



The Bravewell Collaborative

Teaching Manual

to accompany the Medical Education Training Videos

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Introduction: This Website

This website/DVD is designed to improve doctor-patient communication education and thereby to make a positive impact on the potential therapeutic and healing effects of medical encounters.

The first part consists of a detailed presentation on doctor-patient communication, which introduces learners to the importance of the topic, developments in the field, and effective teaching based on core communication competencies. This is intended for use by learners or by faculty in creating their own initial lecture or presentation. We have found that a good format is a brief lecture followed by an interview with a standardized patient in which the interviewer stops at interesting nodes and asks the audience of learners what to do next, or pauses to explain or comment.

The second part consists of a teacher's guide to doctor-patient communication. Here you can download or view eight videos of real doctors working with real patients, in several settings. These patient interview videos can be used as learning tools. Included is a general teaching guide as well as suggested lesson plans based on each of the 8 videos.

In Appendix K there is a PowerPoint presentation for download that can be used as an introductory lecture for students or as material for students to review independently.

The Videos

Eight videos can be downloaded or viewed from this website and used as learning tools. Each video has on it a meter and with it a metered transcript so students and faculty can be sure they are discussing the same portion of the encounter.

Video 1: Dr. Peterson, Dr. Cohen, and a geneticist with Barbara L.

Synopsis: Part 1: Ms. L. has been recently diagnosed with breast cancer and sees Dr. Cohen (a plastic surgeon) for the first time for advice on treatment options for breast reconstruction. Part 2: Follow-up appointment with Dr. Peterson (Ms. L.'s breast surgeon). Part 3: Dr. Peterson and the geneticist reveal her long-awaited test results. These videos run for approximately 60 minutes.

Video 2: Dr. David Coun with Altagracia Maribel W.

Synopsis: Altagracia Maribel W. is Spanish-speaking and comes to see her regular physician to discuss her back pain and her elevated sugar. She has brought in a medication that a friend gave to her. This video runs for approximately 15 minutes.

Video 3: Dr. Richard Greene with Maria V.

Synopsis: Mrs. V. is Spanish-speaking and presents to Dr. Greene with multiple, varied symptoms. She has a history of depression. This video runs for approximately 14 minutes.

Video 4: Dr. David Stevens with Taides N.

Synopsis: Taides N. presents to Dr. David Stevens complaining of pain in her legs for the past 2-3 months. Dr. Stevens explores her underlying issues and discusses a management plan with her. This video runs for approximately 25 minutes.

Video 5: Dr. Johnson with Virginia P.

Synopsis: Virginia P. presents to Dr. Johnson with congestion, coughing and associated chest pain. Ms. P. wonders if it is allergies and goes to Dr. Johnson seeking advice and treatment after trying different

medications that did not help. The video runs for approximately 8 minutes and includes the medical interview and examination.

Video 6: Dr. Kathleen Hanley and Chong H.

Synopsis: Chong H. presents to Dr. Kathleen Hanley complaining of a long history of intermittent vomiting which has become increasingly frequent and associated with pain and diarrhea. Chong H. is a Chinese-speaking patient and the interview is conducted via remote simultaneous interpretation. This video runs for approximately 15 minutes.

Video 7: Dr. Kimura with Julia P. and her mother

Synopsis: Julia P. is 13 years old and presents with her mother to Dr. Kimura, a pediatric rheumatologist. Ms. P. has been referred by her general pediatrician for ongoing headaches and blurry vision. She has seen various doctors and had various tests, with no definitive diagnosis found. This video runs for approximately 20 minutes.

Video 8: Dr. Roberta Lee and Elliot B.

Synopsis: Elliot B. presents to Dr. Roberta Lee for a second visit. This is to follow up on his various concerns including sleeping problems, obesity, diet, and Type 2 diabetes. This video runs for approximately 25 minutes.

How to use these materials

This website/DVD can serve as a laboratory for the learner's own description of what they see and experience in watching doctors and patients in a new way, as professional and healer. They can relate their own observations to core, empirically derived concepts and precepts of communication and healing. This provides students with a platform from which they can devise other valuable approaches which can be practiced in role play and other exercises or standardized or real patient based experiences.

The accompanying videos are not intended to depict "perfect" physician-patient interviews; rather they demonstrate realistic communications in "real" clinical settings. These videos can be used as triggers, examples of good and bad, for exercises on many listening skills, and as a virtual laboratory for communications skills learning and discovery.

The presentation materials, including the introductory lecture provided as a downloadable PowerPoint presentation (*click here to access*), and videos can be used by educators/presenters working in any health discipline or medical specialty. Educators/presenters do not have to be communication experts but it helps to know the core references.

Overview of learning objectives

After working through these materials, learners will be able to:

- Describe the importance of effective physician-patient communication in improving patient outcomes
- Understand the medical interview as a core clinical skill with measurable competencies
- Know and be able to demonstrate those competencies at stage specific levels of skill and integration
- Review established models of effective doctor-patient communication (e.g., Macy Model, Kalamazoo Consensus)
- Develop skills in analyzing medical interviews according to empirically derived concepts and precepts of communication and healing
- Develop clinical competence in core communication skills as described by the Macy Model of Doctor-Patient communication
- Describe common communication barriers, personal and general, that occur in some medical encounters and strategies to overcome these
- Use their own personal reactions as data to deepen real time understanding of practitioner-patient encounters

PART 1: The Science of Doctor-Patient Communication

Why do doctor-patient communications matter?

The medical interview is the major medium of patient care and therefore is of central importance to practitioners from both professional and personal perspectives.¹

The interview is a principal determinant of the accuracy and completeness of data elicited from the patient.

It is the most important factor in determining patient adherence to the plans agreed on—whether to take a medication, take a test, or change a life style.

The interview is the keystone of patient and provider satisfaction.

More than 80% of diagnosis is derived from the interview.

Interview related factors have been shown to impact outcomes of care such as:

- Symptom resolution
- Pain control
- Physiological responses
- Daily functioning
- Emotional health

Through the medical interview a clinician can most influence the doctor-patient relationship and therapeutic aspects of the medical encounter.

Therapeutic nature of the medical encounter

Before the modern era of pharmaceuticals and other medical interventions, sick people sought care from physicians. Many of these patients experienced a therapeutic benefit for this care and started on the road to healing.⁴

Only in 1910 did the average patient seeing the average provider finally have a greater than 50% chance of benefitting!

Clinical relationships can be therapeutic, independent of medical, diagnostic and treatment activities. Healing aspects of encounters can be enhanced by employing specific interview skills.⁵ For example:

- Learning counseling strategies that help patients cope with stress and illness or with bad news.
- Educating patients effectively.

- Enabling patients' own decision making about their health, thereby reframing the encounter from one where the patient feels helpless to one where the patient feels empowered to help him or herself.
- Developing strategies to increase the likelihood of the patient's changing unhealthy lifestyle behaviors.
- Increasing the reliability and completeness of the data you get.
- Eliciting difficult to discuss or stigmatized information (such as illicit drug use or psychological problems).
- Helping promote patients' active participation in their own self care and well being. This may result in increasing patients' sense of accountability, responsibility, self-esteem and confidence.
- Helping the patient move from passivity to activity, from feeling helpless to feeling effective, from having lost their idealized self to realizing a new competent self.
- Facilitating the patients' movement through the grief and loss of becoming sick or diseased to emergence as coping with their reality in useful ways.

Often physicians and other health care professionals may not even be aware of the healing results of patient encounters.

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What we know about doctor-patient communications

History (derived from ¹)

The history of communications teaching and standard dogma (i.e., prevailing views) has evolved through a series of phases: the prehistoric; classical and ancient; rhetorical; exhortative/charismatic; descriptive empirical; experimental empirical; and the consensus dulled by the dismal meta-analytic.¹

The importance of communication in medicine was generally understood by prehistoric human healers. Fabrega emphasizes that even in the smallest social units, such as isolated tribal groups of as few as five, sick people need to show their sickness in order to seek and get help.² Healers need also to understand their patients' diseases and illnesses and to plan and execute their healing rituals and treatments³.

The rhetorical phase was marked by authors such as Osler and exemplified by Peabody in his *The Care of the Patient* (1927) with its dictum, “for the secret of the care of patients is in caring for the patient.”⁴

Next, great clinician-educators such as William Morgan and George Engel codified in 1969 an approach described as *The Clinical Approach to the Patient*.⁵ They differed from prior eras in including an overarching approach to care, claiming to set a standard, and finding time in the curriculum to teach the mandated skills. What was lacking from a current perspective were objective data that what they exhorted was of demonstrated value, concerning such outcomes as knowledge gained, skills acquired, skills enduring and skills applied in practice.

While Morgan and Engel’s approach was being published, Korsch and colleagues in 1968⁶ systematically examined actual interviews. She captured sequential interviews in a pediatrics emergency department and showed what was really happening according to a rudimentary classification scheme. She demonstrated that the doctors and the parents were speaking different languages. This work permanently changed the communications analysis business.

Modern communications analysis

The real innovation, which ensured that a valid and reproducible empirical base of information would evolve into semi-quantitative analysis eventually justifying models and theory, was foreshadowed by Bales who, for sociological research purposes, invented his Interactional Analysis method.⁷ In this method, an encounter was captured on tape and then every thought or phrase, technically an utterance, was arranged into a set of categories that were mutually exclusive (every utterance went into just one bin) and exhaustive (a bin could be found for every utterance).

In the early 70’s, Deborah Roter adapted the Bales method to medical interviews, first for her doctoral thesis and subsequently in print.⁸ The Roter Interactional Analysis Scheme (RIAS) became the gold standard method of evaluating what is actually happening verbally in interviews. Highly reliable, reproducible, and relevant, at higher reproducibility and coding reliability rates than most research or clinical tests, it categorizes every utterance into one of 34 categories that most subsequent authors have found adequate for their thinking and analysis. Since then, Roter and her colleagues have added items and subscales to especially reflect content needs of particular areas, such as the emergency room or palliative care.

Inui and colleagues strikingly critiqued this approach as stripping rich interactions of meaning, reproaching RIAS. In reviewing such systems, they asserted that schema such as Roter’s ought to:

Ideally, an interactional analysis system should...take into account the salient dimensions of interpersonal communications...characterize information exchange that occurs through several

channels: through tone of voice, sighing, pauses...(and) gesture, facial expression...the context...and the sequencing of communication behaviors...and attempt to change behavior in light of such lessons.⁹

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Can we teach doctor patient communications?

In pursuit of a broader influence in medical education about healing and communicating, in 1979, Lipkin and Putnam initiated the first interest group in the Society of General Internal Medicine (then SREPCIM), which came to be called the “Task Force on the Doctor and Patient”, evolving in 1993 into the current American Academy on Communication in Healthcare (AACH). Lipkin, a colleague of George Engel, and Putnam, a collaborator with Bill Stiles in creating an interactional process analytical method, recognized that the then evolving new science required innovation in teaching and practice. Lipkin argued that that precisely as in cardiology or chemotherapy, what is said and done by doctors and by teachers of doctors should, where feasible, have an empirical basis, a theoretical structure, sound values, and be taught using demonstrably effective methods. These criteria were the basis of the coming revolution in teaching medical communications.

In 1984, Lipkin et al. published a comprehensive curriculum for the medical interview which provided a roadmap for the teaching and research of the group.¹ The curriculum had four general objectives: patient-centered interviewing and treatment; an integrated approach to clinical reasoning and patient care; personal development of humanistic values; and psychosocial and psychiatric medicine. Each objective had extensive, empirical (where possible; and clarity about its lack where necessary) knowledge, skills and attitudes specified. It discussed teaching strategies, options and evaluation. Within the same time frame, two other Task Force participants, Cohen-Cole and Bird, described three

functions of the interview: (a) gathering information; (b) developing a relationship; and (c) communicating information, noting that specific teachable behaviors could be allocated to each function.² Regular meetings of this developing, invisible college of interested persons led to a surprising recognition, that even the best teachers and biggest experts needed significant work on their own skills.

In response to this need, Lipkin in 1982² invented a course model that synthesized educational ideas from Engel³, Freire⁴, Rogers^{5,6} and Knowles⁷. He then created actual courses that used small groups to both learn about personal skills and how to improve them, and how to integrate such learning into the real world and daily practice. It used Rogerian (and later other) group methods to help the learner overcome any personal barriers, rooted in his or her own development and psychological structures, to progress. It used a task focus, in the form of a real time project, to synthesize and foster integration of these learnings.

In 1983, Dennis Novack and William Clark initially directed what became a still ongoing annual course on teaching interviewing,⁸ which spawned similar courses in the United Kingdom, under the auspices of the Medical Interview Teachers Association and now has active offshoots in Scandinavia, Switzerland, and Italy.

The Lipkin Model has been documented to change knowledge, skills, and attitudes²; to demonstrate a dose response⁹; to change real world behavior in the short term and durably; to elicit personal growth and transformational experiences in learners¹⁰; and to be applicable across higher order learning situations as in cancer care, substance abuse, disaster response¹¹, pain management, and education itself.¹² It has grown and evolved as the major model of the AACH and many of its trainees. The place of communications teaching in medical school curricula had shifted from being present in roughly 35 percent of US schools in 1978 to about 75 per cent in 1992.⁸

Parallel developments have been created at many programs including the University of Western Ontario (Stewart, Brown, Weston); Michigan State (Smith, Fortin); and for many levels of learner from medical students to cancer specialists (Fallowfield, Maguire).

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Is there a better way to teach doctor-patient communications?

Maguire’s 1986 study of medical students demonstrated that communication skills training with video feedback led to stronger listening, clarification, and inquiry skills five years later.¹

In a controlled trial, a cross-institutional curriculum project, the Macy Initiative, demonstrated that communication competencies of third-year medical students improved, as measured by a comprehensive, multi-station, objective structured clinical examination.² There is also evidence that postgraduate communication skills training impacts on clinician behaviors and outcomes.^{3,4} This evidence was subsequently reviewed and used to develop a comprehensive, consensus-based approach to teaching.⁵

Role play, feedback via videotape review, observation and feedback in small groups are some of the many effective teaching methods to be employed, but no specific method has been shown to be superior to another.⁶

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The issue of consensus

Consensus is emerging concerning what was empirically validated as the core of teach-worthy communications skills. One example was the Toronto consensus statement.¹ In 1995, the AACH published its authoritative reference text, which covered clinical care, education, and research as an exposition of communication training for internal and family medicine.²

One recent synthesis of communication skills training was expressed in a highly condensed form in the two Kalamazoo consensus statements.^{3,4} These were significantly influenced by the more extensive Macy Initiative in Health Communication⁶In the Macy project, a process of faculty survey, literature review, and expert opinion was used to evolve a set of 60 or so “competencies” or behaviors, expressed so as to be measurable, believed to be essential for graduating physicians.⁵ These were organized in a logical schema depicting the flow of the medical interview, as described in the next section ‘Competencies for teaching about communications and healing.’ Each of the major headings contains sub-items which are behaviorally expressed, measurable using simple techniques, and empirically derived. A cohort, controlled study demonstrated that this complex set of skills (the evaluation measured some 30, which had been blinded to the curricular designers) could be taught and significantly changed behavior over a year.⁶

Since then, although there have been serial syntheses and consensus efforts (always a moving target), the core principles of communication skills training have remained quite stable, once one translates the babble of new language for common concepts.⁷

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Competencies for teaching about communications and healing

Core Communication Skills for Practicing Physicians (from the Macy Initiative Competency Document Developed by New York University School of Medicine, Case Western Reserve University School of Medicine, and University of Massachusetts Medical School, 1999) ¹

This represents a defined set of communication skills competencies created through extensive review of the literature, survey of the three schools' faculty and student bodies and input from experts and national accreditation boards. These competencies outline the essential skills required of all physicians.

Macy Initiative in Health Communication Core Competencies

- I. Structure of the Medical Interview
 - a. Prepare self and environment
 - b. Open
 - c. Survey Problems (Determine the patients chief concerns)
 - d. Gather information and calibrate interview
 - e. Develop and maintain relationships
 - f. Manage flow
 - g. Communicate information
 - h. Close
 - i. Communicate between visits

II. Communication with the Patient

The Three Functions of the Medical Interview

1. Identify the Problem-
 - Elicit complete and accurate information, observe essential data, form and test hypotheses (problem-solving), identify psychosocial and other contextual variables.

2. Develop and Maintain Relationships-
 - Communicate respect for the patient and elicit the patient's perspective, respond with empathy to patient's concerns, demonstrate professionalism, and recognize and respond to conflict in the Doctor/Patient relationship.
3. Education and Counseling-
 - Assess the patient's understanding of current problems, explain recommended course of action, and negotiate a mutually agreeable treatment plan with the patient.
4. Patient activation (inducing the patient to be more active on his or her behalf) is thought by some (authors included) to warrant standing as a fourth function. Applications –
 - Types- New patient interview, established patient interview, chronic condition, family interview, utilizing a medical interpreter, telephone interview, and e-mail communication.
 - Situations/Content Areas- Advanced /directives, giving bad news, informed consent, limitation of treatment, organ and tissue donation, MO/Insurance limitation, abusive relationships, substance abuse, genetic counseling, non-adherent patient, taking a sexual history, and talking to children of different developmental ages.

III. Communication about the Patient

1. Oral Communication
 - Types- Case presentations, telephone requests, consults, formal presentations.
 - Situation/Content Areas- Complication, transfer, discharge, death and court testimony.
2. Written Communication
 - Types- Medical Record (H&P, SOAP, consult note) and e-mail.
 - Situation/Content Areas- Discharge, transfer and death summaries; death certificate and court deposition.
3. Team Communication
 - Types- Work rounds, attending rounds, and treatment planning teams.
 - Situation/Content Areas- Negotiating differences in treatment options, negotiating turf issues, referrals, consultations, disagreeing with a superior, small group dynamics.

IV. Communication about Medicine and Science

1. Oral Communication
 - Types- Grand Rounds, lay presentations, lectures and conferences.

- Situations/Content Areas- Manage interruptions and changes in context.
2. Written Communication
 - Types- Patient information, public health forum, scholarly papers and presentations.

See appendices A-G for detailed explanation of each component.

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PART 2: Guide to teaching communication skills with real physician-patient videos

This serves as a general guide for how to engage students in learning on patient-doctor communication, and includes ideas for teaching format and content. In the section following this, there are nine suggested lesson plans with more directed and specific teaching instructions.

Teaching format

Many different exercises can be done using these tapes. In every exercise, students should reflect on their own reactions to the patient, practitioner, and the content and affect in the encounter and consider healing versus negative features of the exchange. Examples follow.

A class-based exercise with large-group discussion

For example:

- Give a prior reading [e.g., Lipkin M (2008). The medical interview. In: Feldman M, Christiansen J, eds. Behavioral Medicine, 3rd edition, pp. 1-9. McGraw Hill Medical, New York] or homework assignment (could be research or answering some questions based on a video clip), show a video or a video segment, and lead a group discussion;
- Ask students to view video on their own, read on communication theme(s), and make a set of observations. Then lead a group discussion;

Exercises to do in pairs or small groups after watching the video(s):

- Checklists, for example good vs. could-be-improved communication list (see appendix A) to be used as feedback form;
- Role play to practice techniques that the students prepared in their homework, role play improvements, alternative scenario role plays;
- Live role play challenges seen with better solutions, with option to videotape and then discuss. Students can also practice switching roles;
- Students provide feedback to each other after practicing role plays.

Student discussion of doctor- patient communication elements

Students observe the medical interviews in each video and relate them to the elements of the Macy Model of Doctor-Patient Communication. (See appendix A-H) Students can then be directed to address specific questions based on structure, flow and function of the medical interview. They can also be alerted to pertinent communication issues relevant to the particular video interview. The questions listed below can be introduced via different teaching formats described above and are a framework to introduce students to essential communication elements and skills.

Structure and Flow

- How do the patient's several problems impact on an encounter?
- How does the patient's own agenda impact on the structure and flow of the interview?
- How does the beginning of an encounter impact what happens in the session? What ways of beginning the encounter work efficiently?
- How does the end of an interview impact the outcome of the encounter? What ways of concluding the encounter work efficiently?
- Discuss time management strategies that could enhance interview efficiency.

Function

Information gathering (See appendix D)

- Observe and comment on the form of questions used by physician in the interview.
- What important verbal and nonverbal cues did the patient present?
- What minimal encouragers are used?
- Do you think the physician understood the patient's needs and expectations of the visit?
- Did the patient and physician have differing views of the problem?
- Do you think the patient had a hidden/alternative agenda?
- Did the physician learn about the patient's beliefs, family, community, cultural and/or religious aspects?

Developing and maintaining the relationship (See appendix B)

- Observe the physician-patient relationship.
- Note each of the PEARLS (Partnership, Empathy, Apology, Respect, Legitimization, Support) skills in an interview. If not present, how could they have been utilized?
- How were emotions handled in the interview and are there any alternative ways to approach this?

Providing information and counseling (See appendix F)

- Discuss the style and level of patient education provided in the interview.
- How does the physician ensure understanding by the patient? Are there any other techniques that you would employ?
- Comment on the language used in the interview.
- Do you feel that physician and patient participated in shared decision making?
- Observe and describe the physician's process of treatment or management plan negotiation, if any.

Do you think any other functions exist and are pertinent? (See appendices A-G)

- Pertinent communication issues that may be relevant.
- What healing skills do you see present, what wounding skills are on display?
- Discuss alternative healing methods or treatments—their value, risks, and place in a medical interview.
- How does translation impact the process? Be specific.
- How does gender impact this interview?
- How does culture enter into this encounter?
- Comment on pros and cons of having the computer in the room and how it impacts the relationship and interview process. How does the doctor use it?
- Comment on the impact of the room set-up or environment on the relationship.
- Describe efficient ways of discussing medication with patients. How may this impact on patient adherence?
- Discuss strategies for the dealing with depressed and anxious patients.
- Discuss issues regarding the adolescent medical interview.

- Discuss dealing with bad news.

Suggested lesson plans

Each of these lesson plans are based on specific communication themes relevant to one of the real doctor-patient videos downloadable from this website or on the DVD.

Lesson plan 1

Have students review one video and record in a Google document or written presentation to give to other students:

- What positive and negative interactions do you observe?
- Characterize them.
- Relate them to the Macy Model.
- Reflect on your own reactions to patient, practitioner, and the content and affect present.

Lesson plan 2

Theme: Overview of Macy Model of Doctor-Patient Communication (See appendices A-G.)

Teaching Objectives:

- Learn the essential elements of the Macy Model of Doctor-Patient Communication.
- Learn to read patients' non-verbal communication and "cues."
- Develop communication skills in opening a medical interview, asking open ended questions (information gathering), using PEARL statements (relationship building), helping patients to understand their condition (patient education and sharing information), negotiating a management plan and closing an interview.

Suggested reading:

Kalet A, Pugnaire MP, Cole-Kelly K, et al. Teaching Communication in Clinical Clerkships: Models from the Macy Initiative in Health Communications. *Acad Med.* 2004;79:511-520.

Kalamazoo Consensus Participants in the Bayer-Fetzer Conference on Physician Patient Communication in Medical Communication. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Acad Med.* 2004;76:390-393.

Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R and all the participants in the American Academy on Physician and Patients Conference on Education and Evaluation of Competence in Communication and Interpersonal Skills. (2004)

Assessing competence and interpersonal skills. The Kalamazoo II report. Acad Med. 2004;79:495-507. Fortin AH, Dwamena F, Smith RC. Patient- and Doctor-Centered Interviewing. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Brody D, Novack DH. Therapeutic Aspects of Medical Encounters. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008. Lipkin M. The medical interview. In Feldman M, Christiansen J, eds. Behavioral Medicine, 3rd edition. New York, McGraw Hill Medical, 2008: pp. 1-9

Instructions

Use any one or more of the real patient-physician videos as a learning tool.

Student homework task: watch one of the videos and write down your thoughts on how the doctor performed each element of the Macy Model

In the next class present to the group what your thoughts were and lead a large group discussion on the following questions:

- Were all the essential elements of the Macy Model apparent in the interview?
- How did the doctor open the interview?
- How did the doctor gather the necessary information to understand the patient's concerns?
- How did the doctor find out about the patient's personal, psychological, family, and social history?
- What does the group think were the patient's main concerns and feelings?
- What are examples of non verbal communications the doctor used? Discuss.
- What PEARLS statements did the doctor use? Discuss.
- Comment on the patient's non verbal communication.
- What is the communication skill called Ask-Tell-Ask? How was it used in the video?
- Did the doctor use appropriate language with the patient?
- Did the doctor and patient agree on a management plan? How did the doctor negotiate this plan?
- Were the patient's expectations met? How did the doctor achieve this?
- How did the doctor close the interview?

Students then divide into small groups or pairs to role play improvements on specific interactions. Each pair or group prepares a role play focusing not on the characters (doctor and patient) in the video

but on one element of the Macy Model. For example, one role play on gathering information about the patient problem, one on patient education, one on negotiating a management plan.

Students then regroup and each pair demonstrates the improvements and their rationale to the group.

Lesson plan 3

Theme: Informed decision making, breaking bad news, and relationship building.

Teaching objectives:

- Students to learn communication skills specific to situations of informed decision making and breaking bad news.
- Discuss relationship building skills including PEARL and the therapeutic effect of these on the medical encounter. (See appendix B.)

Suggested reading:

Kalet A, Pugnaire MP, Cole-Kelly K, et al. Teaching Communication in Clinical Clerkships: Models from the Macy Initiative in Health Communications. *Academic Medicine*. 2004; 79:511-520.

Braddock CH. Informed Decision-Making. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Quill T. Giving Bad News. Braddock CH. Informed Decision-Making. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Fallowfield L, Jenkins V, Farewell V, et. al., Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomised controlled trial *THE LANCET* • Vol 359 • February 23, 2002

Back A, Arnold R, Tulsy J. Mastering Communication With Seriously Ill Patients Balancing Honesty With Empathy and Hope. (UK) Cambridge U Press 2009, 176 pp.

Video 1: Dr. Peterson, Dr. Cohen, and a geneticist with Barbara L.

Synopsis: This video has three parts (about 1 hour viewing time in total) separated in time, so students get a sense of the patient's ongoing illness, physician visits and treatment decisions she is faced with

Part 1: Barbara has been recently diagnosed with breast cancer and sees Dr. Cohen (a plastic surgeon) for the first time for advise on treatment options for breast reconstruction.

Part 2: Barbara has a follow-up appointment with Dr. Peterson (Barbara's breast surgeon).

Part 3: Dr. Peterson and the geneticist reveal to Barbara her long awaited test results.

Instructions

Before the class, students can be given homework to read on informed decision making and review the Macy Model of Doctor-Patient Communication.

Play the first part. Then lead a group discussion addressing the following:

- What skills were used to elicit the patient's reason for the visit?
- What is the effect of the physician's language on the flow of the consultation?
- How did you experience the physician's method of educating her patient on the options for breast reconstruction surgery?
- Students divide into pairs or small groups and conduct role play improvements.

Play the second part of the video. Then lead a large-group discussion addressing the following:

- How does Dr. Peterson's patient education style differ from that of Dr. Cohen's?
- Students divide into pairs or small groups and conduct role play improvements.
- Divide students into pairs for a 5 minute role play. Each takes a turn to be Barbara and Dr. Peterson. The topic is that Dr. Peterson is breaking the news to Barbara that she is BRCA1 positive.

Play the third part of video and then lead a group discussion addressing the questions below (can also be done as an exercise in pairs then followed by a group discussion):

- What essential elements of informed decision making does Dr. Peterson employ?
- What PEARL statements do Dr. Peterson and the geneticist use?
- Discuss strategies for breaking bad news to patients (example: bringing in family member for support).

Lesson plan 4

Theme: Discussing medication and lifestyle, developing the relationship, and negotiating treatment.

Teaching objectives:

- Students learn effective ways of gathering and providing information on medication and lifestyle prescriptions. (See appendices C-E.)
- Discuss barriers to patient change and adherence.

- Learn strategies for overcoming these barriers.
- Discuss relationship building skills including PEARL and the therapeutic effect of these on the medical encounter (See appendix B).

Suggested reading:

Kalet A, Pugnaire MP, Cole-Kelly K, et al. Teaching Communication in Clinical Clerkships: Models from the Macy Initiative in Health Communications. *Academic Medicine*. 2004; 79:511-520.

Grueninger U, Duffy FD, Goldstein M. Patient education in the medical encounter; how to facilitate learning, behavior change, and coping. In Lipkin M, Putnam SM, Lazare A. *The Medical Interview: clinical care, education, and research*. New York, Springer-Verlag, 1995: pp 122-133.

Williams SL, Haskard KB, DiMatteo MR. Patient Adherence. In Feldman M, Christensen J. *Behavioral Medicine: a guide for clinical practice*. NY, McGraw-Hill Medical, 2008:158-162. O'Connell D. Behavior Change. In Feldman M, Christensen J. *Behavioral Medicine: a guide for clinical practice*. NY, McGraw-Hill Medical, 2008:141-157.

Goldstein MB, Duffy DF,
<http://webcampus.drexelmed.edu/doccom/user/static/authors/MichaelGoldstein.htm> Shochet R. Promoting Adherence and Health Behavior Change. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Video 2: Dr. David Coun with Altagracia Maribel W.

Synopsis: Altagracia Maribel W. is Spanish speaking and comes to see her regular physician to discuss her back pain and her elevated sugar. She has brought in an unprescribed medication that a friend gave to her. This video plays for about 15 minutes.

Instructions:

Before the class students can be given homework to read up on the Macy Model of Doctor-Patient Communication.

Play the video to your group and supply them with handouts of Good vs. Could Be Improved columns (see Appendix H.) Students can jot down their thoughts on what was good and what could be improved on in Dr. Coun's interview

A group discussion can follow addressing the following questions:

- How did Dr. Coun build a relationship with Ms. W.?
- What do you think Ms. W.'s main reason for visiting was?
- What strategies could be used in this interview to discuss difficult lifestyle issues such as obesity?

Student can divide into pairs and do role play improvement based on the original handouts they wrote on while watching the video. Instructors can also ask for role play volunteers and do large-group role play improvement exercise.

Lesson Plan 5

Theme: Dealing with the anxious patient, dealing with cultural diversity and negotiating a management plan (See appendix G.)

Teaching objectives:

- Learn the ways in which the medical encounter and the medical interview can be therapeutic.
- Learn effective strategies for gathering information from an anxious patient. (See appendix C.)
- Discuss the impact of cultural diversity on diagnosing mental illness and the medical interview.

Suggested reading:

Christensen JF. Suggestion and hypnosis. In Feldman M, Christensen J. Behavioral Medicine: a guide for clinical practice. NY, McGraw-Hill Medical, 2008:34-43.

Locke SE. Anxiety and Panic Disorders. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Chou C, Pearlman E, Risdon C. Understanding Difference and Diversity in the Medical Encounter: Communication across Cultures. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Video 3: Dr. Richard Greene with Maria V.

Synopsis: Mrs. V. is Spanish-speaking and presents to Dr. Greene with several varied symptoms. She has a history of depression. This video plays for about 14 minutes.

Instructions:

Before the class, students can be given homework to read up on the Macy Model of Doctor-Patient Communication; on the use of the PHQ-9; and on somatization and depression; advanced students may want to read Ekman on facial expression of emotions

Play the video to your group and supply them with handouts of Good vs. Could Be Improved columns. Students can jot down their thoughts on what was good and what could be improved on in Dr. Greene's interview. Ask students to keep in mind any emotional cues from Ms. V.

Students can divide into groups or volunteer for a role play exercise in front of a large group. One student is Dr. Greene and the other is Ms. V. The aim of the interview is for Dr. Greene to explore why and whether Ms. V. is anxious.

After the role play exercise students gather again and a group discussion can follow addressing these questions:

- What ways were effective or ineffective in gathering information from the patient during your role play(s)?
- What emotional cues of Ms. V. did you observe?
- What do you think Ms. V.'s main reason for coming to Dr. Greene was?
- How could culture, family, and community impact on communication with Ms. V., and ultimately on her management?

Lesson plan 6

Theme: Communication with depressed patients including information gathering, non-verbal communication, and patient education.

Teaching objectives:

- Learn specific skills to enhance communication with depressed patients.
- Learn effective strategies for gathering information from a depressed patient. (See appendix C.)
- Explore strategies for helping patients with depression understand their condition and management options. (See appendix F.)

Suggested reading:

Cole SA et. al. Depression. In Feldman M, Christensen J. Behavioral Medicine: a guide for clinical practice. NY, McGraw-Hill Medical, 2008:199-226.

Cole S. Communication with Depressed Patients. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Video 4: Dr. David Stevens with Taidés N.

Synopsis: Taidés N. presents to Dr. David Stevens complaining of pain in her legs for the past 2-3 months. Dr. Stevens explores her underlying issues and discussed a management plan with her. This video plays for about 25 minutes.

Instructions:

Before the class students can be given homework to read up on the Macy Model of Doctor-Patient Communication.

Play the video to your group and ask them to make a note of non-verbal communication techniques displayed by Dr. Stevens. Afterwards lead a large-group discussion to address the following questions:

- What communication techniques does Dr. Steven's use to elicit information from Ms. N.?
- Comment on Ms. N.s' reaction to Dr. Steven's interview.
- Comment on the structure and flow of the interview.

Students can divide into groups or volunteer for role play exercise in front of a large group. One student is Dr. Stevens and the other is Ms. N. The aim of the interview is for Dr. Stevens to explain to Ms. N. what his impression of her diagnosis is.

After the role play exercise students gather again and a group discussion can follow addressing these questions:

- What ways were effective or ineffective in explaining to patients the diagnosis of depression?
- Explore examples of PEARL statements that can be used when educating depressed patients about their condition (this could also be a homework task.)
- Discuss ways of addressing the issue of pharmacological management of depression with patients.

Lesson plan 7

Theme: Gathering information, patient education and approaches to smoking cessation counseling.

Teaching objectives:

- Learn effective techniques for gathering information in a medical interview. (See appendix C)
- Explore how the patient's perspective may impact on the outcome of the medical interview. (See appendix D)
- Discuss barriers that may be faced when educating patients on lifestyle change (for example smoking cessation) and medication prescriptions. (See appendix F)

Suggested reading:

Kalet A, Pugnaire MP, Cole-Kelly K, et al. Teaching Communication in Clinical Clerkships: Models from the Macy Initiative in Health Communications. *Academic Medicine*. 2004; 79:511-520.

Rogotti NA. Smoking. In Feldman M, Christensen J. Behavioral Medicine: a guide for clinical practice. NY, McGraw-Hill Medical, 2008: pp 163-170.

Goldstein MG, Swartz S. Tobacco Intervention. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Video 5: Dr. Johnson with Virginia P.

Synopsis: Virginia P. presents to Dr. Johnson with congestion, coughing and associated chest pain. Virginia wonders if it is allergies and goes to Dr. Johnson seeking advice and treatment after trying different medications that did not seem to help. The video plays for about 8 minutes and includes the medical interview and examination.

Instructions:

Before the class students can be given homework to read up on the Macy Model of Doctor-Patient Communication.

As a large-group activity or as a homework assignment ask students to describe communication skills that can help gather information from patients (for example open-ended questions, allowing the patient to complete his or her opening statement, relationship building skills, assessing motivation and readiness).

Play the video to your group and after lead a large-group discussion to address the following questions:

- What communication techniques does Dr. Johnson use to elicit information from Ms. P.? Are there any techniques that you know that did not present in the video?
- Do you think the patient's concerns matched the concerns of Dr. Johnson?
- Comment on Dr. Johnson's approach to raising the issue of smoking in the medical interview. Was Ms. P. motivated to give up smoking for improving her asthma and her general health?

Students can divide into groups or volunteer for role play exercise in front of a large group. One student is Dr. Johnson and the other is Ms. P. The aim of the interview is for Dr. Johnson to explain to Ms. P. that the diagnosis is asthma and that smoking may worsen asthma. Instruct student playing Ms. P. to act a little resistant, so that students can practice communicating with patients resistant to advice and change.

After the role play exercise students gather again and a group discussion can follow addressing these questions (can also be done as a homework assignment):

- What ways were effective or ineffective in explaining to patients the diagnosis of asthma?
- Discuss ways of addressing the issue of smoking cessation with patients in a medical interview.

Lesson plan 8

Theme: Interviewing patients of non-English-speaking backgrounds.

Teaching objectives:

- Discuss the challenges of interviewing patients of non-English-speaking backgrounds.
- Explore the impact of using an interpreter on the structure, flow and function of a medical interview. (See Appendix A-G.)
- Discuss specific communication issues that may arise during an interview using an interpreter service (for example informed consent and decision making, responding to emotional cues.)

Suggested reading:

Denberg T, Feldman MD. Cross-cultural communication. In Feldman M, Christensen J. Behavioral Medicine: a guide for clinical practice. NY, McGraw-Hill Medical, 2008:100-110.

Chou C, Pearlman E, Risdon C. Understanding Difference and Diversity in the Medical Encounter: Communication across Cultures. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Video 6: Dr. Kathleen Hanley and Chong H.

Synopsis: Chong H. presents to Dr. Kathleen Hanley complaining of a long history of intermittent vomiting which has become increasingly frequent and associated with pain and diarrhea. Chong H. is a Chinese-speaking patient and the interview is conducted via remote simultaneous interpretation. This video plays for about 15 minutes.

Instructions:

Before the class, students can be given homework to read up on the Macy Model of Doctor-Patient Communication.

Play the video and then lead a large-group discussion addressing the following questions:

- What potential scenarios may arise with a patient of non-English speaking background (for example translation and interpretation, family member may do interpreting) and what effect could this have on the flow and structure of a medical interview?
- What minimal encouragers did Dr. Hanley use to engage Mr. C.?
- Comment on how Mr. C. handles the interpretation and how he relates to Dr. Hanley.
- Comment on how Dr. Hanley handles the interpretation?
- How did Dr. Hanley address Mr. C's needs and expectations, and negotiate a plan?

- What issues may arise if Dr. Hanley decides that Mr. C. may require a medical procedure requiring consent?

Lesson plan 9

Theme: Communicating with adolescents/the adolescent medical interview, responding to non verbal cues, bringing up psychological and social aspects in the medical interview (taking a psychosocial history).

Teaching objectives:

- Identify communication barriers that may be encountered when interviewing adolescents.
- Learn communication skills that may overcome these barriers.
- Discuss SSHADESS screening (Strengths, School, Home, Activities, Drugs, Emotions (depression and suicidality), Sexuality and Safety). (See appendix I.)
- Learn the importance of reading patients' non-verbal cues and being able to respond to them within the medical interview. (See appendix D)

Suggested reading:

Friedman LS. Adolescents. In Feldman M, Christensen J. Behavioral Medicine: a guide for clinical practice. NY, McGraw-Hill Medical, 2008:82-89.

Ginsburg KR, Tomescu O. Communicating with Adolescents. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Video 7: Dr. Kimura with Julia P. and her mother

Synopsis: Julia P. is 13 years old and presents with her mother to Dr. Kimura, a pediatric rheumatologist. Miss P. has been primarily referred by her general pediatrician for ongoing headaches and blurry vision. Miss P. has seen various doctors and had various tests, with no definitive diagnosis found. This video runs for approximately 20 minutes.

Instructions:

As a homework task, students can review the Macy Model of Patient-Doctor communication and the SSHADESS screen (see appendices A-G and J.)

Play the video and ask students to make notes on their thoughts and feeling on:

- The opening of the video
- Dr. Kimura's information gathering
- Miss P. and her mother's responses during the interview
- The outcome of the interview

Students can divide into small groups to review their thoughts and feelings on the video and then the group can rejoin to discuss collective thoughts (one student from each small group could present to the large group). Alternatively you could lead a large-group discussion addressing the students' thoughts and feelings about the video and also addressing the following:

- How does Dr. Kimura find out Miss P.'s chief complaint(s)?
- How does Dr. Kimura relate to Miss P. and her mother?
- Discuss ways to manage an encounter with an adolescent patient.
- How do mother and daughter relate to each other?
- How does Dr. Kimura use PEARLS statements? How does she use minimal encouragers?
- What does Dr. Kimura learn about depression, anxiety and issues at home?
- How do you feel about the diagnosis speculation?
- Describe Miss P.'s non-verbal messages.
- How do you think Miss P. and her mother feel at the end of the interview?
- Discuss issue of obtaining medical consent with adolescent patients.

Students could then divide into small groups and participate in role play improvements.

You could also give students "what if" scenarios to role play:

- What if after a few minutes of speaking with Miss P. and her mom, Dr. Kimura wanted to speak with Miss P. alone, how would she go about it?
- What if Dr. Kimura was indeed concerned about depression? How would she introduce this idea to Miss P. and furthermore assess Miss P. for having suicidal ideation?
- How could Dr. Kimura discuss sexual issues with Miss P.?

Lesson plan 10

Theme: Establishing the patient's chief concern, managing patient expectations, building the doctor-patient relationship and the therapeutic value of the medical encounter, patient education, and negotiating a treatment plan.

Teaching Objectives:

- Review the Macy Model of Doctor-Patient Communication. (See appendices A-G.)
- Describe essential communication elements in a medical interview. (See appendices A-G.)
- Explore challenges in dealing with competing demands including patients' expectations, multiple medical problems etc.
- Understand the potential therapeutic effects of the medical encounter and strategies to achieving this.
- Learn communication skills for patient education. (See appendix F.)

Suggested reading:

Brody D, Novack DH. Therapeutic Aspects of Medical Encounters. Doc.com website. Available at: http://webcampus.drexelmed.edu/doccom/user/individual_logon_2.asp. Accessed November, 2008.

Video 8: Dr. Roberta Lee and Elliot B.

Synopsis: Elliot B. presents to Dr. Roberta Lee for a second visit. This is to follow up on his various concerns including sleeping problems, obesity, and Type 2 diabetes. This video runs for approximately 25 minutes.

Instructions:

Students should review the Macy Model of Doctor-Patient Communication before the class as homework.

Play the video to the group and ask the students to make notes on how Dr. Lee conducts the medical interview in relation to the Macy Model and its essential communication elements. Conduct a large-group discussion after students have watched the video to see what the students thought.

Additional discussion questions for the group:

- How does Dr. Lee set an agenda and manage the patient's expectations?
- How does Dr. Lee establish a rapport and build a relationship with the patient?
- Describe the structure and flow of the interview. Do you feel it was organized? Do you feel that it was efficient?
- Comment on how Dr. Lee positions herself in relation to the patient and on how the room is set up.

- Describe the process by which Dr. Lee ensures that the patient understands her. For example, during the explanation for the 4-7-8 breathing exercise how does Dr. Lee ensure that the patient understands?
- How does Dr. Lee conclude the interview? Did she negotiate a treatment plan?
- Comment on Dr. Lee's non-verbal communication.
- How does the patient respond to Dr. Lee as the interview proceeds? Do you feel the interview had a therapeutic effect for the patient?

Students divide up into pairs or small groups for role play to practice patient education skills. One student is Dr. Lee and the other Mr. B.

Potential scenarios for role play:

Dr. Lee explains to Mr. B. why it's important for him to lose weight.

Dr. Lee educates Mr. B. about the value of resistance training exercises.

Optional activity: students could also practice taking a psychosocial history in a role play between Dr. Lee and Mr. B. (See appendix J).

Appendices

Appendix A: Preparation and Opening

I. Prepare

- a. Review the patient's chart and other data
- b. Assess and prepare the physical environment
 - i. Optimize comfort and privacy
 - ii. Minimize interruptions and distractions
- c. Assess one's own personal issues, values, biases, and assumptions going into the encounter

II. Open

- a. Greet and welcome the patient and family member present
- b. Introduce yourself
- c. Explain role and orient patient to the flow of the visit
- d. Indicate time available and other constraints
- e. Identify and minimize barriers to communication
- f. Calibrate your language and vocabulary to that of the patient
- g. Accommodate patient comfort and privacy

Appendix B: Fundamental Skills to Maintain During the Entire Interview

I. Use Relationship Building Skills

- a. Allow patient to express self
- b. Be attentive and empathic non-verbally
- c. Use appropriate language
- d. Communicate non-judgmental, respectful, and supportive attitude
- e. Accurately recognize emotion and feelings
- f. Use PEARLS Statements (Partnership, Empathy, Apology, Respect, Legitimization, Support) to respond to emotion instead of redirecting or pursuing clinical detail

II. Manage Flow

- a. Be organized and logical
- b. Manage time effectively in the interview

Appendix C: Gather Information

I. Survey Patient's Reasons for the Visit

- a. Start with open-ended, non-focused questions
- b. Invite patient to tell the story chronologically ("narrative thread")
- c. Allow the patient to talk without interrupting
- d. Actively listen
- e. Encourage completion of the statement of all of patient's concerns through verbal and non-verbal encouragement ("tell me more," the exhaustive "what else?")
- f. Summarize what you heard. Check for understanding. Invite more ("anything more?")

II. Determine the Patient's Chief Concern

- a. Ask closed-ended questions that are non-leading and one at a time
- b. Define the symptom completely

III. Complete the Patient's Medical Database

- a. Obtain past medical and family history
- b. Elicit pertinent psychosocial data
- c. Summarize what you heard and how you understand it, check for accuracy

Appendix D: Elicit and Understand Patient's Perspective

- a. Ask patient about ideas about illness or problem
- b. Ask patient about expectations
- c. Explore beliefs, concerns and expectations
- d. Ask about family, community, and religious or spiritual context
- e. Acknowledge and respond to patients concerns, feelings and non verbal cues
- f. Acknowledge frustrations/challenges/progress (e.g., waiting time, uncertainty)

Appendix E: Communicate During the Physical Exam or Procedure

- a. Prepare patient
- b. Consider commenting on aspects and findings of the physical exam or procedure as it is performed
- c. Listen for previously unexpressed data about the patient's illness or concerns

Appendix F: Patient Education

- a. Use Ask-Tell-Ask approach to giving information meaningfully
 - Ask about knowledge, feelings, emotions, reactions, beliefs and expectations
 - Tell the information clearly and concisely, in small chunks. Avoid "doctor babble."
 - Ask repeatedly for patients understanding
- b. Use language patient can understand
- c. Use qualitative data accurately to enhance understanding
- d. Use aids to enhance understanding (diagrams, models, printed material, community resources)
- e. Encourage questions

Appendix G: Negotiate and Agree on Plan

I. Negotiation

- a. Encourage shared decision making to the extent the patient desires
- b. Survey problems and delineate options
- c. Elicit patient's understanding, concerns, and preferences
- d. Arrive at mutually acceptable solution
- e. Check patient's willingness and ability to follow the plan
- f. Identify and enlist resources and supports

II. Close

- a. Signal closure
- b. Inquire about any other issues or concerns
- c. Allow opportunity for final disclosures
- d. Summarize and verify assessment and plan
- e. Clarify future expectations
- f. Assure plan for unexpected outcomes and follow up
- g. Thank patient - appropriate parting statement

Appendix H: Good vs. Could Be Improved Check List

This table lists communication tasks that may enhance or hinder communication and the therapeutic relationship between doctor and patient. There are of course many other tasks that could be added to either column. The list below is a starting point. This list could be given to students to use as means for giving feedback. For example, giving feedback to fellow students during role play exercise.

Good	Could be improved
Established rapport	Interrupting when patient's describe their concerns
Allowed patient to describe their "story"	Being judgmental or moralizing
Active listening	Using complicated medical jargon
Using patient friendly language	Dismissing the patient's perspective
Asked open-ended questions	Not showing empathy or human concern
Uses PEARL statement	Not using PEARL statements
Uses Ask-Tell-Ask technique to share information	Not showing empathy or human concern
Considers psychosocial and medical aspects	Not responding to patient's non-verbal cues
Checks patient understanding	Not negotiating a plan, but perhaps dictating it
Shows good eye contact	Diverting focus from psychosocial to medical
Helps patient feel comfortable	Not checking patient's understanding

Appendix I: SSHADESS screen

This is an acronym to trigger appropriate questions when completing a psychosocial history from an adolescent patient.

Strengths, School, Home, Activities, Drugs, Emotions (depression and suicidality), Sexuality and Safety

Appendix J: Topics to cover in a psychosocial history

- Home
- Work/daily activities
- Diet and exercise
- Tobacco, alcohol, drugs, caffeine
- Financial stability
- Personal relationships and social supports
- Sexuality (orientation, problems or concerns)
- Domestic violence/abuse
- Stress
- Mood
- Health beliefs
- Childhood and family relationships
- Schooling
- Cultural/ethnic background
- Functional status (Self care and managing activities of daily living)

Appendix K: PowerPoint presentation (*click here to download*)

Appendix L: Physician Interviewers

Stephanie Cohen, MD
Plastic and Reconstructive Surgeon
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David Coun, M.D.
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Oluwatumininu Johnson, M.D.
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Vice Chair, Department of Integrative Medicine
Co-Director, Integrative Medicine Fellowship Program
Center for Health and Healing, Beth Israel Medical Center

Bert Petersen, Jr, MD
Surgical Oncology
Hackensack University Medical Center (at time of filming)

David L. Stevens, MD
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