Teaching clinical communication: a mainstream activity or just a minority sport?

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Plan

1. Why does clinical communication often appear to be a minority sport in medical education?

2. How to overcome this: integrate, don’t separate

3. Five specific areas of integration

4. A new UK consensus statement to help integrate communication into the mainstream

5. The progression to maturity in communication curricula
Premise 1

Medical education cannot ignore the central importance of effective clinical communication to high quality healthcare.
Premise 1

Clinical competence - the ability to integrate:

- knowledge
- communication
- physical examination
- problem-solving
All slides with a white background are additional slides to the original Oslo presentation.

These slides provide selected research evidence that augment the concepts presented in Oslo.
Are there problems in communication between doctors and patients?

- reasons for the patient's attendance
- gathering information
- explanation and planning
- adherence to plans
- medico-legal
- lack of empathy and understanding
Kurtz, Silverman and Draper (2005; 2nd Ed)
Teaching and Learning Communication Skills in Medicine
Radcliffe Medical Press

Silverman, Kurtz and Draper (2005; 2nd Ed)
Skills for Communicating with Patients
Radcliffe Medical Press
Discovering the reasons for the patient’s attendance

- 54% of patients’ complaints and 45% of their concerns are not elicited (Stewart et al 1979)

- in 50% of visits, the patient and the doctor do not agree on the nature of the main presenting problem (Starfield et al 1981)

- only a minority of health professionals identify more than 60% of their patients’ main concerns (Maguire et al 1996)

- consultations with problem outcomes are frequently characterised by unvoiced patient agenda items (Barry et al 2000)

- doctors frequently interrupt patients so soon after they begin their opening statement that patients fail to disclose significant concerns (Beckman and Frankel 1984, Marvel et al 1999)

- doctors often interrupt patients after the initial concern, apparently assuming that the first complaint is the chief one, yet the order in which patients present their problems is not related to their clinical importance (Beckman and Frankel 1984)
Gathering information

- doctors often pursue a “doctor-centred”, closed approach to information gathering that discourages patients from telling their story or voicing their concerns (Byrne and Long 1976)

- both a “high control style” and premature focus on medical problems can lead to an over-narrow approach to hypothesis generation and to inaccurate consultations (Platt and McMath 1979)

- oncologists preferentially listen for and respond to certain disease cues over others – while pain amenable to specialist cancer treatment is recognised, other pains are not acknowledged or are dismissed (Rogers and Todd 2000)

- doctors rarely ask their patients to volunteer their ideas and in fact, doctors often evade their patients’ ideas and inhibit their expression. Yet if discordance between doctors’ and patients’ ideas and beliefs about the illness remains unrecognised, poor understanding, adherence, satisfaction and outcome are likely to ensue (Tuckett et al 1985)

- doctors only respond positively to patient cues in 38% of cases in surgery and 21% in primary care (Levinson 2000)
Explanation and planning

- In general, 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 overestimate the time they devote to explanation and planning in the consultation by up to 900% (Waitzkin 1984, Makoul et al 1995).

- Patients and doctors disagree over the relative importance of imparting different types of medical information; patients place the highest value on information about prognosis, diagnosis and causation of their condition while doctors overestimate their patient’s desire for information concerning treatment and drug therapy (Kindelan and Kent 1987).

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

- There are significant problems with patients’ recall and understand of the information that doctors impart (Tuckett et al 1985, Dunn et al 1993).

- Only the minority of patients achieve their preferred level of control in decision making in cancer treatment (Degner et al 1997).
Patient adherence

- patients do not comply or adhere to the plans that doctors make: on average 50% do not take their medicine at all or take it incorrectly (Meichenbaum and Turk 1987, Butler et al 1996)

- non-compliance is enormously expensive. The cost of wasted funds spent on prescription medications used inappropriately or not used in Canada amounts to 5 billion a year, based on an annual expenditure of 10.3 billion and data indicating that 50% of prescription medications are not used as prescribed. Estimates of the further costs of non-adherence (including extra visits to physicians, laboratory tests, additional medications, hospital and nursing home admissions, lost productivity and premature death) were CAN$ 7-9 billion in Canada (Coambs et al 1995) and US$billion plus in the US (Berg et al 1993)
Medico-legal issues

- Breakdown in communication between patients and physicians is a critical factor leading to malpractice litigation (Levinson 1994). Lawyers identified physicians’ communication and attitudes as the primary reason for patients pursuing a malpractice suit in 70% of cases (Avery 1986).

- Beckman et al (1994) showed that the following four communication problems were present in over 70% of malpractice depositions: deserting the patient, devaluing patients’ views, delivering information poorly and failing to understand patients’ perspectives.

- Patients of obstetricians with a high frequency of malpractice claims are more likely to complain of feeling rushed and ignored and receiving inadequate explanation, even by their patients who do not sue. (Hickson et al 1994)

- In several states of the USA, malpractice insurance companies award premium discounts of 3 to 10% annually to their insured physicians who attend a communication skills workshop (Carroll 1996)
Lack of empathy and understanding

- numerous reports of patient dissatisfaction with the doctor-patient relationship appear in the media. Many articles comment on doctors’ lack of understanding of the patient as a person with individual concerns and wishes

- there are significant problems in medical education in the development of relationship building skills: it is not correct to assume that doctors either have the ability to communicate empathically with their patients or that they will acquire this ability during their medical training (Sanson-Fisher and Poole 1978, Suchman and Williamson 2003)
Premise 1

Research into clinical communication

• More effective interviews:
  - accuracy
  - efficiency
  - supportiveness

• Enhanced patient and health professional satisfaction

• Improved health outcomes for patients
Research evidence to validate the use of specific communication skills:

- process of the interview
- satisfaction
- recall and understanding
- adherence

**outcome:** decreased patient concern
symptom resolution
physiological outcome
Process of the interview

- the longer the doctor waits before interrupting at the beginning of the interview, the more likely she is to discover the full spread of issues that the patient wants to discuss and the less likely will it be that new complaints arise at the end of the interview (Beckman and Frankel 1984, Joos et al 1996, Marvel et al 1999, Langewitz et al 2002)

- the use of open rather than closed questions and the use of attentive listening leads to greater disclosure of patients’ significant concerns (Cox 1989, Maguire et al 1996, Wissow et al 1994)

- asking “what worries you about this problem” is not as effective a question as “what concerns you about this problem” in discovering unrecognised concerns (Bass and Cohen 1982)

- the more questions patients are allowed to ask of the doctor, the more information they obtain (Tuckett et al 1985)

- picking up and responding to patient cues shortens rather than lengthens visits (Levinson et al 2000)
Patient satisfaction

- patient satisfaction is directly related to the amount of information that patients perceive they have been given by their doctors (Hall et al 1988)
- information giving, expression of affect, relationship building, empathy and higher patient centeredness lead to increased patient satisfaction. (Williams S, Weinman et al 1998)
- in cancer patients, satisfaction with the consultation and the amount of information and emotional support received are all significantly greater in those who reported a shared role in decision making (Gattellari et al 2001)
Patient 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)

- 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)

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

- The provision of audio or video tapes of the actual interview and writing to patients after their consultation increase patient satisfaction, recall, understanding and patient activity (Tattersall et al 1997, McConnell et al 1999, Sowden et al 2001, Scott et al 2001)
Adherence

- 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)

- 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)
Outcome

Symptom resolution

- 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 or referral (The Headache Study Group 1986)
- training doctors in problem-defining and emotion-handling skills not only leads to improvements in the detection of psychosocial problems but also to a reduction in patient’s emotional distress up to six months later (Roter et al 1995)
- in the management of sore throat, satisfaction with the consultation and how well the doctor deals with patient concerns predicts the duration of illness (Little et al 1997)
- patient-centred communication is associated with better recovery from discomfort and concern, better emotional health two months later and fewer diagnostic tests and referrals (Stewart et al 2000)
Outcome

Physiological outcome

- giving the patient the opportunity to discuss their health concerns rather than simply answer closed questions leads to better control of hypertension (Orth et al 1987)

- decreased need for analgesia after myocardial infarction is related to information giving and discussion with the patient (Mumford et al 1982)

- providing an atmosphere in which the patient can be involved in choices if they are available leads to less anxiety and depression after breast cancer surgery (Fallowfield et al 1990)

- patients who are coached in asking questions of and negotiating with their doctor not only obtain more information but actually achieve better BP control in hypertension and improved blood sugar control in diabetes (Kaplan et al 1989, Rost et al 1991)
Premise 2

Communication skills can be taught and learnt

And we know which methods work
Premise 2

Aspergren K (1999)
Teaching and Learning Communication Skills in Medicine: a review with quality grading of articles
Medical Teacher 21 (6)

Teaching Patient Communication Skills to Medical Students: a review of randomised controlled trials
Evaluation and the Health Professions 30 (1)
Aspergren K (1999)
Teaching and Learning Communication Skills in Medicine: a review with quality grading of articles
Medical Teacher 21 (6)

- Overwhelming evidence for positive effect of communication training
- Medical students, residents, junior doctors, senior doctors
- Specialists and general practice equally
Rutter and Maguire (1976) showed in a controlled trial that medical students who underwent a training programme in history-taking skills reported almost three times as much relevant and accurate information. Confirmed by Irwin and Bamber (1984) and Evans et al (1989).

Evans et al (1991) showed that medical students who learned key interviewing skills were diagnostically more efficient in interviewing medical and surgical patients and yet took no more time.
Langewitz et al. (1998) demonstrated that specific patient-centred communication skills can be taught to residents in internal medicine over a 6-month period.

Smith et al. (1998) showed that a one month intensive training course in interviewing and related psycho-social topics for primary care residents improved their knowledge about, attitudes toward and skills in interviewing, with both real and simulated patients.

Humphris and Kaney (2001) demonstrated an improvement in communication skills in medical students over 17 months of their undergraduate teaching following a comprehensive and on-going communication skills course.

Fallowfield et al. (2002) showed that senior clinicians working in cancer medicine have many difficulties when communicating with patients, with patients’ relatives and with professional colleagues. In a randomised controlled trial of 160 oncologists from 34 UK cancer centres, an intensive 3-day training course produced significant subjective and objective changes in key communication skills three months later.

Yedidia et al. (2003) evaluated the effects of a communications curriculum instituted at 3 US medical schools. The curriculum significantly improved third-year students’ overall communications competence as well as their skills in relationship building, organization and time management, patient assessment, negotiation and shared decision making-tasks.
Stillman et al (1977) demonstrated that trained students maintained their post-training superiority over their non-trained peers at follow up a year later.

Maguire et al (1986) followed up their original students five years after their training. They found that both groups had improved but those given communication skills training had maintained their superiority in key skills such as using open questions, clarification, picking up verbal cues and coverage of psychosocial issues. These effects were found in interviews with patients with both psychiatric and physical illnesses.

Bowman FM et al (1992) showed that the improvement in interviewing skills of established general practitioners following an interview training course was maintained over a two year follow-up period.

Oh et al (2001) showed that trained medicine residents use of patient-centred interviewing skills significantly improved after an intensive course and these improvements were maintained for 2 years.
Which methods of learning work

Maguire et al 1978 randomised medical students into four training conditions and discovered the following key steps:

• the provision of detailed written guidelines of the areas to cover and the skills to use
• the opportunity to practice interviewing under controlled conditions
• observation by both self and facilitator
• the provision of feedback by an experienced facilitator with the aid of audio or video tape

Evans et al 1989 compared:

• a series of 5 one hour lectures covering the background to communication training and the verbal, non-verbal and listening skills that were helpful in the medical interview. Students were given comprehensive hand-outs, including relevant theory and research.
• 3 two hour workshops, after the lectures, using experiential methods such as role play, discussion, videotaping with real and simulated patients and feedback
Premise 2

The need for experiential learning

- active small group or 1:1 learning
- observation of learners
- video or audio recording and review
- well-intentioned feedback
- rehearsal
Plan

1. Why does clinical communication often appear to be a minority sport in medical education?
Why clinical communication often appears to be a minority sport

1. **Do real clinicians model this?**
2. **Does bedside teaching back it up?**
3. **Do learners think it is an add-on?**
4. **When doesn’t it occur?**
5. **Who doesn’t teach it?**
6. **Is it rigorously assessed?**
7. **Do the teachers understand the research?**
8. **Is there a planned curriculum?**
9. **Have teachers been trained?**
Why clinical communication often appears to be a minority sport

- Do real clinicians model this?
- Does bedside teaching back it up?
- Do learners think it is an add-on?
- Is it rigorously assessed?
- When doesn't it occur?
- Do the teachers understand the research?
- Is there a planned curriculum?
- Is clinical communication integrated into all clinical challenges students learn?
- Don't teach
Summary point 1

Learners still often perceive clinical communication teaching as an optional extra, not central to their learning
Plan

1. Why does clinical communication often appear to be a minority sport in medical education?

2. How to overcome this: integrate, don’t separate
What do we know about curriculum design?

Without training, medical students’ communication skills deteriorate as the curriculum progresses (Helfer 1970)

Without reinforcement, learning from one-off courses deteriorates over time (Engler et al 1981, Craig 1992)

Residents graduating from schools with more comprehensive sustained communication courses have better interpersonal skills (Kauss et al 1980)

At the very least, a curriculum with more sustained communication training in yrs 1-3 led to less deterioration in yr 4 (Hook & Pfeiffer 2007)

Integrated longitudinal programmes achieve more effective sustained increase in skills (van Dalen et al 2002)
So how does this research translate into designing a communication curriculum?

- A curriculum rather than a course
So how does this research translate into designing a communication curriculum?

• A curriculum rather than a course

• A helical rather than linear curriculum - review and reinforcement
So how does this research translate into designing a communication curriculum?

- A curriculum rather than a course
- A helical rather than linear curriculum - review and reinforcement
- Integrated not separated from the rest of the medical curriculum
Summary point 2

If clinical communication is not integrated throughout the curriculum, it will always be perceived as an inessential frill.
Plan

1. So why does clinical communication often appear to be a minority sport in medical education?

2. How to overcome this: integrate, don’t separate

3. Five specific areas of integration
Five specific areas of integration

a. Integration with history taking skills

b. Integration with practical skills

c. Integration with specialty teaching

d. Integration with the hidden curriculum

e. The crucial role of assessment in integration
Communication skills teaching model

versus

Traditional medical history model
Communication model (process)

- Initiating the session
- Gathering information
- Building relationship
- Structuring the interview
- Explanation and planning
- Closing the session
Traditional Medical History Model (content)

- Chief complaint
- History of the present complaint
- Past medical history
- Family history
- Personal and social history
- Drug and allergy history
- Systematic enquiry
Another confusion between process and content

Communication skills teachers have introduced their own new content
content to be discovered in gathering information:

the bio-medical perspective  
(disease)

sequence of events
symptom analysis
relevant systems review

background information - context

past medical history
drug and allergy history
family history
personal and social history
review of systems
content to be discovered in gathering information:

the patient’s perspective
(illness experience)
ideas and beliefs
concerns and feelings
expectations
effects on life
content to be discovered in gathering information:

<table>
<thead>
<tr>
<th>The bio-medical perspective (disease)</th>
<th>The patient’s perspective (illness)</th>
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<tbody>
<tr>
<td>sequence of events</td>
<td>ideas and beliefs</td>
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**Background information - context**
- past medical history
- drug and allergy history
- family history
- personal and social history
- review of systems
So what’s the solution?
Effective history taking is essential to the practice of high quality medicine.
Effective **communication** is essential to the practice of high quality medicine.
Effective clinical method is essential to the practice of high quality medicine.
THE CALGARY- CAMBRIDGE GUIDES TO THE MEDICAL INTERVIEW

Academic Medicine;78(8):802-809
Five specific areas of integration

a. Integration with history taking skills

b. Integration with practical skills

An innovative model for teaching and learning clinical procedures

Medical Education 36: 628-34
Five specific areas of integration

a. Integration with history taking skills

b. Integration with practical skills

c. Integration with specialty teaching
University of Cambridge
clinical rotations
Integration with specialty teaching

Stage 2

Obstetrics and gynaecology

Paediatrics

Psychiatry

Major adult diseases/Infection-GU/oncology

Elderly, neurosciences, rheumatology and orthopaedics
Stage 2

Obstetrics and gynaecology
- Dealing with diversity

Paediatrics
- Interviewing children and parents
- Student selected difficulties

Psychiatry
- Psychiatric interviewing
  - Assessing suicidal risk and depression following an overdose
  - Interviewing the patient with delusions and hallucinations

Major adult diseases/Infection-GU/oncology
- The sexual history
- Practical clinical skills/communication course

Elderly, neurosciences, rheumatology and orthopaedics
- The explanation and planning course (three sessions)
Five specific areas of integration

a. Integration with history taking skills
b. Integration with practical skills
c. Integration with specialty teaching
d. Integration with the hidden curriculum
Integration with the hidden curriculum

- Formal communication skills teaching
- Informal communication skills teaching
- Modelling
Five specific areas of integration

a. Integration with history taking skills
b. Integration with practical skills
c. Integration with specialty teaching
d. Integration with the hidden curriculum
e. The crucial role of assessment in integration
Assessment essential for driving the communication curriculum forward

Assessment acts a tool for integration
Simulated Clinical Encounter Examination (SCEE)
Description of the SCEE

- OSCE-style examination

- 12 stations
  - 4 stations of history taking and clinical reasoning
  - 4 stations of explanation and planning
  - 4 stations of other inter-personal skills

- Simulated patients and examiners

- 2 hours 40 mins face-to-face testing time
What does the SCEE test?

- Process skills of doctor-patient communication
- Integrated with content and clinical reasoning
- Tests clinical competence in the medical interview
Summary point 3

Pay constant attention to the many opportunities for integration throughout the medical school curriculum

Involve all disciplines and all contexts
Plan

1. So why does clinical communication often appear to be a minority sport in medical education?

2. How to overcome this: integrate, don’t separate

3. Five specific areas of integration

4. A new UK consensus statement to help integrate communication into the mainstream
A new UK consensus statement

Martin von Fragstein, Jonathan Silverman, Annie Cushing, Sally Quilligan, Helen Salisbury & Connie Wiskin

on behalf of the UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education

UK consensus statement on the content of communication curricula in undergraduate medical education

Medical Education 2008
http://www3.interscience.wiley.com/journal/119879061/issue
Plan

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5. The progression to maturity in communication curricula
Increasing maturity

The 20 year approach:
- invest in faculty development
- involve faculty in teaching and assessment
- involve senior students and junior doctors back into the programme

The progression to maturity in communication curricula

- Single stand-alone course in early years
- Multiple stand-alone courses in early years
- Integrated helically and with clinical teaching throughout curriculum
- Increasing number of communication domains covered
- Fully integrated into assessment
Conclusion

Integrate

Collaborate

Persevere