Clinical Communication: Form a Better Therapeutic Relationship With Your Patients

Use these skills to form a positive patient-physician foundation for all the other steps of doctoring

Ron Jones MD, FACP
Summa Health System Internal Medicine
IM Business Curriculum 2023-24

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IM Business Curriculum

Why a Business Curriculum? | ACGME Milestones | Triple Aim | Module Overview

Why a Business Curriculum?

In 2021 and beyond, physicians need training and preparation before they sign a contract and enter their first practice location. Our internal surveys have identified a need in our graduates for training in the areas of healthcare reimbursement, population medicine, advanced communication with patients, EHR documentation and leading clinical teams. Our faculty has responded with the IM Business Curriculum, a modular approach to ongoing education in all these areas during resident learning months in the IMC.

What kind of patient is hard for you?

Feeling stressed by…

Angry patient

Substance use/addicted

Passive

Misinformed

Zulman, et al. Practices to foster physician presence and connection with patients in the clinical encounter. JAMA Mar 17 2020; 323(1):70-81

Effective communication with patients lowers physician burnout

The evidence points to “the relationship between the clinician’s level of satisfaction and their ability to build rapport with their patients, their ability to express care and warmth [as] being critical in staving off burnout and cultivating joy in work.”

Emily Aaronson MD

1. AMA Physician Health. July 7, 2017

Why is this important for the patient?

The human connection:

Helps a patient participate in their own health

Improves medical outcomes

Improves symptom control

Improves function

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Create a therapeutic relationship

Five practices to foster Physician presence and connection with patients in the clinical encounter


Clinical Review & Education

JAMA | Special Communication

Practices to Foster Physician Presence and Connection With Patients in the Clinical Encounter

Donna M. Zulman, MD, MS; Marie C. Haverfield, PhD; Jonathan S. Shaw, MD, MS; Cati G. Brown-Johnson, PhD; Rachel Schwartz, PhD; Aaron A. Tierney, BA; Dori L. Zionts, MS, PH; Yada Safaeinili, MPH; Meredith Fischer, MA; Sonoo Thadaney Israni, MBA; Steven M. Asch, MD, MPH; Abraham Verghese, MD

IMPORTANCE Time constraints, technology, and administrative demands of modern medicine often impede the human connection that is central to clinical care, contributing to physician and patient dissatisfaction.

OBJECTIVE To identify evidence and narrative-based practices that promote clinician presence, a state of awareness, focus, and attention with the intent to understand patients.

EVIDENCE REVIEW Preliminary practices were derived through a systematic literature review (from January 1997 to August 2017, with a subsequent bridge search to September 2019) of effective interpersonal interventions; observations of primary care encounters in 3 diverse clinics (n = 27 encounters); and qualitative interviews with physicians (n = 10), patients (n = 27), and nonmedical professionals whose occupations involve intense interpersonal interactions (eg, firefighter, chaplain, social worker; n = 10). After evidence synthesis, promising practices were reviewed in a 3-round modified Delphi process by a panel of 14 researchers, clinicians, patients, caregivers, and health system leaders. Panelists rated each practice using 9-point Likert scales (−4 to +4) that reflected the potential effect on patient and clinician experience and feasibility of implementation. After the third round, panelists selected their "top 5" practices from among those with median ratings of at least +2 for all 3 criteria. Final recommendations incorporate elements from all highly rated practices and emphasize the practices with the greatest number of panelist votes.

FINDINGS The systematic literature review (n = 73 studies) and qualitative research activities yielded 31 preliminary practices. Following evidence synthesis, 11 distinct practices were reviewed by the Delphi panel, 8 of which met criteria for inclusion and were combined into a final set of 5 recommendations: (1) prepare with intention (take a moment to prepare and focus before greeting a patient), (2) listen intently and completely (sit down, lean forward, avoid interruptions), (3) agree on what matters most (find out what the patient cares about and incorporate these priorities into the visit agenda), (4) connect with the patient's story (consider life circumstances that influence the patient's health; acknowledge positive efforts; celebrate successes), and (5) explore emotional cues (notice, name, and validate the patient's emotions).

CONCLUSIONS AND RELEVANCE This mixed-methods study identified 5 practices that have the potential to enhance physician presence and meaningful connection with patients in the clinical encounter. Evaluation and validation of the outcomes associated with implementing the 5 practices is needed, along with system-level interventions to create a supportive environment for implementation.

Editorial (pages 11 and 13)

Audio and Video and Supplemental content

CME Quiz at jamanetwork.com/learning

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1. Zulman, et al. Practices to foster physician presence and connection with patients in the clinical encounter. JAMA March 17, 2020; 323(1):70-81

Create a therapeutic relationship

Prepare with intention

Listen intently and completely

Agree on what matters most

Connect with the patient's story

Explore emotional cues

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Stronger medical partnerships

Be prepared to be present (read chart, create a simple map of topics, so you won't have to refer to notes more than needed)

Listen actively:

- **Greet** the patient by name and introduce yourself
- **Sit** facing them, eyes on them and not the computer or your notes
- **Lean** towards them slightly; react without interrupting when possible
- **Reflect back** to them the information they've just supplied so they know you heard them: "OK, let's see if I have everything. The pain started about three weeks ago..."
- **Show gratitude** that they expressed their trust in coming to see you today
- **Be sure to review** any plans before closing the interview, inviting the patient to form them with you

1. Aquina. April 2 2019. Building Better-Doctor-Patient Relationships in Less Time. Accessed at https://aquinahealth.com/2019/04/02/building-better-doctor-patient-relationships-in-less-time/

Prepare with intention

Familiarize yourself with the patient you are about to meet (Prechart)

- Be sure to include social history, setting

Minimize the need to read long entries in the chart while with the patient

Create a “ritual” to focus your attention before a visit (Before you knock...) Release-Focus.

Be aware of your own mental state: take a deep breath in and out: become available to *this* patient.

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Listen intently and completely

Listen with the whole body using receptive body language:

- Sit down, lean in, orient one's body toward the patient (trust, relationship building, patient satisfaction)

Don't interrupt during opening description of illness.

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Agree on what matters most

Learn what your patient cares about and incorporate these priorities into the **visit agenda**

Ask them: “What are your own health goals right now? And for the future?”

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Connect with the patient's story

Consider the circumstances that influence your patient's health.

- Be curious
- Ask about their sociocultural background:Who do you live with? Are there barriers you face to better health?

Acknowledge your patient's efforts, celebrate successes

What's one thing you can contribute positively toward your patient's journey?

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Explore emotional cues

Pay attention to emotional cues. Notice, **name** and **validate** your patient's emotions to become a trusted partner in their health.

- Trembling, poor eye contact
- Asks repeatedly about something
- Expresses a worry, fear, loss or concern

Based on their emotions, what can you learn about what they **value**? **Can you say that back to them**?

- "It sounds as if this recent hospitalization has put your work on hold and that's really important to you."

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Respond to emotion with empathy

NURSE is a helpful mnemonic

- **N Name** the emotion

  “You sound frustrated”
- **U Understand**

  “It is understandable that you feel this way”
- **R Respect**

  “I can see you really care about your mother”
- **S Support**

  “We will do everything we can to support you through this process”
- **E Explore**

  “Can you tell me more about”

Avoid: Listening with the intent to reply

Instead try: Focusing on understanding

Avoid: Focusing only on facts

Instead try: Listening to patients and families and addressing emotional responses

Elizabeth Gundersen MD, recommends downloading the VitalTalk Tips app or going to www.vitaltalk.org. Covered by Mollie Frost in ACP Internist June 2023/Vol 43 No 6

Respond to medical misinformation

Don't: Attack the patient for their beliefs

Instead: Recognize the patient's desire to learn or protect their health

Avoid: Responding with a litany of facts

Instead: Understand the patient's underlying values or concerns first

Don't: Focusing only on facts

Instead: Use analogies.

- "I took the shot but still got COVID"
- "Wearing seatbelts reduces serious harm but isn't 100%."

The Coalition for Trust in Health & Science provides resources at https://trustinhealthandscience.org/myth-busting

Article by Charlotte Huff, ACP Internist June 2023 Vol 43 No. 6

Better patient communication lowers physician burnout

The evidence points to “the relationship between the clinician’s level of satisfaction and their ability to build rapport with their patients, their ability to express care and warmth [as] being critical in staving off burnout and cultivating joy in work.” Emily Aaronson MD

1. AMA Physician Health. July 7, 2017

Clinical Communication: How to Conduct Shared Decision Making

Activate patients in their own care by inviting them to participate in clinical decisions

Ron Jones MD, FACP
Summa Health System Internal Medicine
IM Business Curriculum 2021

Core Professional Skill Set

Summa Health

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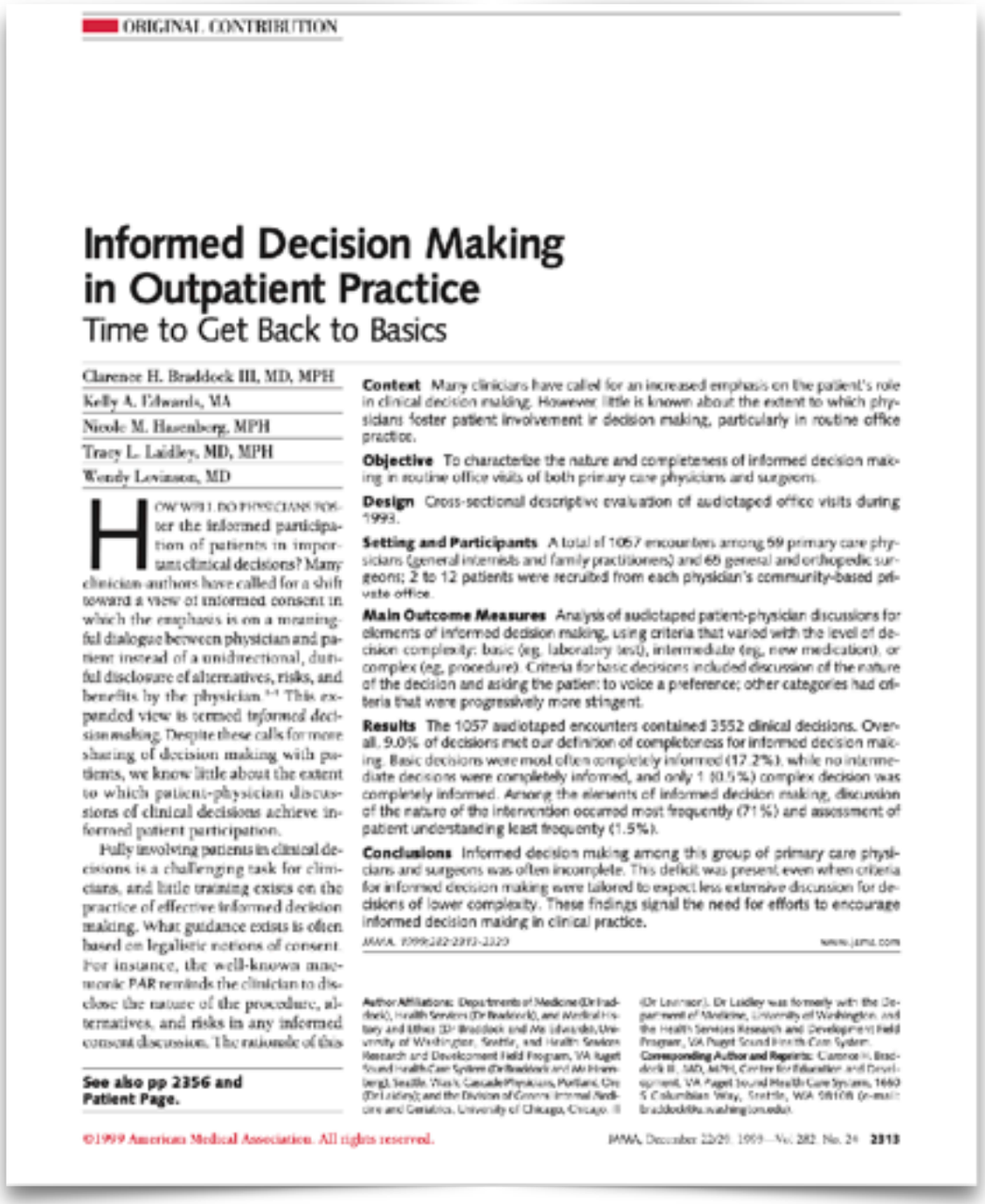
Shared decision making: *PARA-2*

Forming a specific plan together is a type of informed consent that engages the patient in their own care.

- **Plan**: Discuss why an action needs to be taken
- **Alternatives/Risks:** Discuss alternate care paths with benefit/risks of each
- **Ask** the patient which care path they favor
- **Agree** on a plan of follow up to the problem

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

Shared decision making



ORIGINAL CONTRIBUTION

Informed Decision Making in Outpatient Practice
Time to Get Back to Basics

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Tracy L. Laidley, MD, MPH
Wendy Levinson, MD

Context Many clinicians have called for an increased emphasis on the patient's role in clinical decision making. However, little is known about the extent to which physicians foster patient involvement in decision making, particularly in routine office practice.

Objective To characterize the nature and completeness of informed decision making in routine office visits of both primary care physicians and surgeons.

Design Cross-sectional descriptive evaluation of audiotaped office visits during 1993.

Setting and Participants A total of 1057 encounters among 59 primary care physicians (general internists and family practitioners) and 65 general and orthopedic surgeons; 2 to 12 patients were recruited from each physician's community-based private office.

Main Outcome Measures Analysis of audiotaped patient-physician discussions for elements of informed decision making, using criteria that varied with the level of decision complexity: basic (eg, laboratory test), intermediate (eg, new medication), or complex (eg, procedure). Criteria for basic decisions included discussion of the nature of the decision and asking the patient to voice a preference; other categories had criteria that were progressively more stringent.

Results The 1057 audiotaped encounters contained 3552 clinical decisions. Overall, 9.0% of decisions met our definition of completeness for informed decision making. Basic decisions were most often completely informed (17.2%), while no intermediate decisions were completely informed, and only 1 (0.5%) complex decision was completely informed. Among the elements of informed decision making, discussion of the nature of the intervention occurred most frequently (71%) and assessment of patient understanding least frequently (1.5%).

Conclusions Informed decision making among this group of primary care physicians and surgeons was often incomplete. This deficit was present even when criteria for informed decision making were tailored to expect less extensive discussion for decisions of lower complexity. These findings signal the need for efforts to encourage informed decision making in clinical practice.

JAMA. 1999;282:2313-2320 www.jama.com

How well do physicians foster the informed participation of patients in important clinical decisions? Many clinician authors have called for a shift toward a view of informed consent in which the emphasis is on a meaningful dialogue between physician and patient instead of a unidirectional, dutiful disclosure of alternatives, risks, and benefits by the physician.[1-3] This expanded view is termed *informed decision making*. Despite these calls for more sharing of decision making with patients, we know little about the extent to which patient-physician discussions of clinical decisions achieve informed patient participation.

Fully involving patients in clinical decisions is a challenging task for clinicians, and little training exists on the practice of effective informed decision making. What guidance exists is often based on legalistic notions of consent. For instance, the well-known mnemonic PAR reminds the clinician to disclose the nature of the procedure, alternatives, and risks in any informed consent discussion. The rationale of this

See also pp 2356 and Patient Page.

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Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

Elements of Shared Decision Making

R 1. Discussion of the **patient's role** in decision-making

R 2. Discussion of the **clinical issue** or nature of the decision

3. Discussion of the **alternatives**

4. Discussion of the potential **benefits and risks** of the alternatives

5. Discussion of the **uncertainties** associated with the decision

6. Assessment of the **patient's understanding**

R 7. Exploration of the **patient's preferences**

R = Required for Basic Decisions

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

Basic Decision Making

Example: Lab test

Complete: “I think we should check your thyroid level to see if that is causing your fatigue. Does that seem reasonable?”

Absent: “I’d like to check some blood tests. Here’s the slip to take to the lab.”

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

1. Discussion of patient's role in decision making

Rationale: Many patients are not aware that they can and should participate in decision making

Examples:

- "I'd like us to make this decision together."
- "It helps me to know how you feel about this."
- "I'm happy to share my views and help you reach a good decision. Before I do, would you like more details about your options?"

Required for all decision making

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

2. Discussion of the clinical issue or nature of the decision

Rationale: A clear statement what is at risk helps clarify what is being decided on and allows the physician to share some of his/her thinking about it.

Examples:

- "This is medication that would help with..."
- "The blood test will tell us..."

Required for all decision making

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

3. Discussion of the alternatives

Rationale: A decision is always a choice among certain options, including doing nothing at all. This is not always clear to the patient without an explicit discussion.

Examples:

- "You could try the new medication or continue the one you are on now."

Required for Intermediate or complex Decisions

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

4. Discussion of the benefits and risks of the alternatives

Rationale: We frequently discuss the pros of one option and the cons of another without fully exploring the pros and cons of each. A more balanced presentation allows the patient's decision to be more informed.

Examples:

- "The new medication is more expensive but you only need to take it once a day."
- "Screening for colon cancer using the stool cards is easier for you but the colonoscopy is more precise.

Required for Intermediate or complex Decisions

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

5. Discussion of uncertainties associated with the decision

Rationale: While often difficult, a discussion of uncertainties is crucial for a patient's comprehensive understanding of the options. Thoughtful discussion can promote trust and encourage adherence.

Examples:

- "The chance that this will help is excellent."
- "Most patients with this condition respond well to this medication, but not all."

Required Only for Complex Decisions

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

6. Assessment of patient's understanding

Rationale: Once the core disclosures are made, the physician must check in with the patient to know if what he/she said so far makes sense. Fostering understanding is really the central goal of informed decision making.

Required for Intermediate or complex Decisions

Examples:

- "Does that make sense to you?"
- "Are you with me so far?"

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

7. Exploration of patient preference

Rationale: Physicians may assume that patients will speak up if they disagree with a decision, but patients often need to be asked for their opinion. It should be clear to the patient that it is appropriate to disagree or ask for more time.

Examples:

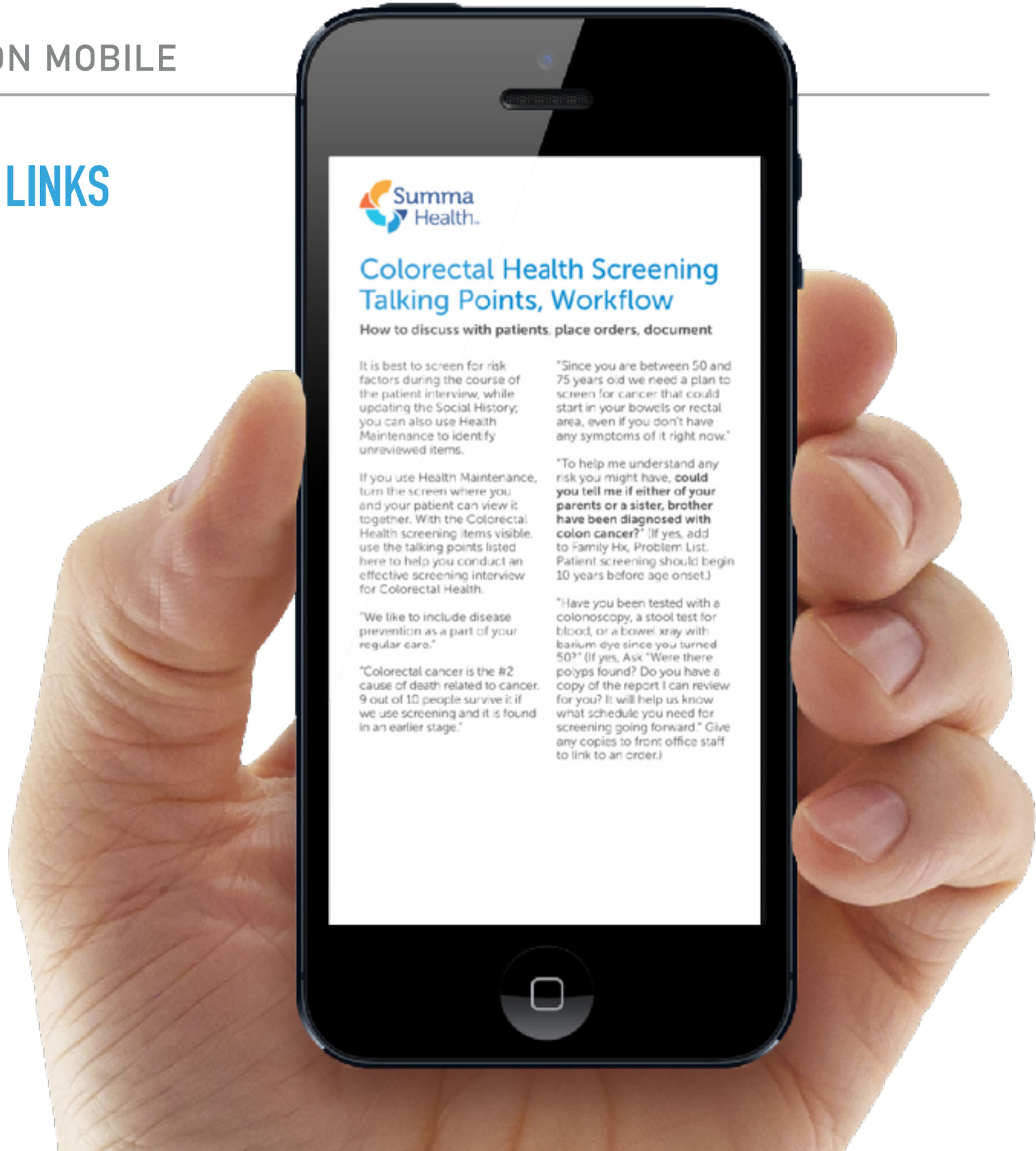
- "Does that sound reasonable?"
- "What do you think?"

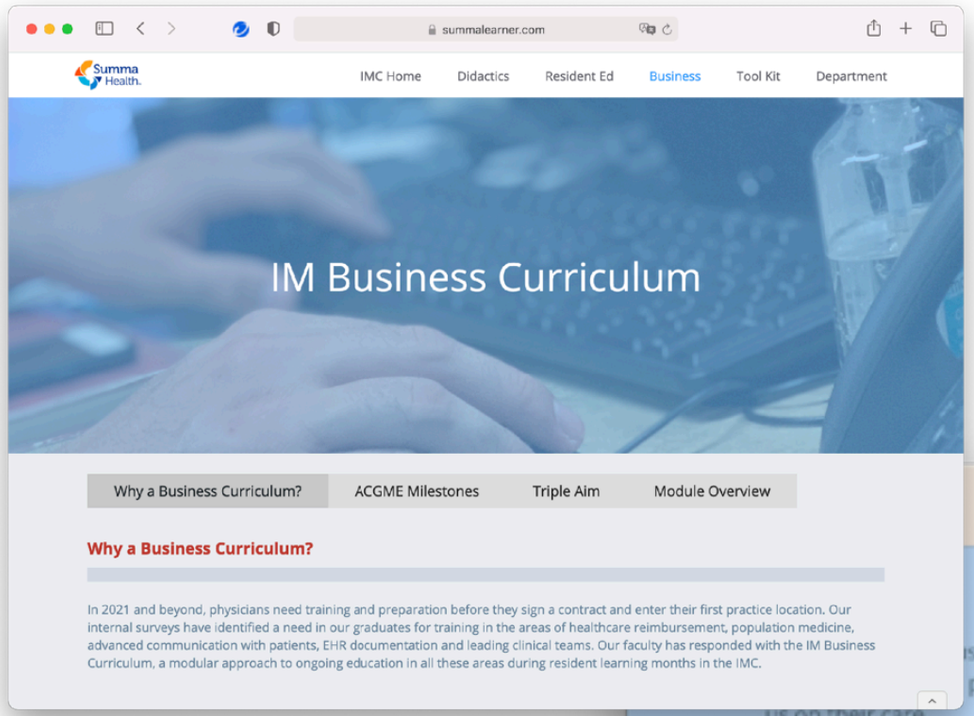
Required for all decision making

Braddock, CH. Informed Decision Making in Outpatient Practice: Time to Get Back to Basics. JAMA Dec 22/29, 1999-Vol 282, No. 24 pp 2313-2320

SUMMA LEARNER TOOL KIT LINKS

- Toolkit
- IMC
- PCMH
- Talking Points by subject

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Module Overview
Why a Business Curriculum?
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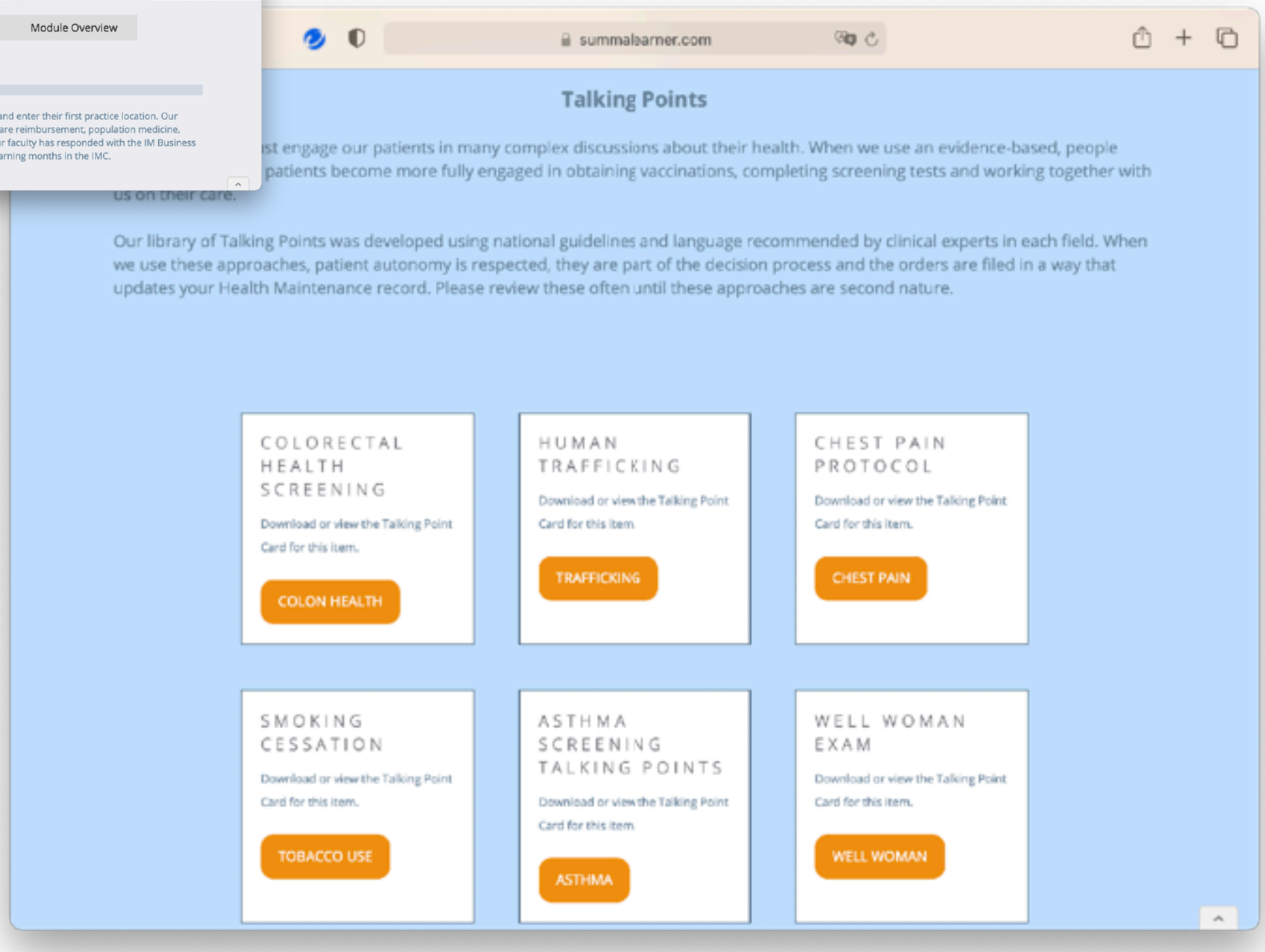
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Talking Points
st engage our patients in many complex discussions about their health. When we use an evidence-based, people
patients become more fully engaged in obtaining vaccinations, completing screening tests and working together with
us on their care.
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