Teaching Clinician/Patient Communication Skills throughout the Continuum of Medical Education

Janice L. Hanson, PhD, EdS

Why teach clinician/patient communication skills?

Until 20-30 years ago, communication skills did not receive much explicit attention in medical education programs, although many clinicians provided exemplary role models for communicating with patients and conveyed these skills informally. Beginning in the 1980’s, medical schools began to develop communication skills curricula, primarily for the preclinical years of medical school. In 1999, experts in physician-patient communication gathered in Kalamazoo to produce a consensus statement on the seven essential sets of communication tasks to provide guidance for teaching and practice. (Academic Medicine, 2001) Since then, communication skills curricula, observation and evaluation tools, and research have proliferated—although much of the formal education remains in the early years of medical school or in continuing education programs.

The burgeoning body of research suggests that communication between patients and their healthcare providers affects patient outcomes such as quality of life for children with asthma and their caregivers (Carpenter et al., 2013), use of asthma action plans (Ring et al., 2012), management of postoperative pain (Sugai et al., 2013) and pain in patients with breast cancer (Smith et al., 2010), patients’ ability to handle “treatment burden” after a stroke (Gallacher et al., 2013), patients’ self-efficacy in diabetes self-management (Inoue, Takahashi & Kai, 2013), both physical symptoms and health anxiety in patients with medically unexplained physical symptoms (Weiland et al., 2012), and patients’ adherence to treatment plans (Liu et al., 2013; Schoenthaler et al., 2012). In particular, healthcare providers’ expression of empathy for patients affects outcomes for patients with cancer (Lelorain et al., 2012) and migraines (Attar & Chandramani, 2012), and clinician warmth and listening are associated with greater patient satisfaction (Henry et al., 2012). Families of patients in the ICU who experience good communication with their loved ones’ healthcare providers experience less anxiety and depression (Lauterette et al., 2007). Physicians’ understanding of patients’ social contexts affects outcomes in patients with diabetes (Kruse et al., 2013).

While these studies look at the direct effects of communication between physicians and patients, the indirect effects of communication between patients and their healthcare providers may be even greater (Street, 2013).
Excellent communication enables physicians and other healthcare providers to learn essential information for patients’ care. For example, patients’ preferences differ from physicians’ judgments as related to medical decision-making (Mühlbacher & Juhnke, 2013); furthermore, patients’ priorities may shift over time (Cheraghi-Sohi et al., 2013). Adolescents’ perspectives and preferences for treatment may require special attention (Thompson et al., 2013).

Communication skills education improves the quality of health care providers’ communication with patients (Cochrane Database Systematic Review, 2013; Gordon, Darbyshire & Baker, 2012) and, in particular, their use of a patient-centered communication approach (Cochrane Database Systematic Review, 2012) and skills in motivational interviewing (Childers et al., 2012). Contrary to popular belief, patient-centered communication does not necessarily take more time than doctor-centered communication (Desjarlais-Keklerk & Wallace, 2013). Therefore, communication between patients and their healthcare providers deserves explicit and ongoing attention during each stage of medical education and into practice and across all the healthcare professions. Knowing what learners experience in our own continuum of medical education will help us provide more effective education for the learners in our medical education programs as they continue to develop as professionals.

What happens in Foundations of Doctoring during the preclinical years in the University of Colorado School of Medicine?

Medical students in the Foundations of Doctoring curriculum, which was inspired by the Calgary-Cambridge communication curriculum, experience two small group coaching sessions with standardized patients and expert communication skills coaches during each of their first two years. Phase 1 teaching covers 21 specific skills focused on introductions and agenda setting, gathering information, providing structure and building relationships. Phase 2 adds an additional 19 skills while strengthening the structural and relational foundations built during Phase 1. Phase 2 skills relate to sharing information with patients, negotiating a mutual plan of action, and closing an interview with forward planning. (See the combined Phase 1 and Phase 2 checklist.) In the Culturally Effective Medicine Thread, the medical students are introduced to the broad concept of culture and its impact on providing effective health care. The focus is on the outcome of the interaction between the health care provider/system and the patient. This thread expands the definition of culture beyond generally-assumed race and ethnicity to include race, ethnicity, language, religion, sexual orientation, gender, disability, socioeconomic status and geography, acknowledging that all of these attributes effect the delivery and quality of care.

What happens in the Child Health Associate Physician Assistant (CHAPA) program?

The CHAPA Program teaches and reinforces concepts and skills around clinician/patient communication longitudinally across the three-year curriculum. As part of the first and second year behavioral medicine courses, learners are taught communication techniques in didactic lectures and apply these skills in high-fidelity simulation exercises, peer-peer role playing and mock interviews with standardized patients. Summative exams, administered at the end of the 2nd and 3rd years of training, are comprised of clinical cases, each of which includes assessment of communication. Communication with patients, patients’ families and other clinical team members is an important component of the evaluation of future physicians’ assistants by clinical preceptors across all three years of training.
What happens in the pediatric clerkships, end of block assessments and sub-internships?

Reinforcement of communication skills taught during the Foundations of Doctoring occurs during the Pediatric clerkship, although not systematically. Preceptors may focus on communication skills when observing history taking or information giving for a Structured Clinical Observation or when providing feedback for clinical evaluations. Pediatric clerkship students experience a session that teaches the HEADSSS (home, education, activities, depression, sex, suicide and safety) interview for adolescents. End of block assessments include an Objective Structured Clinical Examination (OSCE) that evaluates students’ communication skills along with other clinical skills.

All pediatric sub-interns complete an Advanced Communication Skills Project in which an attending physician observes them during an advanced communication activity. Examples of advanced communication activities include: discussing risks and benefits of treatment options, need for blood transfusion or dramatic change in a patient’s condition, talking with angry family members, family care conferences during which both positive and negative outcomes are discussed and discussing a new diagnosis which impacts a patient’s life. The observing physician completes an evaluation form and provides feedback to the sub-intern.

What happens in the pediatric residencies and fellowships?

In the residencies and fellowships, communication skills develop in the context of mentored practice in clinical settings. One of the requirements of the pediatric residency is to demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients and their families. Family-centered rounds provide a clinical setting that incorporates these skills. Family-centered rounds, in which attending physicians conduct hospital rounds in patients’ rooms in the presence of family members, facilitate the exchange of information between the family and the child’s health care team and encourage the involvement of the family in the decisions made during rounds.

Formal sessions that relate to communication include time spent on cultural competence and building an understanding of the context of patients’ lives during the advocacy rotation and participation in family conferences. Fellows work on topics related to communication such as cultural awareness, death and dying, biomedical ethics and professionalism as part of the core curriculum that spans all pediatric fellowships.

Feedback and evaluation

Two of the Pediatric Milestones for which we are now responsible to document residents’ progress encompass communication with patients and families (see the box with the complete Milestone descriptions). As preceptors work with students, residents and fellows in clinical settings and complete Descriptive Comments Forms to describe their performance and provide feedback, these milestones provide guidance about the continuum of progress in communication skills.
1. **Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds**

- Uses standard medical interview template to prompt all questions. Does not vary the approach based on a patient’s unique physical, cultural, socioeconomic, or situational needs. May feel intimidated or uncomfortable asking personal questions of patients.

- Uses the medical interview to establish rapport and focus on information exchange relevant to a patient’s or family’s primary concerns. Identifies physical, cultural, psychological, and social barriers to communication, but often has difficulty managing them. Begins to use nonjudgmental questioning scripts in response to sensitive situations.

- Uses the interview to effectively establish rapport. Able to mitigate physical, cultural, psychological, and social barriers in most situations. Verbal and nonverbal communication skills promote trust, respect, and understanding. Develops scripts to approach most difficult communication scenarios.

- Uses communication to establish and maintain a therapeutic alliance. Sees beyond stereotypes and works to tailor communication to the individual. A wealth of experience has led to development of scripts for the gamut of difficult communication scenarios. Able to adjust scripts ad hoc for specific encounters.

- Connects with patients and families in an authentic manner that fosters a trusting and loyal relationship. Effectively educates patients, families, and the public as part of all communication. Intuitively handles the gamut of difficult communication scenarios with grace and humility.

2. **Demonstrate the insight and understanding into emotion and human response to emotion that allow one to appropriately develop and manage human interactions**

- Does not accurately anticipate or read others’ emotions in verbal and nonverbal communication. Is unaware of one’s own emotional and behavioral cues and may transmit emotions in communication (e.g., anxiety, exuberance, and anger) that can precipitate unintended emotional responses in others. Does not effectively manage strong emotions in oneself or others.

- Begins to use past experiences to anticipate and read (in real time) the emotional responses in herself and others across a limited range of medical communication scenarios, but does not yet have the ability or insight to moderate her behavior to effectively manage the emotions. Strong emotions in oneself and others may still become overwhelming.

- Anticipates, reads, and reacts to emotions in real time with appropriate and professional behavior in nearly all typical medical communication scenarios, including those evoking very strong emotions. Uses these abilities to gain and maintain therapeutic alliances with others.

- Perceives, understands, uses, and manages emotions in a broad range of medical communication scenarios and learns from new or unexpected emotional experiences. Effectively manages her own emotions appropriately in all situations. Effectively and consistently uses emotions to gain and maintain therapeutic alliances with others. Is perceived as a humanistic provider.

- Intuitively perceives, understands, uses, and manages emotions to improve the health and well-being of others and to foster therapeutic relationships in any and all situations. Is seen as an authentic role model of humanism in medicine.
Growing evidence internationally shows that while many students receive communication skills education during their preclinical years, instruction decreases dramatically during clinical education. European medical schools have begun a major initiative to push communication skills education into the clinical years of medical school and graduate medical education. Still, curricular opportunities for instruction and observation remain scarce. When faculty members are unaware of the learners’ foundational education in communication, the challenges are compounded. On our campus, the Foundations of Doctoring curriculum prepares medical students with all the core communication skills needed to engage in clinical interaction. The task of teachers in the clinical years is to support and enhance these skills as they apply and practice them in clinical settings. Systematic opportunities to continue and enhance communication skills instruction, observation and evaluation in the context of clinical care must be provided if we are to produce high quality clinicians.

Recently both US and UK medical schools have encouraged collaborations between clerkship directors and communication and clinical skills faculty to provide curricular instruction in issue-specific communication, using existing curricular time to address clinical content while providing reinforcement and opportunity to practice communication in clinical contexts. Within residencies, some programs are requiring focused observation, feedback and evaluation of resident skills including communication skills while others are encouraging greater use of video reflections and checklists to evaluate progress in communication skills. These efforts, while laudable, are the exception rather than the rule. The question for us is, how can we create these systematic opportunities and garner the resources needed to develop and enhance communication skills?

In the busy clinical environment reverting to provider-centered rather than patient-centered communication skills may make us feel efficient and effective. However, the research data tell us otherwise and clearly show us that, in order to achieve the best outcomes for patients, we must use the seven essential communication sets that we know are effective for all our encounters with patients and families.

Janice L. Hanson, Ph.D., Ed.S.
Professor of Pediatrics and Family Medicine
Director of Educational Research and Development, Department of Pediatrics
University of Colorado School of Medicine

Kirsten J. Broadfoot, Ph.D.
Visiting Associate Professor of Family Medicine
Assistant Director and Communication and Curriculum Development Specialist, CAPE
Associate Director of Communication, Foundations of Doctoring Curriculum
University of Colorado School of Medicine

J. Lindsey Lane, BM.BCh.
Professor of Pediatrics
Vice Chair for Education, Department of Pediatrics
University of Colorado School of Medicine

With contributions from
Jonathan Bowser, PA-C., Director, Child Health Associate/Physician Assistant Program
Paritosh Kaul, M.D., Associate Professor of Pediatrics
Barry Seltz, M.D., Assistant Professor of Pediatrics
Jennifer Soep, M.D., Associate Professor of Pediatrics
INTRODUCTIONS AND AGENDA SETTING
1. Introduces self and clarifies role, demonstrating respect and interest
2. Elicits patients’ FULL agenda (complaints and concerns)
3. Negotiates mutual agenda and outlines roadmap of interaction

GATHERING INFORMATION
4. Encourages patient’s story primarily through open questions
5. Allows patient to complete their thoughts without interruption (pauses)
6. Reflects back patient’s responses (reflective listening) to verify information
7. Elicits the patient’s perspective (ideas, beliefs, concerns, expectations)
8. Elicits patient’s biomedical history
9. Elicits patient’s background and life context

CLOSING AND FORWARD PLANNING
10. Summarizes visit comprehensively
11. Affirms continuity of care, with immediate and future next steps
12. Final check in with patient for any other concerns or additions

PROVIDING STRUCTURE AND FLOW
13. Structures dialogue in logical sequence
14. Signposts transitions to next topic logically and smoothly
15. Synthesizes and summarizes information at the end of each section
16. Attends to timing, keeping on task as appropriate

BUILDING A RELATIONSHIP
17. Asks permission before discussing sensitive or difficult topics or procedures
18. Accepts patient views and feelings nonjudgmentally
19. Demonstrates appropriate nonverbals, including the use of notes and technology
20. Pays attention to and respects patient’s circumstances, adapting verbally and nonverbally (incl. silence)
21. Demonstrates empathy, including self-disclosure where appropriate and relevant
COMMUNICATION CHECKLIST—FOUNDATIONS OF DOCTORING PHASE 2

SHARING INFORMATION
1. Elicits patient understanding of illness or situation
2. Shares clinical information (rationale, procedures, consequences) in manageable chunks and checks
3. Uses words patient understands, as well as diagrams and models when appropriate
4. Tailors information to patient’s perspective

NEGOTIATING MUTUAL PLAN OF ACTION
5. Discusses ALL options (including no action)
6. Elicits patient’s perspective on information, options and decisions
7. Negotiates common goals, facilitating patient’s desired involvement in decision making
8. Partners with patient to tailor a suitable plan of action, discussing impact, support and responsibilities

SUSTAINING STRUCTURE AND FLOW
9. Structures dialogue in logical sequence
10. Signposts transitions to next topic logically and smoothly
11. Synthesizes and summarizes information at the end of each section
12. Attends to timing, keeping on task as appropriate

SUSTAINING RELATIONSHIP
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REFERENCES

NOTE: Reference list with abstracts available upon request from Pat Schmitter, patricia.schmitter@childrenscolorado.org.