires) — one for physicians and one for patients. Physicians complete and mail in an assessment questionnaire for each of 10 patient visits and 10 different patients complete and mail in a questionnaire. The results are interpreted by the program's Assessment Team, led by Dr. Moira Stewart of the Centre for Studies in Family Medicine, University of Western Ontario. Participating physicians receive a confidential report designed to inform them about current strengths as well as areas for improvement.

6

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*Resources**

A variety of training materials and other resources on patient-physican communication are available. The sources for some of these resources are identified below.

- Primary Care Institute, 1000 South Avenue, Box 140, Rochester, New York 14620, (716) 242-8100, Fax (716) 473-2302.
- *The Four Habits of Highly Effective Clinicians: A Practical Guide*, Richard Frankel, Ph.D., and Jerry S. Stein, M.D., 1996, Physician Education and Development, Kaiser Premanente, Northern California Region.
- *CME Curriculum on Communication Skills for Primary Care Physicians*, Dr. Debra L. Roter, Johns Hopkins University, School of Hygiene and Public Health.

Resource Booklet

Talking Tools II

Putting Communication Skills to Work