The "Intensive"—A Program to Improve Communication Performance

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Abstract

This article describes a program for improving clinical communication skills. The program features a 1-week residential phase that focuses on 4 factors in communication performance: personal theories and beliefs, ethical frames of reference, skill development, and psychological history. Participants engage in encounters with standardized patients and receive feedback from an instructor, the standardized patients, and other participants. The skills learned during the residential phase are reinforced through monthly meetings with a "coach" over the course of a year. Informal follow-up with past participants suggests that the majority of clinicians who participate in the program make important gains in improving communication behavior.

Their rationalizations are predictable: "I'm a good clinician—I don't give the patients everything they want like the other physicians in the practice, so they mark me down." "The nurses are simply incompetent and I'm the only one who doesn't treat them gingerly." "Only a couple of patients send in the surveys and I just got a bad bunch." "I'm the one who's productive; the others waste time with patients." By the end of the first evening, most of them say that since they are there, they might as well make the most of it. By the end of the week, they are effusive about how much they have gained from the experience.

The Bayer Institute for Health Care Communication offers an Intensive Communication Skills program for clinicians to improve their communication skills. The program makes use of videotaped encounters with standardized patients to enable participants to observe and receive feedback on their actual behavior. While some participants attend the program voluntarily, more often clinicians have been referred by their employer or group becasue of patient complaints, low patient satisfaction scores, and disgruntled staff. The program has 3 phases: a preparation phase, a 1-week residential program, and a year-long follow-up with a "coach." This article describes elements of the program and how results are being measured.

Program Description

Phase 1: Preparation

Phase 1 occurs a month before the week-long residential program. First, the participant is sent a packet of articles to read as a way of introducing him or her to the science of clinician-patient communication. Second, participants are asked to audiotape or videotape up to 5 encounters. These taped encounters provide a baseline for the participant, and the participants bring the tapes to the 1-week program. Third, participants meet with their coach. The coach is a local person who has been selected by the Bayer Institute or by the referring organization to work with the participant for a full year. This initial meeting provides the coach and the participant with an opportunity to get to know one another and to establish specific goals for the participant. The taped encounters can be reviewed to give the coach some understanding of the current skill level of the participant.

Phase 2: The Residential Program

The second phase is the week-long residential program. There are a total of 40 instructional hours in the program. The residential nature of the program brings the participant away from beepers and other distractions. Residential sites are best if they are sufficiently far away that participants will not be tempted to drive home at night after evening sessions (there are 3 evening sessions).

During the residential week, most of the time is spent in small working groups of 3 or 4 participants and 1 or 2 instructors. The large group (12 to 24 participants) gathers only for lectures and selected exercises. The content and activities of the residential program are based upon the premise that communication performance is a consequence of 4 factors: personal theories and beliefs regarding communication, ethical frames of reference, skill development, and personal psychological history.

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Belief systems. The first factor is the theoretical belief system that the participant has about clinician-patient communication. The conceptual framework of Argyris and Schön is used to explore the participant's beliefs [1,2]. Participants are asked to develop an espoused theory of clinician-patient communication. They are then asked to examine the congruence and consistency of their stated beliefs vis-à-vis their behavior as well as the demonstrated effectiveness of their theory. Participants test their theories against videotaped case situations for completeness and utility. The participants' own theory rather than one imposed by others functions as the lens through which their behavior is observed during the week. However, by comparing their theories with those of experts in the field, participants are able to refine their theories and test them for similarity or dissimilarity with the state of the art.

Typically, participants begin by stating very general beliefs that cannot be tested: "It is important to be caring." The facilitator will ask, "How would I know you are caring? What would I see or hear you do that would let me—or the patient—know you care?" Eventually, participants re-frame their statements so they can be tested: "It is important to listen carefully to the patient to the extent that I can quickly and accurately summarize what the patient has said to me."

Skills. The second factor is the skills that the participant is able bring to the clinician-patient encounter. We define a skill as *a purposeful sequence of action*. Because "knowing about" is not the same as "being able to do," a great deal of energy is spent on the development of skills.

Skills important for clinical communication (eg, negotiating an agenda, discovering the patient's self-diagnosis, expressing sympathy) are presented, and participants are then asked to practice these skills with standardized patients using both set and improvisational cases. A coaching approach is used in the development of skills. The instructor does not wait until the end of an interaction to provide feedback if the participant is struggling. Simply repeating ineffective behavior is not useful. Every effort is made for the participant to have a successful experience utilizing the communication skills he or she is developing. Multiple coaching techniques are used to assure that this takes place, including demonstration, instruction, successive approximation, and repetition. The goal of the instructor is to ensure that the participant develops or improves core skills to the extent that the average patient could discriminate between before and after skill levels. All participants receive videotapes of their practice sessions for review. In working with the standardized patients, participants are encouraged to stop the action immediately when they want to try something a different way.

The participants receive feedback from 3 sources: the instructor, the standardized patients, and other participants in the small group. These multiple reports enable the participant to assess the validity of the feedback and make choices about what they do and do not want to change [3,4]. Universally, the participants report that the work with the standardized patients is the most powerful part of the program. The following exchange is typical:

Participant: How did that go?
SP: Donna Jones felt that you were all business. You asked a lot of questions about what was wrong with her but didn't seem to care or be interested in how the disease was affecting her and her life. Her problem, as she experiences it, is not simply the discomfort in her legs, it is also that she can't spend time with her grandchildren.
Participant: How would I ask her about that?
SP: Directly. Ask her what it is like to live with the discomfort she is experiencing and ask her how it affects her life.
Participant: Yeah, but I can't do anything about that.
SP: You don't have to. Knowing that you understand is enough.
Facilitator: Knowing about a problem doesn't mean you have to fix it. The empathy can be a simple human acknowledgment of your understanding. Do you want to try it and see how it feels?
Participant: Sure, why not.

Ethical values. The third factor is the ethical frame of reference that the participant brings to the clinician-patient encounter. Most of the participants who attend the Intensive program have not thought about communication, whether with patients or staff, as an ethical act. While participants have studied the ethics of biomedical decision making in medical school, courses in ethics rarely present the communicative process as having an ethical frame.

During the Intensive program the participant is exposed to a variety of ethical approaches to clinician-patient interaction. Participants are surprised when they are asked to watch the movie *Groundhog Day*, in which actor Bill Murray plays a misanthropic TV weatherman trapped in a time loop in Punxatawney, Pennsylvania, for whom the same day keeps repeating over and over. His character goes through the entire range of ethical development, from self-defeating narcissism in the beginning of the film to a recognition that service to others leads to a more fulfilling life, even when "thanks" are not forthcoming [5,6]. The character grows in his ability to see people as valued "others" rather than as objects for his own use. He also learns to harness his knowledge as a vehicle for service rather than manipulation. Program participants are encouraged to reflect upon the ethical

principles that emerge from the movie and how they might apply them to their work with patients.

Personal history. The fourth factor addressed in the Intensive is the psychological history that the participant brings to the clinician-patient encounter. One of the exercises invites the participant to consider his or her "hot buttons," situations that trigger an emotional or defensive reaction. Participants are asked to examine what it is about these situations that causes them to feel embarrassed or threatened [1]. They are then asked to assess their current strategies for reacting to those hot button situations. New, potentially more effective strategies are explored and practiced with standardized patients. To convert the new strategy into a skill, the participant's "hot buttons" are deliberately pushed by the standardized patient so the participant can practice the new strategy. "I go ballistic when someone questions my competence." So, the standardized patient questions away. The new strategy may call for curiosity about what the patient is afraid of rather than a defensive counterattack.

What is the source of the "hot button?" For most clinicians, the answer can be found somewhere in their families of origin. To explore this psychological history, participants are introduced to the genogram, a graphic mechanism for displaying the relational history of a family [7,8]. A group leader presents his or her own genogram as a way of introducing the concept, and then participants construct their own genograms. They are encouraged to call home for information they may have forgotten or may not know. During the time that participants are constructing their genograms, the faculty remains "on call" in case participants run into troubling memories or feelings. From the construction of their own genograms and hearing about the families of other group members, participants become aware that every patient (and every clinician) comes into the examination room with a unique history. This history may explain a great deal of the interaction that takes place. For example, the participant who was the first in her family to go to college, let alone medical school, guards her status as a physician like a treasured state of being: "Question my competence, will you?" In the safety of the small group, the prompting of the genogram releases years of feeling alienated from the family of origin ("I'm not like them anymore") and the chosen professional life ("I don't ever feel like I really belong"). With this awareness it becomes easier for the participant to replace defensive action with curiosity and empathy.

Phase 3: Back Home Coaching

Change in practice behavior is unlikely to occur without reinforcement in the clinical setting. Without reinforcement and support, the participant is liable to revert to previous patterns of behavior, however ineffective they may be. Back home coaching by knowledgable and skilled physicians or psychologists counters this barrier to learning. Many of the coaches are drawn from the faculties of the Bayer Institute for Health Care Communication and the American Academy on Physician and Patient; in addition, referring and sponsoring organizations often have capable coaches.

Coaches are asked to meet with participants on a monthly basis for 1 year after the participant completes the residential program. They are asked to work with the participant for an hour to an hour and a half in face-to-face meetings to review and work with audiotapes or videotapes of the participant's clinical encounters. As resources, coaches are provided with a demonstration video of a model coaching session as well as 2 papers: one on coaching and one on performance improvement. If fees are to be charged, it is recommended that the coach charge the participant the average rate for a psychotherapy session in that area of the country.

Faculty

Because of the emphasis on coaching and the emotional content that is part of the week's work, the experience and skills of program faculty are critical. Two models have emerged. The original model was to pair a practicing physician who had excellent coaching and communication skills with a behavioral scientist. The second model employs a behavioral scientist who has done extensive work in clinician-patient communication or a physician who is also a behavioral scientist. It has become clear that the coaching skills and familiarity with the clinical world are critical components. The faculty member has to be willing to engage the participant in the coaching process and has to be sensitive to the emotional responses of the participant during the course of the week. The course requires much more of faculty than simply observing and providing feedback.

We believe that it is important for faculty to have some behavioral science background. It is not unusual to make a mental health referral during or at the end of the Intensive. Over the years we have encountered participants who were severely depressed. We have made the decision to employ faculty members who will be able to detect psychopathology. Most often referrals are made for participants who would benefit from psychotherapy to resolve psychological or interpersonal issues they are currently experiencing. Participant feedback on these referrals has been gratifying. In all settings where the Intensive is offered, a psychiatric back-up system has been put in place in case a participant needs immediate care.

Confidentiality

The Intensive does not provide written assessment of participants. It is strictly an educational experience, and referral agencies, sponsors, and participants are informed of this at enrollment. Participants can work during the week without

being afraid that they will be formally evaluated or that the results of this assessment will be provided to their employers or partners. It is not unusual for a participant to attend the Intensive as one element of a formal work improvement process; in the past, these participants have requested that we provide a written assessment in order to influence the decision of the sponsor. However, it is our belief that providing this assessment would inhibit learning, and we do not provide them.

Outcomes

The effectiveness of the Intensive process has been measured in 3 ways. First, Kaiser Permanente in Northern California and HealthPartners in Minneapolis use the Intensive program on a regular basis and conduct quarterly patient satisfaction surveys. Because these organizations survey patients on a continuous basis, it has been easy to abstract before and after scores and to track scores over the long term. Both organizations report that most participant patient satisfaction scores improve about one quartile. Approximately 25% of participants do not show improvement, while another 25% have improved by as much as 2 quartiles. Scores have been reported to continue to be improved 3 years after participation in the Intensive program. These data are proprietary to the 2 organizations and have not been published.

Second, we evaluated a group of 18 physicians, 9 assigned to the Intensive group and 9 assigned to a wait-list control group. We assessed before and after audiotapes of visits using the checklist instrument SEGUE developed by Greg Makoul [9]. With one exception, "identification of next steps," the SEGUE instrument detected no significant increases in the 18 specific communication tasks that were coded by the research staff. There are several possible explanations for this. The group studied was quite small, and there was great variability in skills across both the intervention and control groups. SEGUE is a checklist instrument based upon specific communication tasks and may not be able to detect more subtle attitudinal or behavioral changes (such as tone of voice). Global ratings may be more sensitive to change than checklist approaches. Also, because each individual clinician chose a small number of the 18 specific SEGUE behaviors to focus on during the course, it may not be appropriate to measure improvement in all skills across all participants. The issue of instrumentation to measure change in communication behavior is one that the field continues to struggle with [10].

Finally, in a follow-up telephone survey of clinicians 3 months and 6 months after attending the Intensive, the clinicians consistently volunteered that they were enjoying the practice of medicine again. As one clinician reported, "I'm back to why I went into medicine and it feels good."

Conclusion

We believe that all 3 phases of the Intensive are critical ingredients in the success of the program. Using an interactive format, the program addresses 4 factors in communication performance: personal theories and beliefs, ethical frames of reference, skill development, and psychological history. There is now a large base of experience with the program that reaches back several years with several hundred participants. The majority of the participants make important gains by participating in the process.

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