

Teaching communication Skills:

Structure, key issues and practical methods

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Aims: Part 1

- Discuss and review consultations models for teaching communications skills
- Identify skills required, practice and challenges
- Share teaching practice



Aims: Part 2

- Review and discuss consent
- Communication skills to enhance patient self management and exercise adherence
- Review and discuss reassurance



Communication skills

- lots of options in the tool kit

Types and purpose of communication skills in the curriculum?

- Generate a list in groups of 5
- Elect scribe for feedback to group

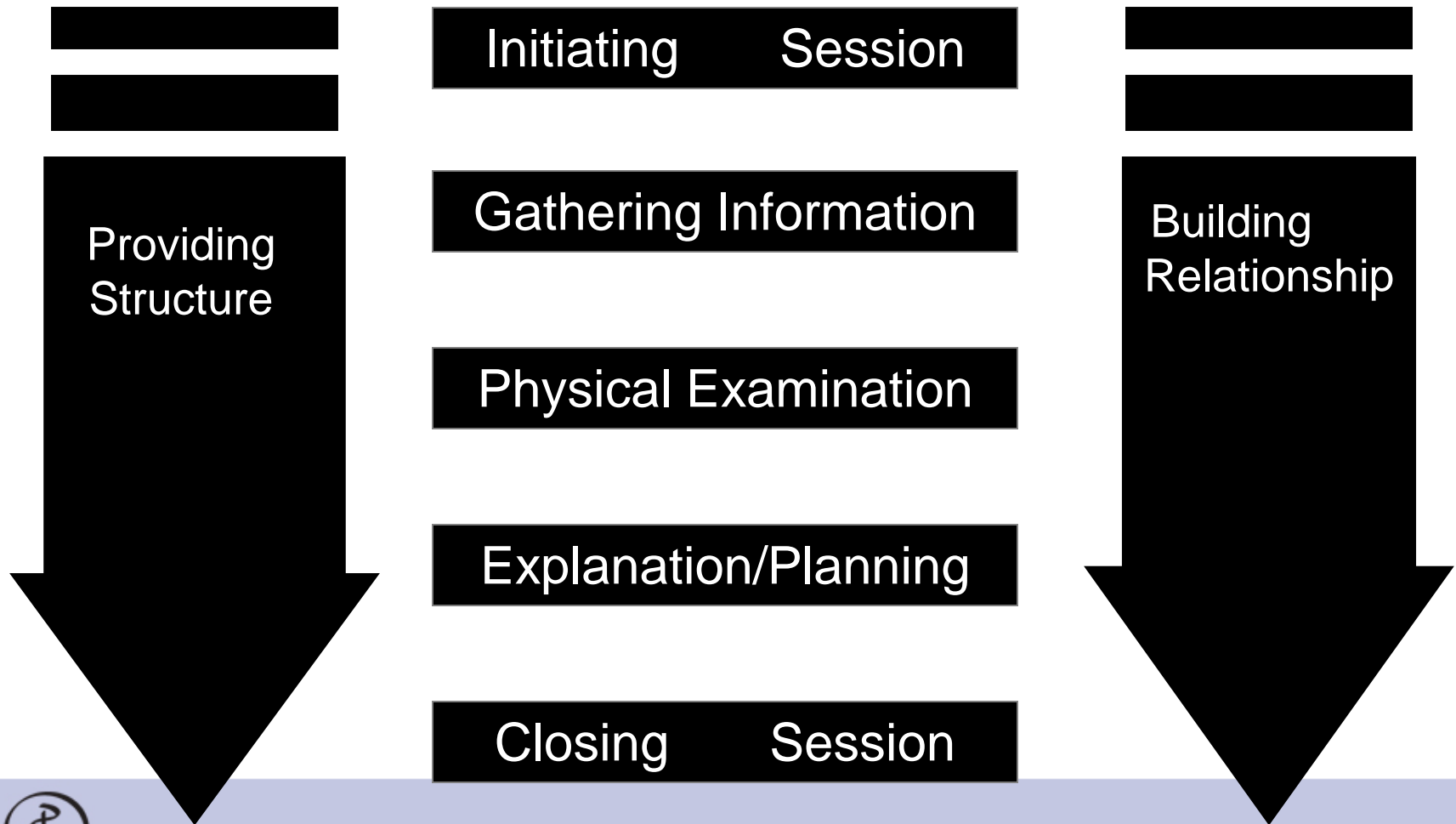


Types of comm skills

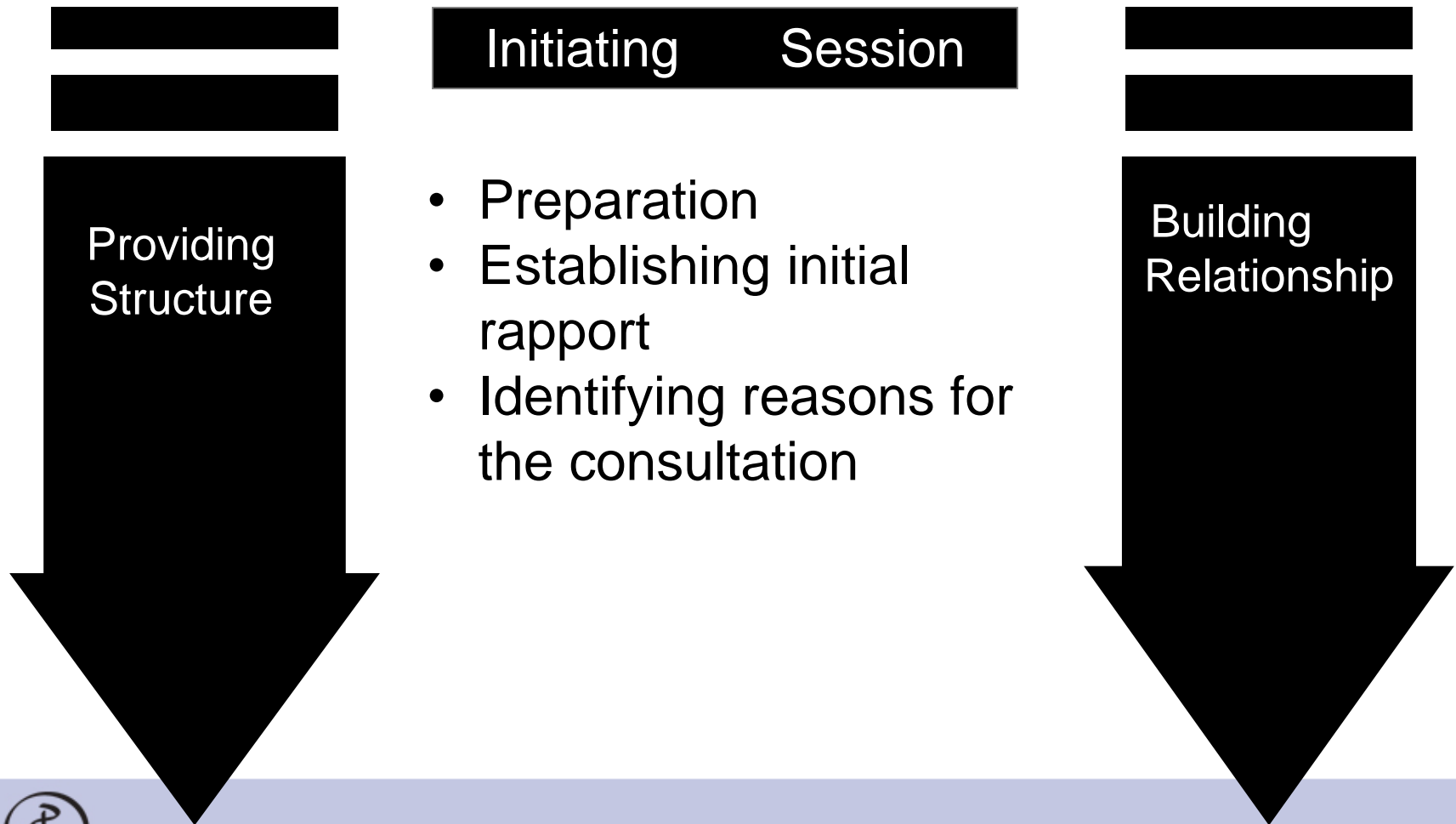
- Content skills – what we communicate
 - questions, responses, info, treatment etc
- Process skills – how we do it
 - Ways we communicate, verbal and non verbal, how relationship is developed, the way organise and structure communication
- Perceptual skills – what we think and feel
 - Internal decision making, reasoning, attitudes, compassion, mindfulness, integrity, biases distractions



CALGARY-CAMBRIDGE GUIDES FRAMEWORK FOR THE MEDICAL CONSULTATION



CALGARY-CAMBRIDGE GUIDES FRAMEWORK ADAPTED FOR THE OSTEOPATHIC CONSULTATION





Providing
Structure

Gathering Information

- Exploration of the patient's problem or condition to discover:
 - ☐ Biomedical perspective
 - ☐ Patient's perspective
 - ☐ Background information - context

Building
Relationship





The diagram illustrates the components of a physical examination. It features two large black arrows pointing downwards, one on the left and one on the right. The left arrow is labeled 'Providing Structure' and the right arrow is labeled 'Building Relationship'. Between these two arrows, there is a central text block containing a bulleted list and the title 'Physical Examination'. The bulleted list includes 'Explanation of examination', 'Information gathering', and 'Explaining'. The entire diagram is set against a white background with a light blue footer.

Providing
Structure

- Explanation of examination

Physical Examination

- Information gathering
- Explaining

Building
Relationship





Providing
Structure

Explanation/Planning

- Providing the correct type and amount of information
- Aiding accurate recall and understanding
- Achieving a shared understanding: incorporating the patient's illness framework
- Planning: shared decision making

Building
Relationship





Providing
Structure

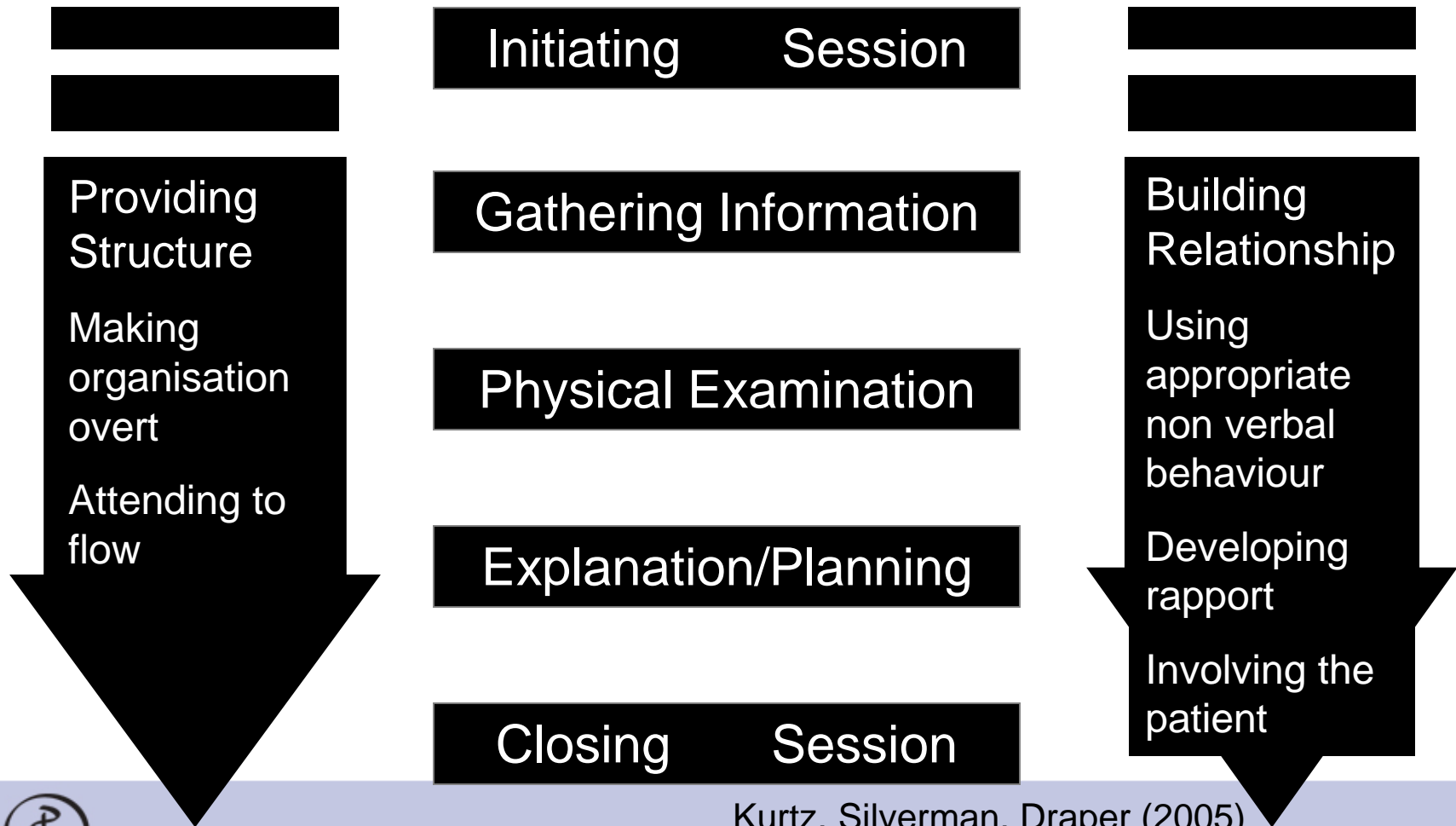
Closing Session

- Ensuring appropriate point of closure
- Forward planning

Building
Relationship



CALGARY-CAMBRIDGE GUIDES FRAMEWORK FOR THE MEDICAL CONSULTATION



Kurtz, Silverman, Draper (2005)



Using the structure

Having a structure can be useful:

- Prevents “wander” and missing points
- Reorientation
- Refocus
- Provides a flexible structure
 - Where am I in the consultation? What do I and patient want to achieve?
 - How do I get there?



Practical teaching

- In groups of 5 discuss your observations of teaching communication skills. Elect a scribe to feedback
- Consider the following:
 - What works well?
 - What is hard to teach?
 - What are the obstacles to developing graduates that have effective communications skills?



Sharing practice

Practical teaching session

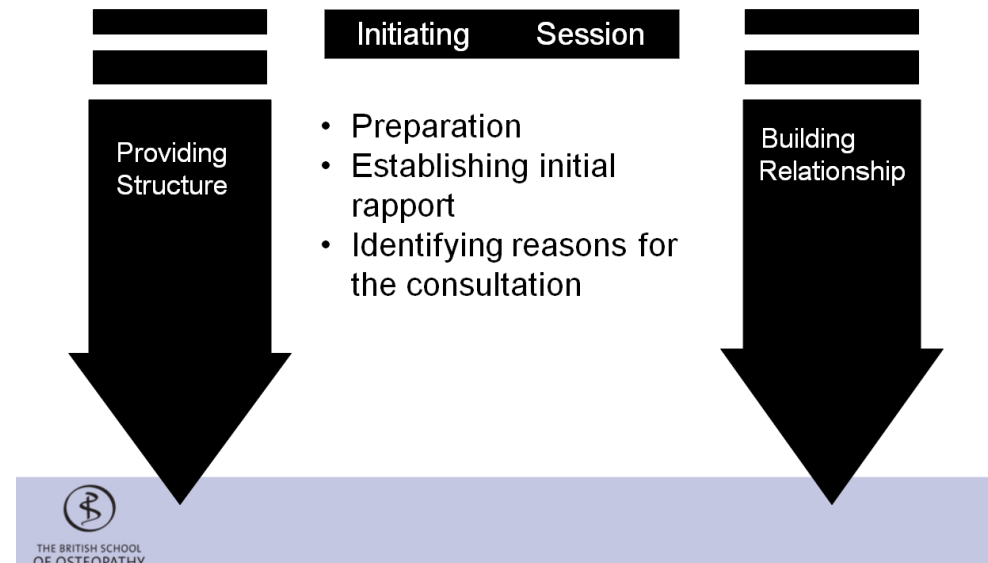
- Greeting and beginning of consultation
 - Patient role played by teacher / facilitator Yinka
 - Student practitioner played by Steve
 - Freeze frame
 - Jump in, jump out using participants
- Other examples



Linking the practical to the structure

- **Content skills:**
Substance of questions and responses, focus of questions
- **Process skills:** Ways of communication verbal and non verbal, style of question and organisation of flow
- **Perceptual skills:**
Reasoning, compassion, picking up on cues, mindfulness

CALGARY-CAMBRIDGE GUIDES FRAMEWORK ADAPTED FOR THE OSTEOPATHIC CONSULTATION



Consent at the beginning of the consultation

- Part of initiating the consultation
- Establishing partnership and transparency
- What's needed?



Underpinning principles of consent

- Autonomy
- Beneficence



When can these principles clash?

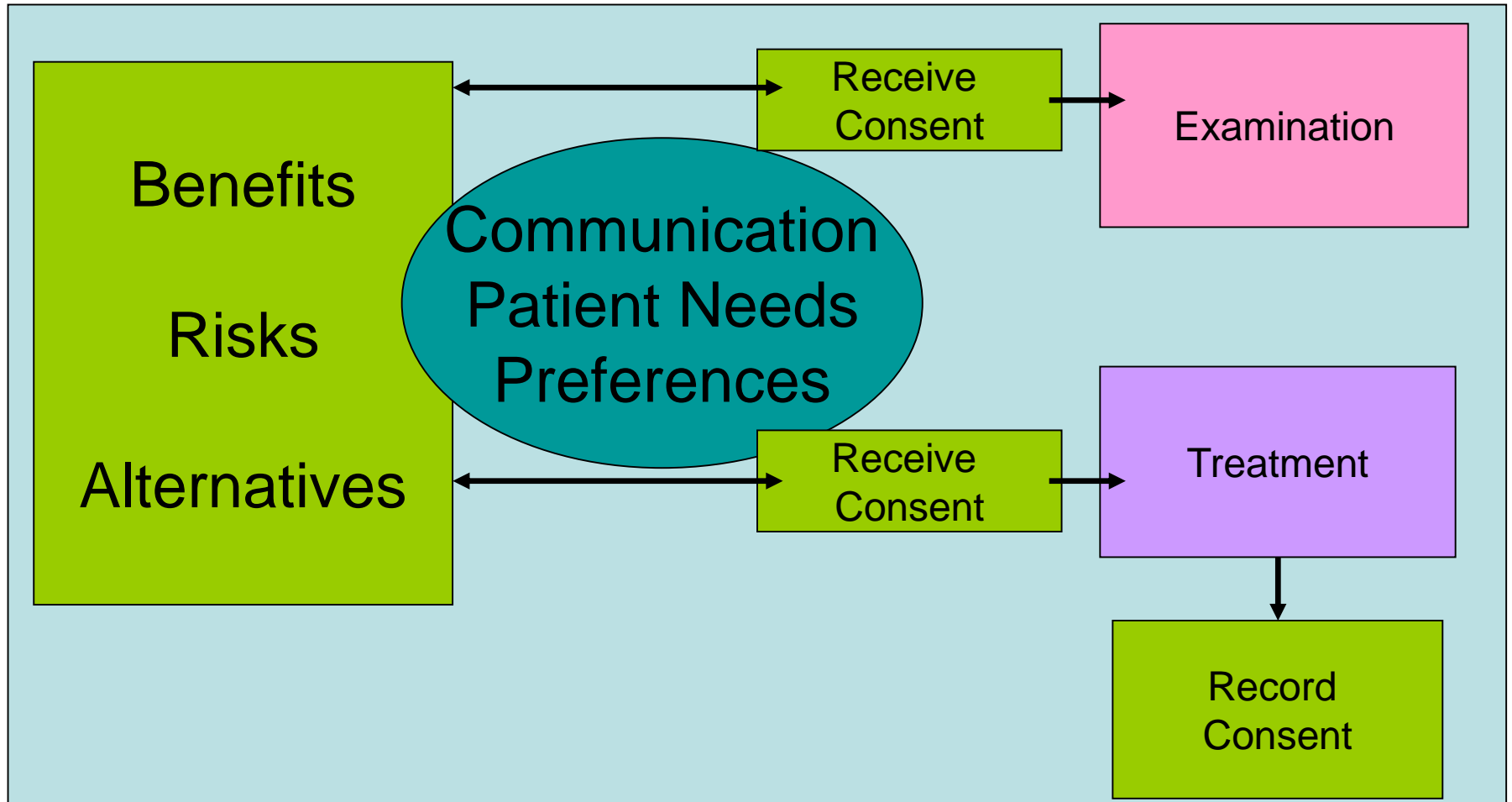


Autonomy - Beneficence

- Recent child case in UK brain cancer chemotherapy ok, radiotherapy no consent given to court....
- In osteopathy exercise interventions, manipulation....pelvic floor...



Patient osteopath partnership



Process

Prerequisites

Information:

- Risks Benefits Alternatives
- Voluntariness
- No-coercion
- Competence
- Understanding

Decision making

- Discussion
- Opportunity to ask questions
- Compare and contrast information
- Retention of information

Consent or reject intervention

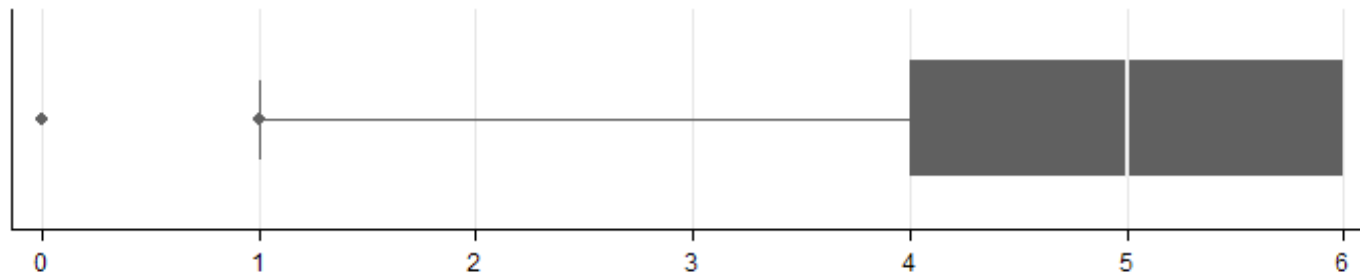


“Activity types” in the consultation

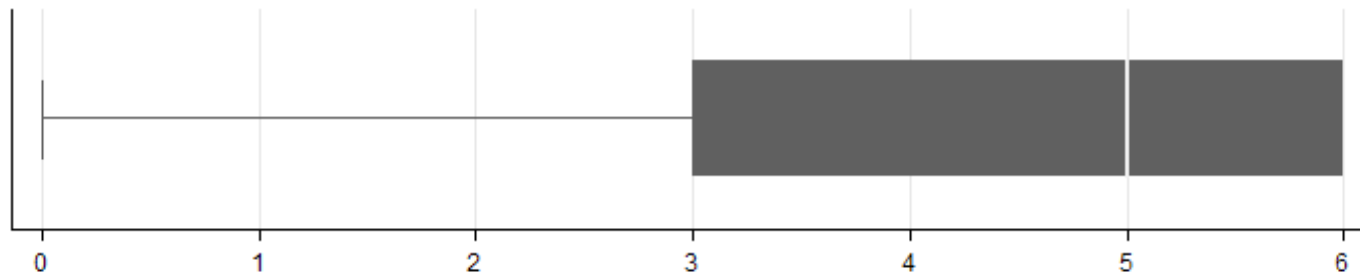
- Activities characterised by behaviour
 - Example of a lecture
 - Constraints
- What activity types are there in the consultation?
- How might we identify receiving consent as an activity?



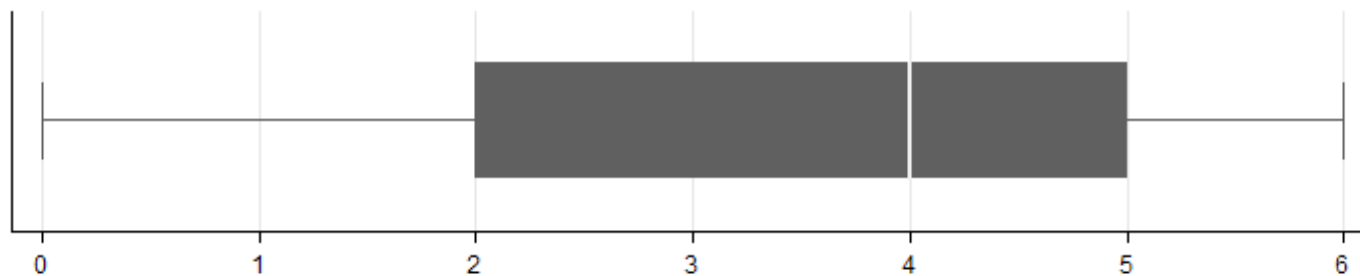
Informing patients osteopaths – Benefits, Risks, Outcomes/No treatment



Benefits of the recommended treatment



Risks of the recommended treatment



Outcomes of no or alternative treatments

Never

Always



Did the osteopath talk about:		Yes		No		Total
		n	%	n	%	
Reasons for examination	New pat	195	86.3	31	13.7	226
	Rtn pat/new symp	174	68.5	80	31.5	254
	Rtn pat/ongoing	781	59.7	527	40.3	1,308
Likely benefits of treatment	New pat	190	84.1	36	15.9	226
	Rtn pat/new symp	201	78.5	55	21.5	256
	Rtn pat/ongoing	938	69.3	416	30.7	1,354
Likely risks of treatment	New pat	107	50.0	107	50.0	214
	Rtn pat/new symp	81	34.9	151	65.1	232
	Rtn pat/ongoing	414	33.6	817	66.4	1,231
Likely outcome of no treatment or alternative treatment	New pat	103	48.4	110	51.6	213
	Rtn pat/new symp	98	41.5	138	58.5	236
	Rtn pat/ongoing	443	35.7	798	64.3	1,241

New patients recall more discussion
Risks and alternatives lowest levels of recall – 50% at best



What patients that complain say

‘The treatment to my back all happened very quickly. During this, I do not remember [osteopath] explaining what she was doing in any great detail or offering any explanations as to why she was carrying out this treatment.’

[Osteopath] did not explain what he was doing on this occasion. He has explained it to me in the past and so I think he knows that I know what he is doing.’

‘[Osteopath] said that there was a bit of stiffness in my neck. She said she would try to correct this and that I would hear another ‘pop’. Again, [osteopath] did not explain the details of what she was doing or why she was doing it. She moved my head from the left to the right a couple of times, while her hands were still covering my ears, and I heard the ‘pop’.’



- [Osteopath] didn't explain what he was doing and why, but because I have known him for so long I just left it to him and was happy chatting to him generally.'
- '[Osteopath] did not examine me any more than that and did not explain to me what he was about to do. [He] then yanked my foot in a violent way, I think he did this two or three times.'



The good and the bad

- Concerns about type and impact of information to be given
- Difficulties being understood
- Range of patient views, faith, attendance and memory
- Positive empathy and relationship building
 - mediates interpretation of events, forewarned is forearmed



Recording consent

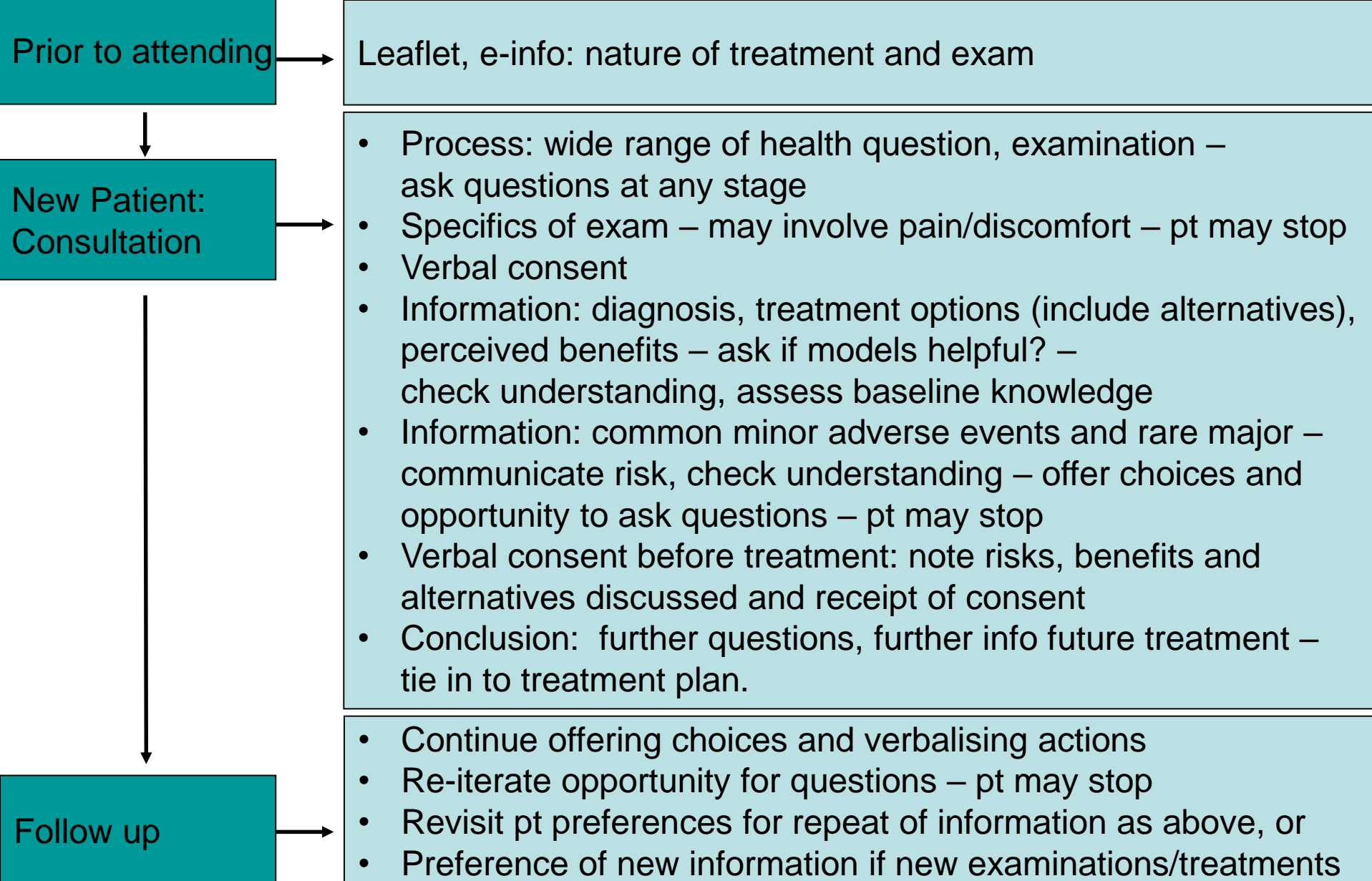
- Written and verbal consent equivalent
- Contemporaneous notes key
 - Record of care
 - Hand over care to others
 - Ability to reflect on practice
 - Defence if complaint
 - Note risks explained to patient, consent received or declined
 - Remember these notes might be needed years later – who will remember more accurately pt or prct?
 - Routine practice, claim or evidenced



Challenge for practitioners and students

- To provide sufficient information for patients to make an informed choice of action (autonomy)
- To balance with desire to achieve good outcomes (beneficence)
- Osteopaths need knowledge of risk, illness, disease, contra-indications, effectiveness of interventions, assessment of patient progress, etc: High level clinical skills and reasoning
- Individual calculations with individuals includes uncertainty – characteristic of professional action





Summary

- Forewarning is key to minimising negative impact of common treatment reactions and is an important element in maintaining acceptability
- Receiving consent is key to OPS and is an opportunity to build rapport and work in partnership with patients
- Recording process is important
- Defining expectations and type of behaviour in context of consent is important for teaching process



Using comms skills to enhance self management and exercise adherence

- Self management recommended for back pain and other msk conditions - but adherence poor, small effects on pain and disability
- Self management
 - Strategies to monitor and manage own health
 - Learn skills
- Challenge to enhance self management



Oliveira et al., 2012

Recent work in physio

- Practitioners can promote autonomous motivation and greater behavioural persistence
- Interventions needed to develop autonomy supportive communication
- Strategies identified drawing on Self Determination Theory



Low self-determination

High self-determination

ASK

Using Open-Ended Questions

"Tell me"/"What"/"How" are useful terms when asking questions, as they allow the patient to elaborate on his/her story.
Example: *"What kind of things are you doing to alleviate the pain at the moment"*

Using Single Questions

Avoid asking multiple questions at one time. Instead, ask one question and wait for a response before asking a second question.

Staying Silent

Allow the patient to complete sentences and finish speaking before following up with further questions.

Paraphrasing

After listening to the patient, summarize your perception of the main points. Examples: *"So what I am hearing is that..."* or *"It sounds like..."*

Empathizing

Show the patient that you understood the emotions that went along with the issue being discussed. Examples: *"I can see this upsets you"* or *"That must be very frustrating"*.

Gauging Patient
Readiness
to accept advice

Ask the patient if he or she is ready to consider advice regarding activities outside the clinic. Example: *"There a number of things you can do that will help ... would you like to hear a few suggestions?"*



ADVISE

Catering for Different Learning Preferences

Use a selection of methods (aural, visual, kinesthetic) to educate the patient (during session and take home materials); these methods cater for multiple learning preferences.

Closing the Loop

Ask patients to paraphrase/demonstrate information that had been provided. Provide corrective feedback as required, and re-test understanding. Example: *"To be sure that I was clear, could you please tell me, in your own words, your understanding of the . . ."*

Providing a Rationale

Explain to the patient the rationale behind your advice. Example: *"As we discussed earlier, your back needs support from the muscles around. So, if you can do these exercises, you can really provide your back with extra support . . ."* or *"Research shows that PA, such as walking, is a great way to . . ."*

Providing Opportunities for Patient Input or Choice

Ask the patient to provide input or make choices when providing advice. Example: *"Getting some physical activity –like going for a walk, riding your bike or swimming – is really good for your back. Is there a type of exercise that you prefer?"*

Using Autonomy Supportive Phrases Instead of Controlling Language

Support and encourage the patient to accept personal responsibility for his/her recovery. Avoid coercion or guilt inducing phrases. Examples: *"Here are some things that will help you overcome. . ."* or *"If you complete these exercises then you'll strengthen your back and it will be less likely to give you pain"*, instead of *"Do this for me"* or *"You have to. . ."* or *"You must. . ."*



AGREE

Employing SMART
Goal Setting

Agreed on goals that are Specific, Measurable, Achievable, Recorded, and Time-based. Example: *Earlier you mentioned that you are finding it hard walking for long periods. For this week we could set a target of 15 minutes walking per day, how many days do you think you could achieve that target in the next week?"*

Ensuring Active
Patient Participation in
Goal Setting

Ask the patient for his/her opinions/comments during goal setting. Take into account patient's subjective history (e.g. family/work commitments). Example: *What time of day would suit you best for these exercises?*



ASSIST

Identifying Barriers
and Obstacles

Discuss at least one likely barrier to following treatment advice.
Example: *"Is there anything you can think of that might stop you from accomplishing your exercise goal?"*

Identifying Solutions
and Obstacles

Brainstorm with the patient ways to overcome this barrier (e.g. 'identifying enablers' and 'cognitive restructuring').
Examples: *"Walking can be a fun and social activity that doesn't seem like hard work. How would you feel about walking with a friend/neighbor?"* and suggest changing thoughts from *"I am too out of shape to walk to the shop"* to *"If I take it nice and easy and remember to breathe, relax and take a rest when I need one, I will be able to walk to the shop."*

ARRANGE

Providing a Rehabilitation
Diary

Provide the patient with a rehabilitation diary to help him/her keep track of home-based rehabilitation (e.g., exercise, physical activity).

Following-Up

Suggest a specific follow-up appointment, provide guidance regarding when an appointment should be arranged (e.g., no more than 2 weeks later), or inform the patient that no follow-up appointment is needed.

Offering Contact

Invite the patient to contact you in the event of difficulties or questions.



Cognitive and affective reassurance and patient outcomes in primary care: A systematic review



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ABSTRACT

In the context of uncertainty about aetiology and prognosis, good clinical practice commonly recommends both affective (creating rapport, showing empathy) and cognitive reassurance (providing explanations and education) to increase self-management in groups with nonspecific pain conditions. The specific impact of each of these components in reference to patients' outcomes has not been studied. This review aimed to systematically evaluate the evidence from prospective cohorts in primary care that measured patient–practitioner interactions with reference to patient outcomes. We carried out a systematic literature search and appraisal of study methodology. We extracted measures of affective and cognitive reassurance in consultations and their associations with consultation exit and follow-up measures of patients' outcomes. We identified 16 studies from 16,059 abstracts. Eight studies were judged to be high in methodological quality. Pooling could not be achieved as a result of heterogeneity of samples and measures. Affective reassurance showed inconsistent findings with consultation exit outcomes. In 3 high-methodology studies, an association was found between affective reassurance and higher symptom burden and less improvement at follow-up. Cognitive reassurance was associated with higher satisfaction and enablement and reduced concerns directly after the consultations in 8 studies; with improvement in symptoms at follow-up in 7 studies; and with reduced health care utilization in 3 studies. Despite limitations, there is support for the notion that cognitive reassurance is more beneficial than affective reassurance. We present a tentative model based on these findings and propose priorities for future research.

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Why reassurance?

- Common recommendation in back pain management and other conditions
- Reassurance practitioner core skill
- Challenge in non specific pain conditions where clear causes can not be identified
- Probably an explicit or implicit goal in most clinical consultations
- Most prevalent intervention ?



Definition from Linton et al., Pain, 2008

“reassurance ...removes the fears or doubts of (pain/illness); to comfort... Reassurance always takes place within the dynamics of the interaction between the caregiver who has the intention to reduce worry, and the patient who is concerned. Ultimately, reassurance is achieved if the patient changes his/her behaviour, understanding or thoughts. The method of ‘reassurance’, on the other hand, is in the behaviour of the healthcare provider (HCP).



Categorising reassurance

Affective

- Verbal – non verbal
- Caring
- Empathy and confidence
- Recognising responding to distress
- Generic statements of reassurance

Cognitive

- Explanation of symptoms
- Explicit exclusion of serious pathology
- Agreeing goals
- Negotiating treatment options
- Discussing prognosis – future care
- Checking understanding, obstacles and summarising



Summary from the review

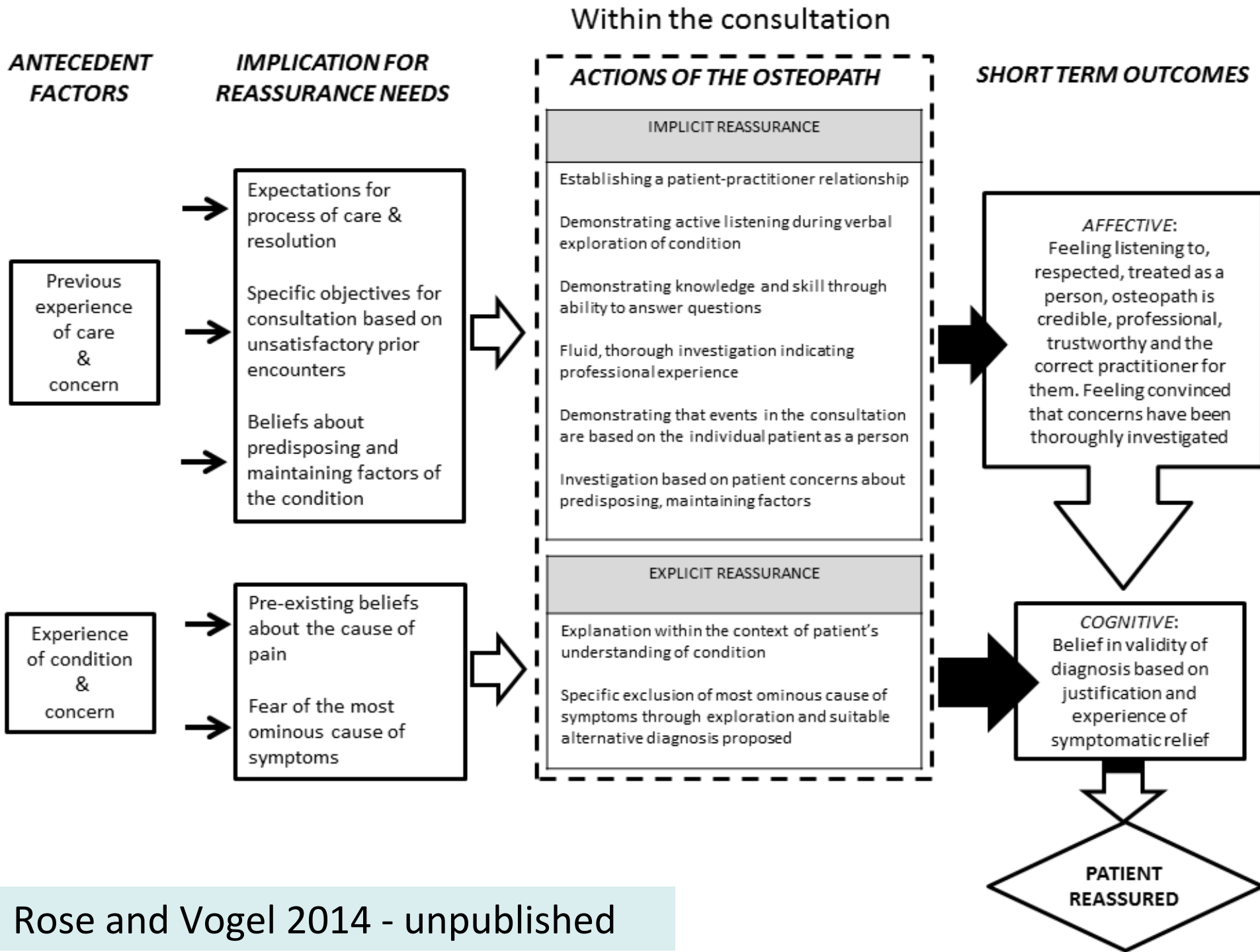
- Cognitive reassurance improves patient outcomes immediately post consultation and at follow up
- Affective at best improved satisfaction and possibly associated with worse outcomes
- The relationship between affective and cognitive reassurance is not clear



Qualitative work

- Reassurance complex and begins early
 - Facilities, greeting, technology, experience and expectations
 - Affective reassurance facilitates cognitive reassurance
 - Communicating: Focus on patient, touch, translating experiences
 - Giving time: Length of appointments and taking time to understand pt perspective





How might we teach reassurance in clinical settings?

Identify key phases in the consultation where you might teach reassurance

Identify the types of behaviour you wish to promote in students to deliver affective and cognitive reassurance



Case example as a teaching tool



Real Case Example

- 30 year old man
- C/O: L/B pain, left buttock and thigh, concerned
- No neuro, no red flags, well in self, no co-morbidity
- Delivery job
- Onset 1/12 prior to consult – picking up two cans of coke



The story

- Sharp pain, lay on floor
- Left work
- Walked a bit felt better, but still “bad”
- Same day, saw private physio recommended by friend
 - “Upset muscles on same side”
- Exercise prescribed, but hurt – felt better
- RTN to work after 2/52 but pain in back and thigh left work....



The story..

- Another physio suggested by friend “Got to be careful who you see”
- “Nerve trapped”
- More exercise
- Some improvement, but still sore
- A&E “damaged muscles in spine” – Pain killers, GP X’s 2 – painkillers: osteopath



What happened?

- Employer wouldn't pay for physio
- Affordability of physio @ £50:00...
- Sick pay minimum
- Angry with employer – thinking about new job, but feels trapped... but keen to RTW.
- Feels uncertain about what's happening



Examination

- No asymmetry
- Reluctant to flex, or move spine, bracing, holding
- Able to move with gentle supportive encouragement
- Somewhat tender lower spinal segments and associated muscles



Fears and thoughts

- “I won’t have sex anymore”
- “Using the toilet too much, sign my back is bad and won’t walk anymore”
- “pain and thinks will seize up – seize up and pain makes me worried - break my spinal cord”
- Going to be like this for the next five years, can’t get job, can’t satisfy wife”
- “Can’t look after myself”
- “Can’t spend time with the kids, because can’t play, jump, cos if over exerts, can’t walk for weeks/ months”
- “In car didn’t feel no pain, started looking for pain and began looking hard and found pain made it all worse”
- “Might not be able to “look after” myself on the street. I’m the sort of guy that likes to confront problems and just get stuck in.”



Who is the patient?

context - self defined

- 30 year old, ex offender, possession of a firearm.
- Rather solve things the street route.
- Ex competitive amateur boxer.
- Family / social :
 - Get on with it attitude “Mother always said to me to get on with it”.
 - Consider myself mentally strong – mother died 4/52 into sentence, really hard but kept going,
 - Father never around,
 - Brother career criminal, substance problems. Lots of people close to me have passed away.
- Difficult to get a job with record



Intervention – cognitive element

- Mixed up with discussion about a talk on affect of fear!
- Reassurance – aimed at fears
- Normalising experience
- Epidemiology of back pain
- Non confirmatory evidence
 - Lifting two cans of coke – strong man
 - Getting better
- Exploration of concerns in detail
- Non confirmatory movements as part of examination and treatment – testing hypotheses
- Take home info – back book



Result

- “Yea can see how mental thing has affected me”
- “Wish someone else had ... could have saved me ££”
- “Feel much better”
- Full ROM
- Plan to RTW acknowledges likely to have some pain as recovers



Affective and targeted reassurance

- Explore symptoms – open questions
- Establish empathy / rapport – listening, responding to cues
- Illicit concerns /feelings – open questions, summarizing
- Illicit illness perceptions/ causal attributions
- Expectations diagnosis/ treatment
- Recognise distress / respond to distress cues
- Psychological support



Cognitive reassurance

- Back pain info: targeted at pts perceptions
- Agree goals
- Negotiate treatment options
- Discuss prognosis future care
- Advise intervention and activity
- Check understanding
- Discuss obstacles
- Summarise final plan
- Give take away info



Challenges

- Explaining non specific diagnoses
- Linking diagnostic explanation to interventions
- Providing clear rational and understanding for self management behaviour
- Combining complex information into a BPS intervention



Summary

- Reviewed function of communication skills and structure of consultation
- Shared practice and identified challenges
- Reviewed some communication in context of consent, self management and reassurance



Key resources:

Skills for communicating with patients.

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Thank you for your attention



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