Can You Hear Me Now? – Improving Clinical Communications

Aaron S. Fink, MD
Professor Emeritus of Surgery
Emory University School of Medicine
Attending Surgeon,
VAMC Atlanta

COMMUNICATION MATTERS!

Session Objectives

Patient Communications

- Overview of clinical communications
  - Import and concerns
  - Initiatives to improve

- Discuss strategies for improving clinician-patient and clinician-clinician communications using informed consent

Clinical Communications

Consultant Physician
Dialog Medical, Inc.
Atlanta, GA

COMMUNICATION MATTERS!
Can You Hear Me Now? – Improving Clinical Communications

I. COMMUNICATION MATTERS

Communication is the clinician’s responsibility:
- An essential component of clinician’s role
  - AAMC and ACGME: skills to be assessed every year of training
- Cannot be delegated
- Has lasting effects over time

Kalamazoo Consensus Statement. Acad Med 2001; 76:390

I. COMMUNICATION MATTERS

Communication Improves Health Outcomes:
- Symptom resolution
- Problem resolution
- Reduction in distress/ anxiety
- Health and functional status
- Blood pressure control
- Pain reduction
- Reduction in role and physical limitations

Communication Improves Diagnostic Accuracy:
- Quantity of clinical data
- Quality of clinical data

–Roter, 2000; Stewart 1999

I. COMMUNICATION MATTERS

Communication improves adherence:
- A clinician’s interpersonal skills are an important predictor of patient adherence:
  - Knowledge of the patient
  - Trust
  - Empathy

Roter et al., 1999; Roter, 1999;

I. COMMUNICATION MATTERS

Improvement in health outcomes:
- Diagnostic accuracy
- Adherence
- Biological and psychological measures

Improvement in social outcomes:
- Patient satisfaction
- Clinician satisfaction
- Informed consent
- Malpractice risk

–Beckman & Frankel, 1984

25% of Americans report they did not follow their clinician’s advice:
- 39% disagreed with the doctor
- 27% concerned about cost
- 25% instructions were too difficult
- 20% it was against personal beliefs
- 7% did not understand

The Commonwealth Fund 2001 Health Care Quality Survey

June 21, 2012
Grady Hospital
Grand Rounds Presentation
Atlanta, GA
Communication Improves Patient Satisfaction:
- 70% of the variance in satisfaction scores can be explained by communication attitude:
  - Non-verbal communication
  - Information giving
  - Shared decision making

Effective communication improves clinician satisfaction:
- Clinicians express greatest satisfaction with the intrinsic reward from patient care and the clinician-patient relationship

Communication improves informed consent:
- Discuss clinical issues or nature of decision
- Discuss alternatives
- Discuss pros and cons of alternatives
- Discuss uncertainties associated with a decision
- Assess patient understanding
- Explore patient preferences
In 15% of episodes, none of the above elements observed

Effective communication reduces malpractice risk:
- 71% cited poor relationships as reasons for claims:
  - 32% felt deserted
  - 29% felt devalued
  - 26% felt information was delivered poorly
  - 13% felt lack of understanding by clinician

Effective communication reduces malpractice risk:
- No difference in clinical quality of care among clinicians with:
  - No claims
  - 1 claim
  - Many claims with low payout
  - Many claims with high payout
- Problems with clinician-patient communication most frequently offered complaint:
  - Patients felt rushed, ignored, misled, uninformed about long-term risks

Effective communication reduces malpractice risk:
- No claims physicians:
  - Oriented patients to process of visit
  - Used facilitative comments
  - Asked patients their opinion
  - Used active listening
  - Used humor and laughed
  - Had longer visits (18.3 vs. 15 minutes)
I. COMMUNICATION MATTERS

Effective communication reduces malpractice risk:
- A doctor who communicates well is likely to build a healthy relationship with a patient. If a bad health outcome did happen, the patient might be inclined to forgive rather than sue.*

→ Good Communication decreases risk of suit

Michelle Mello, PhD, JD, Harvard School of Public Health. NPR Radio Interview: January 15, 2005

II. COMMUNICATION IS A PROCEDURE

I. COMMUNICATION IS A PROCEDURE

Assessed status of interpersonal skill (IPS) training in US medical schools in 1977
- Most schools had IPS courses, although majority < 5 years old
- Most teach process, information gathering, and psychological intervention (e.g. empathy)
- Less than 1/3 teach specific information-giving or counseling skills
- Most courses taught in pre-clinical years with lack of follow-up in clinical years
- Only 1/3 use any outcome-index for evaluation

J Med Educ 1979; 54:29-34

II. COMMUNICATION IS A PROCEDURE

Reassessed status of training in US medical schools:
- Virtually all offered courses on medical interviewing and interpersonal skills
- Most use observation, feedback, simulation and role-playing
- Most lacked faculty development programs
- Most training incorporated with P.E. courses; no systematic observation, feedback or evaluation
- Little coordination or sequencing of skills throughout medical school curricula

JAMA 1993; 269:2101-5
II. COMMUNICATION IS A PROCEDURE

- A typical clinician will conduct more than 160,000 interviews during his/her 40 year career
- Can be learned
- Mastery requires practice and experience

Mishler, 1984

II. COMMUNICATION IS A PROCEDURE

Patients have a “voice”: The voice of experience
Clinicians have a “voice”: The voice of medicine

II. COMMUNICATION IS A PROCEDURE

Bayer Institute for Health Care Communication E4 Model

Model of Complete Clinical Care

Opening
Communication Goals
Empathize
Fix It
Find It
Enlist
Closing
Medical Goals

Medical Goals

Patient-centered Clinical Model

Three Function Model - Brown Interview Checklist
II. COMMUNICATION IS A PROCEDURE

Assembled 21 representatives of:

- Medical Schools
- Residency programs
- CME providers
- Prominent medical educational organizations

Goals:

- “Short list” of elements characterizing effective communication in various clinical contexts
- Providing tangible examples of skill competencies
- Ensuring work-product was evidence based and appropriate for teaching, assessment, and evaluation

Kalamazoo Consensus Conference

Build a relationship - The Fundamental Task:

- Sine qua non of provider-patient communication
- Patient-centered approach to care
- Solicit patient’s “story” while applying diagnostic reasoning
- Ideas, feelings, and values of both patient and provider can influence relationship
- Relationship = partnership; patients active in decisions
- Relationship applies to families and support networks

Relationship ➞ ongoing task within and across encounters

Kalamazoo Consensus Conference

Open The Discussion:

- Allow patient to complete their opening statement
- Elicit full set of concerns
- Establish/maintain a personal connection
II. COMMUNICATION IS A PROCEDURE
Kalamazoo Consensus Conference
**Gather Information:**
- Use open/closed-ended questions appropriately
- Structure/clarify/summarize information
- Actively listen using non-verbal and verbal techniques

**Understand the Patient's Perspective:**
- Explore contextual factors
- Explore beliefs, concerns, and expectations
- Acknowledge and respond to patient’s ideas, feelings, and values

**Share Information:**
- Use language the patient can understand
- Check for understanding
- Encourage questions

**Reach Agreement on Problems and Plans:**
- Encourage patient to participate in decisions
- Check patient’s willingness and ability to follow the plan
- Identify and enlist resources and supports

**Provide Closure:**
- Ask if patient has other issues or concerns
- Summarize and affirm agreement with plan(s)
- Discuss follow-up
II. COMMUNICATION IS A PROCEDURE

Informed Consent

Clinical Imperative
- Provide patient with vital information about benefits, risks and alternatives

Ethical Imperative
- Preserves patient autonomy – the belief that a competent person has the right to determine what will be done to them

AMA Code of Medical Ethics

Obligates a physician to:
- Present the medical facts accurately.
- Help the patient make choices from among the therapeutic alternatives consistent with good medical practice.

Informed Consent Process

Critical Healthcare Process

Clinical Imperative
- Provide patient with vital information about benefits, risks and alternatives

Ethical Imperative
- Preserves patient autonomy – the belief that a competent person has the right to determine what will be done to them

Informed Consent Process

Informed Consent and State Law
- Legislation in all 50 states requires that a patient be advised of all possible complications and alternative treatment options before he or she is allowed to sign a consent form
- Extent of discussion varies from state to state

Essential Elements (JCAHO/CMS)
- Diagnosis; Proposed treatment
- Benefits; Risks of treatment (including no Rx)
- Alternatives
- Date and time

Informed Consent Standards

Prudent patient standard:
- Provider must disclose “all that an average, reasonable patient would consider material to his decision whether to undergo the proposed treatment”

Prudent physician standard:
- What an expert (usually a physician) would or would not have done in a particular situation

*Canterbury v. Spence 464 F.2d 777 (DC Cir 1972)*
Informed Consent Process

Informed Consent and Georgia Law
Butler vs. South Fulton Medical Center*

- Even if provided proper and legal disclosure, a patient must comprehend what the physician is saying and understand the information on the consent form so (s)he can voluntarily offer permission for the proposed intervention.

Informed Consent
How Are We Doing?

Informed Consent Process

Current Challenges with Informed Consent
A review of 540 written consent forms, from 157 hospitals, found the necessary elements of informed consent (purpose, risks, benefits, & alternatives) in only 26% of the documents.


Current Challenges with Informed Consent
A review of 89 written consent forms for radical prostatectomy:
- The potential need for blood transfusion was disclosed on 88.8% of the consent forms.
- HOWEVER, proper consent for blood products was ONLY obtained in 25.8% of the cases.
- 92.1% of patients ultimately received a transfusion.


Informed Consent Process

Patient Comprehension
- Patients’ comprehension of surgical procedures is suboptimal, even if measured immediately following informed consent.
- A survey of 11 studies (n =704) revealed that patients’ comprehension averaged 48%

Significant patient factors:
- Age
- Education
- IQ
- Impaired cognitive function
- Locus of control
- Anxiety

Other significant factors:
- Instrument used
- Content area of questions
- Time since consent

Informed Consent
Automating Informed Consent
Automating Informed Consent

The Department of Veterans Affairs conducted a Pilot Study of an Automated Informed Consent Software tool in two facilities:
- Atlanta VA Medical Center, Atlanta
- Hines VA Medical Center, Chicago

Compared a sampling of patient records after implementation of the automated process (January 2004) to a control group employing paper consents (January 2003).

Automating Informed Consent

The Department of Veterans Affairs opted for a standardized, automated process for completing clinical consents in 2004.

The iMedConsent™ application is launched from within VistA CPRS establishing patient context.

A procedure is selected from within a given clinical specialty.

The iMedConsent™-facilitated informed consent employing the VA process is performed.
Consent to the use of blood products is obtained or refused depending on the type of procedure.

At a minimum, the provider obtaining consent from the patient is documented.

The procedure-specific consent document is complete – additional patient-specific edits may be made.

The patient signature is collected.

All signatures are electronically embedded in the document with date and time stamps.

A note documenting the informed consent discussion is posted to VistA CPRS (the VA’s EHR).
A Simple Strategy for Improving Patient-Centered Communications

Patient Understanding

- Providing informed consent information to patients in written form may increase the patients’ comprehension of the procedure
- Better informed patients may be more compliant, less anxious and more satisfied

Patient Understanding

- Improving missed, incomplete or poorly understood informed consent is a significant patient safety opportunity
- Better informed patients “are less likely to experience medical errors by acting as another layer of protection”


Patient Understanding

NQF Safe Practice 5

- Ask each patient or legal surrogate to “teach back,” or “repeat back” in his or her own words, key information about the proposed treatments or procedures for which he or she is being asked to provide informed consent.

Repeat Back Study

Repeat Back Module

If the “Patient Understood Immediately” button is checked, the following is automatically inserted into the progress note:

“The patient satisfactorily communicated his or her diagnosis.”

If the “Patient Understood with Additional Training” button is checked, the following is automatically inserted into the progress note:

“After further discussion, the patient was able to satisfactorily communicate his or her diagnosis.”

Repeat Back Study

**Setting:**
- 7 affiliated VA Medical Centers (Atlanta, Boston, Denver, Houston, Pittsburgh, Portland, Tampa)

**Subjects:**
- Patients being considered for elective surgery who gave informed consent for the study
- Exclusions: inability to see written materials, non-elective surgery, severe psychiatric illness, patients requiring more than one procedure, ongoing substance abuse, requirement for surrogate consent

**Time to Complete Consent:**
- Time stamps built into iMedConsent™ application

**Comprehension:**
- Pretested, surgery-specific, multiple choice questionnaires (25 items)
- Administered immediately after informed consent

**Anxiety:**
- Short Form STAI

**Surgical Types:**
- Total Hip Arthroplasty (THA)
- Carotid Endarterectomy (CEA)
- Laparoscopic Cholecystectomy (Lap Chole)
- Radical Prostatectomy (RP)

**Providers:**
- Providers who were planning to conduct the informed consent discussion with the patient

**Patient Satisfaction:**
- Decision Making: 20 item questionnaire administered after informed consent
- Care: Veterans satisfaction survey items administered at 1/u visit

**Provider Attitudes and Use of RB:**
- Self-administered questionnaire completed by residents at the end of rotation and by staff at the end of study recruitment
Repeat Back Study

- Statistically significant increase in consent comprehension with RB; effect greatest in CEA (68% → 73%, p=0.02)
- Patient satisfaction was equivalent
- Providers moderately satisfied with electronic consent; most thought RB improved comprehension, and many thought RB was worth the extra time
- The RB process took 2.6 additional minutes on average
  - Time spent in IC process was most strongly associated with improved comprehension

Factors Associated with Reduced Patient Comprehension

- Increasing Age p = .0192
- African-American Race p = <.0001
- Hispanic Ethnicity p = .05
- Education:
  - ≤ Grade 11 p = .0593
  - HS Grad p = .0127
- No Repeat Back p = .0398
- Shorter iMed Time (second model) p = <.0001

Informed Consent

Leveraging Procedure-Specific Consent to Enhance Provider-Provider Communication

Preventing Medical Errors

Wrong-Patient/Procedure/Site Surgery

- State of Pennsylvania
- 30-month period
- A wrong-site surgery event will reach a patient once per year in a 300-bed hospital
- Failure to verify consent forms was a major contributor to errors resulting in the initiation of wrong-site surgery

Wrong Site Surgery Project – Joint Commission

- 5 hospitals and 3 ambulatory surgery centers
- Evaluated near misses and sentinel events before and after implementing measures to enhance verification of patient/site/procedure etc. (including the signed surgical consent)
- Baseline defects declined significantly:
  - Pre-op/pre-op holding: 52% to 19%
  - Operating room: 59% to 29%
Preventing Medical Errors

WHO Surgical Safety Checklist

Ring, Herndon, Meyer: NEJM 2010;363:1950-7

Verification of the Consent

American College of Surgeons Template with WHO Checklist

CONCLUSIONS

Communications underpin virtually every healthcare encounter. Optimal communication:
- Enhances patient safety and improves healthcare outcomes
- Reduces costly delays and healthcare inefficiencies
- Decreases liability risk

Leveraging healthcare technology and using adjuncts (e.g. Repeat Back) may enhance clinical communications and may improve patient comprehension.

We have an obligation to strive for optimal communication within every healthcare encounter.

THANK YOU!!!