

A Workshop in Physician-Patient Communication for Anesthesiology Trainees

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Abstract

Background: Although abundant literature demonstrates the importance of effective physician-patient communication, most research and teaching models in this area are based on a primary care setting, and may not apply to procedural specialties. Some research demonstrates that patients perceive their surgeons' and anesthesiologists' communication skills to be less effective than those of primary care specialists. In order to improve the effectiveness of anesthesiology trainee communication skills and simultaneously address the new ACGME general competency requirements pertaining to such skills, faculty from the Departments of Anesthesiology and Internal Medicine collaborated in the development of a workshop tailored to the needs of this group.

Methods: After reviewing the literature on physician-patient communication in primary care and in procedural specialties, we created and delivered a workshop.

Results: The literature review revealed that although the essential communication skills are the same in primary care and procedural specialties, the anesthesia-patient interaction is unique because it is inherently brief, its function is to prepare for a procedure, not to diagnose and treat, and patient anxiety is generally high due to the imminent surgical procedure. We created a workshop by adapting the Bayer Institute for Health Communication's 4E Model to the anesthesia setting. This teaching model was chosen because it is based on literature that reflects both primary care and procedural settings, because it has been widely and successfully used in brief workshops to physicians, and because it achieves the overall goals of the course. They were 1) to teach the skills related to the essential elements for physician-patient communication and

the functions of the pre-operative anesthesiologist-patient interaction and 2) to partially fulfill the ACGME general competency objectives. In addition to teaching the basic skills of the 4Es (Engage, Empathize, Educate and Enlist), specific examples, video cases, and role plays from the anesthesia setting were used to illustrate common problems in physician-patient communication.

Conclusions: Non-primary care specialties may need to tailor current physician-patient communication models to their setting in order to train residents in interpersonal and communication skills. Our proposal for a physician-patient communication workshop for anesthesiology trainees illustrates one way in which an existing teaching model can be adapted to meet the specific needs of a procedural specialty.

Introduction

Although abundant literature demonstrates the importance of effective physician-patient communication (1-4), most of the research and teaching models in this area are based on a primary care setting, and may not apply to procedural specialties (5). Additionally, recent accreditation changes by the Accreditation Council for Graduate Medical Education (ACGME) require documented evidence of resident competency in the area of physician-patient communication. Faculty from the Department of Anesthesiology collaborated with an expert in physician-patient communication skills from the Department of Internal Medicine in order to address this need. This article provides a review of relevant literature and reports the results of this multi-disciplinary collaboration—a workshop in physician-patient communication for anesthesiology trainees.

Review of the Literature: Current Models of Physician-Patient Communication

The ability to communicate effectively is essential to the task of diagnosing and treating medical patients. Physicians perform approximately 150,000 – 200,000 patient interviews during their careers (1). Effective communication during the medical interview plays an essential role in determining physician-patient rapport, patient and physician satisfaction, patient adherence to the treatment plans, and frequently, the course of the illness itself. Alternatively, ineffective communication in medicine is associated with poor health outcomes, doctor shopping and litigation (2-4, 6). In response to abundant empirical and theoretical evidence supporting the substantial role of effective communication, many medical schools currently include interviewing skills in their curricula.

Courses in physician-patient communication skills have been shown to improve residents' interviewing behaviors (7-10), such as clarifying patients' concerns and beliefs, communicating about treatment options, showing empathy, optimizing the setting, establishing and maintaining the narrative thread, summarizing and making transition statements, and using the facilitation skills of giving feedback, reflecting and showing respect (7). Of particular significance for anesthesiologists whose interactions with patients are frequently tinged with anxiety due to impending surgery, Roter et al (8) demonstrated that a brief course in communication skills improved residents' ability to detect and handle emotional distress without increasing the length of the visit.

In order to summarize the literature on physician-patient communication skills, a consensus statement was recently developed by an invited group of leaders and representatives from major medical institutions and professional organizations (11). The resulting Kalamazoo Consensus Statement was based on five current models of doctor-patient communication: the Bayer Institute for Health Care Communication E4 Model, the Three Function Model/Brown Interview Checklist, the Calgary-Cambridge Observation Guide, the Patient-Centered Clinical Method, and the SEGUE Framework for Teaching and Assessing Communication Skills. After considering these models and several organizations' criteria for teaching and evaluating physician-patient communication, the following seven elements were suggested as essential to effective physician-patient communication: build a relationship, open the discussion, gather information, understand the patient's perspective, share information, reach agreement on problems and provide closure. The Kalamazoo statement provided examples of each element and ensured that each was evidence-based and appropriate for teaching, assessment and evaluation.

These essential elements can form the basis of a workshop on physician-patient communication skills. The task for medical educators in anesthesiology is to determine areas in which the anesthesiology setting is similar to or distinct from other medical settings, and then to adapt the essential elements and current teaching models accordingly.

Review of the Literature: Anesthesiologist-Patient Communication

Although most of the research on physician-patient communication is based in the primary care setting, there are some reports relating to procedural medical practice. Procedural specialists may undervalue the importance of communication in their patient interactions. Fung and Cohen (12) demonstrated that anesthesiologists were unable to predict their patients' priorities on pre-operative and intra-operative care, underappreciating the value patients placed on information. This corroborates insights from other studies in peri-operative care demonstrating that patients placed a high value on communication and information; in one survey (13), orthopedic surgery patients perceived their surgeons' skills in listening and demonstrating care and compassion to be much lower than the surgeons' self assessment. The same patients rated their orthopedists as less caring and compassionate than their primary care physicians. In another study (14) of 143 Australian surgeons who responded to a survey of their perceptions of their communication skills, nearly a third reported feeling 'not competent' in some communication skills, such as increasing patients' ability to remember what they have been told (28.3 %) and encouraging patients to express anxieties about their condition (28.2%). Further, most of the respondents indicated a need for formal training and assessment as part of surgical training, especially in topics such as breaking bad news to patients (80.1%), preparing

patients for surgical procedures (81.3%), and educating patients about diagnosis and treatment (75.0%).

In an observational study of outpatient office visits with general surgeons and orthopedic surgeons, Levinson et al (5) reported that the focus of the interaction was on patient education, including discussing the medical condition, explaining the treatment options and helping the patient to understand the procedure in detail. This pattern is strikingly different from the primary care encounter, during which more time is spent on the history and physical, and less time on patient education. These authors recommend that procedural specialists receive communication skills training that emphasizes patient education and counseling, rather than the same training that is delivered to primary care specialists. The anesthesiologist-patient interaction is unique in several ways, and therefore training anesthesiologists in communication must be adapted accordingly. Unlike physician-patient interactions in the primary care specialties, the focus of the interaction is not to diagnose or engage in a long-term relationship, but rather to help plan a procedure. Pre-procedure patient-anesthesiologist interactions are usually brief and occur in an atmosphere that can be rushed and confusing because the patient must see a multitude of health professionals. In such an environment verbal and non-verbal communication must not only be respectful, but also concise (15).

The preoperative visit serves many functions. It helps the anesthesiologist assess the patient's readiness for anesthesia and surgery, obtain informed consent and decrease costs by improving outcome and facilitating communication among the patient care team (16). The preoperative visit helps the patient understand the role of anesthesia, which can be reassuring and anxiety-reducing. Anxiety can cause undesirable psychological and physiological effects, such as elevated corticosteroids and catecholamines, sodium retention, decreased gastric emptying,

increased anesthetic requirements (17), and increased postoperative pain (18). Effective anesthesiologist-patient communication has been shown to reduce postoperative pain, length of hospital stay, and cost of care (16, 19).

Patients vary greatly in their need to know about anesthetic risks. Many questionnaires have assessed patient anxiety and specific concerns (19-22) and one has shown cross-cultural validity (18). Patients who desire more information tend to be younger (19-25), female (19-22), previously healthy (21-22), anticipate a longer surgical procedure (21,22), and live in an urban area (26). Anesthesia-related information of importance to patients can be divided into concerns about preoperative issues (e.g. type of anesthesia, catheters, length of hospital stay); intra-operative issues (e.g. loss of control, failed surgery, awareness, not waking up); and postoperative issues (e.g. residual paralysis, length of recovery, vomiting, pain, surgical wound pain, shivering) (20-26). Most patients do not give a high priority to being informed about dangerous complications (20,23,26), but anesthesiologists must learn to identify those who would benefit from such information. Patients who are described as 'monitors' seek information about risk, whereas 'blunters' tend to avoid information. Anxiety occurs in 'monitors' for lack of information, and in 'blunters' for too much information (27). Therefore, anxiety is affected by the patients' satisfaction with how appropriately information is delivered, and not necessarily with how much information is transmitted (18).

Anesthesiologists need to be trained to educate patients about their treatment plan, and to encourage patients to express their anxieties about their condition. Despite a landmark report in 1963 demonstrating that the preoperative visit can more adequately prepare patients than intramuscular sedation (28), anesthesiologists still tend to undervalue the importance of communication with patients. According to Fung and Cohen's small survey of surgical

outpatients and their anesthesiologists (12), patients undergoing anesthesia care value highly the aspects of care related to communication and information. Specifically, patients placed a high value on whether their concerns were identified and addressed during the pre-operative phase, on being spoken and attended to during the operative phase, and on being provided with information about complications of surgery and anesthesia, including after discharge. However, anesthesiologists were unable to predict the priority patients placed on various aspects of care because they underestimated the value patients placed on information and communication. Rather than predicting that patients would place a high value on information and communication, they over-estimated the value that patients placed on smooth and trouble-free care. Good bedside manner should not be considered superfluous, bothersome, or irrelevant to the preoperative patient-anesthesiologist encounter.

Teaching Model

Our model for teaching communication skills to anesthesiologists, the Bayer Institute for Health Care Communication E4 Teaching Model (29), integrates the literature on physician-patient communication from primary care, anesthesiology and other procedural specialties. This model was chosen for three reasons. First, it is evidence-based, although admittedly most of the research comes from continuity primary care settings. Second, it has been presented successfully in a half-day workshop format to over 60,000 clinicians (mostly physicians) in North America. Third, it fulfills and integrates the three basic requirements for the course: Accreditation Council on Graduate Medical Education (ACGME) general competency objectives (30), the essential elements for physician-patient communication, and the functions of the pre-operative anesthesiologist patient interaction.

The E4 Model (29) assumes that there are four communication or relationship tasks that must be performed during the medical encounter. Each of these tasks includes specific, evidence-based communication skills: engage the patient, empathize with the patient, educate the patient, and enlist the patient as a partner. We adapted the model so that the general tasks remain the same, but the specific skills of each task are tailored to the anesthesiologist-patient relationship.

Course Description

Objectives: The objectives for the course were adapted from the Accreditation Council on Graduate Medical Education (ACGME) general competency requirement for interpersonal and communication skills, as follows (30): Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients. Residents are expected to [1] create and sustain a therapeutic and ethically sound relationship with patients and [2] elicit and provide information using effective nonverbal, listening, explanatory, and questioning skills.

Workshop Structure: The workshop was taught in a half-day session to ten residents and fellows—seven were interns in their Clinical Base Year and three were pediatric anesthesiology fellows. The interns were finishing their Clinical Base Year in internal medicine, and lacked formal training in the basic communication skills deemed necessary for starting the anesthesiology training; the fellows were added by the fellowship program director who had noticed a deficiency in the communication skills of her fellows. The preoperative anesthesia

visit provided the model interaction for the course, although examples from other types of other perioperative (e.g. pediatric, critical care) interactions were included.

Workshop Content and Teaching Method:

(1) Introduction and Orientation (Method: Interactive lecture): After a brief introduction and orientation to the workshop, participants introduced themselves, described their experience with formal communication skills training, and identified physician-patient communication skills they wanted to learn during the workshop. Some skills they identified were describing complex procedures, obtaining consent, managing treatment refusal, and managing anxiety.

(2) Rationale for Learning and Practicing Physician-Patient Communication Skills (Method: Lecture): This brief lecture provided an overview of the literature on physician-patient communication, with special emphasis and examples from the field of anesthesiology. In particular, reference was made to the anesthesia literature regarding the relationship between communication and physician perceptions, patients' perioperative concerns, 'blunters' and 'monitors', and patient anxiety (12-27).

(3) The Communication Teaching Model (Method: Lecture): This brief lecture provided an overview of the E4 Model.

(4) The Skills and Practice (Method: Interactive lecture, video and discussion, role-plays): Skills and associated techniques were explained, interspersed with videotaped interactions and role-plays. Videotaped physician-patient encounters provided models of interactions for deepening participants' ability to recognize and analyze skills. Role-play cases were carefully prepared ahead to give each resident the opportunity to play the role of the physician and to reflect on his or her own skills, while others played the role of patient or observer, providing feedback to the

“physician.” A sample role-play is provided in the appendix. Videotaped interactions and role-plays were constructed and used with the following roadmap from the E4 Teaching Model.

Engaging the patient provides the foundation for the other skills. This skill includes greeting and welcoming the patient and family, explaining the role of the anesthesiologist, and demonstrating concern for the patient as a person, rather than simply another case. In addition, engaging the patient involves orienting the patient to the purpose of the interaction and gathering information to assess the patient’s readiness for the procedure.

Empathizing with the patient is critical to reassuring and reducing the anxiety that is typical of patients who are facing surgery. Showing empathy involves the sincere demonstration of concern for and curiosity about the emotions, values and experiences of the patient and/or family. Techniques include eliciting and acknowledging patient emotions such as anger, fear, anxiety or uncertainty through reflecting, supporting, respecting and accepting them.

Education involves asking patients what they already know about the anesthesia procedures as well as what they’d like to know, and then filling in the gaps as necessary in simple terms. While some patients, known as ‘monitors,’ prefer to learn as much as possible before the procedure, others, known as ‘blunters,’ may be familiar or may prefer to avoid information in order to reduce their anxiety (27).

Enlistment involves encouraging a partnership between the anesthesiologist and patient in order to make decisions and gain consent and cooperation. Techniques involve offering the patient options, asking the patient if they agree to the plan or if they have any other questions.

(5) Wrap-up and Evaluation: This final component of the workshop allowed participants to summarize what they learned, set goals for application of new concepts, and evaluate the course.

Formal post-workshop evaluations such as illustrated in Table 1 are desirable since they afford the opportunity to evaluate teaching and content and improve quality.

Discussion:

Effective interpersonal and communication skills not only improve the physician-patient relationship, but positive feedback from satisfied patients can enhance residents' self-esteem and improve the reputation of the institution (31). We report the development of a workshop in anesthesiologist-patient communication designed to enhance trainee-patient communication and to address the new ACGME requirements on interpersonal and communication skills.

Abundant literature in medical education has demonstrated that courses on communication skills are effective (2, 7-10). A substantive limitation of our report is the lack of formal validation and outcomes assessment procedures. We plan to administer this course yearly, to all PGY-1 residents upon completion of their Clinical Base Year, and to add an assessment tool in the form of an Objective Structured Clinical Exercise (OSCE) to evaluate acquisition of communication skills. Validation of the assessment tool can be achieved by administering the same exam to all trainees, and then comparing results by level of training. Further outcome assessment may be available from patients, families and other professionals.

Table 1: Example of an Evaluation Tool Used in Our Communications Workshop (n=9)

Instructions: Please help us to increase the effectiveness of the program by responding to the following items.

		Excellent	Good	Fair	Poor
1.	The presenter's mastery of the subject matter	9			
2.	The presenter's human relations skills: listening, interest in the opinion of others, etc.	8	1		
3.	Lecture/introduction and premises	8	1		
4.	Lecture/discussion: engagement and empathy.	6	3		
5.	Case study #1 videotape and discussion	7	2		
6.	Lecture/discussion: education and enlistment	5	4		
7.	Case study #2 videotape and discussion	7	2		
8.	Role Plays	5	4		
9.	Quality of the materials	5	4		

Appendix: Sample Role Play Instructions

Doctor: Take a history of this 74-year-old male who has presented to your clinic for his pre-operative visit prior to radical prostatectomy. Demonstrate the 4Es: engagement, empathy, education and enlistment.

Patient: You are a 74-year-old male . You went to see your doctor because you had to get up so frequently at night to urinate, and your doctor thought you might have cancer. Your doctor suggested that you see a urologist, who suggested that you would need surgery to remove your prostate. You're very nervous about the procedure, since the only surgery you've ever had was when you had your appendix removed when you were a young man. You're especially worried about the anesthesia because you've heard that it's very risky. You are retired have been a widower for three years, and have several children and grandchildren who are a big part of your life.

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