# Communication Skills

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## 1. Introduction

Effective communication skills are central to contemporary medical practice. The manner in which a physician communicates with patients is inextricably linked with patient compliance, emotional adjustment, and performance expectations. [1,2,3,4] Improvements in provider-patient communications have been shown to positively impact patient outcomes,[5] and have been directly associated with overall patient satisfaction.[3,6,7,8] Finally, patients who believe that their providers communicate with them well are less likely to initiate law suits against their providers. [9]

Professionalism and communication skills are enumerated by the American College of Graduate Medical Education (ACGME) as core-competencies, which are difficult to teach and objectively evaluate. In many of the medical and surgical specialties, increasing time constraints and a growing number of technical skills have drastically reduced the time that can be committed towards fostering these humanistic aspects of medical care. [10,11,12,13] As a result, communication skills are often left up to the trainee to learn by observation, or by trial and error. This may create fear, anxiety, and discomfort for the trainee as well as suboptimal care for the patient. [11,13]

## 2. Developing a Toolbox of Essential Communication Skills

The urologist plays a pivotal role in the translation of many complex health issues to patients of all ages, races, educational levels, and socioeconomic backgrounds. Consider, for example the very common scenario in which a patient is referred for prostate cancer screening. The recognition that screening, diagnosis, and treatment interventions may have adverse physical, psychological, and social implications for the patient and his family can only be shared through the use of several communication skills. The complex medical aspects of the discussion, the conflicting clinical data regarding PSA screening, and the highly personal nature of disease's impact on sexual, urinary, and bowel function make for a challenging medical discussion in and of itself. The discussion takes on additional levels of complexity if the patient never went to school, or if his father died of prostate cancer, or if he is the young sole provider for his family. Even in this very common, fairly "routine" example, we can see that an effective urologist needs to have mastery over a large number of difficult communication skills.

The purpose of this communication section is to help you to recognize and develop an armamentarium of communication skills that have proven to be effective in various clinical situations. The specific skills are presented in a task- oriented fashion, which gives each encounter structure and allows for the trainee to develop specific goals for the encounter. This structure also allows for both objective evaluation and self- assessment of whether the task was successfully implemented and where improvements can be made. The process is iterative, and will undoubtedly improve as you become more proficient through deliberate practice. We would encourage you to work with your sponsoring medical school or your program director to develop a strategy that provides an interactive communications experience for house-staff and provider training.

While provider-patient communications form the fulcrum from which health is assessed and care is provided, contemporary health care delivery mandates the participation of many other personnel. Some of these personnel directly impact patient care, such as other physicians, medical and physician assistants, nurses, nurse practitioners, and technicians. Other personnel indirectly impact patient care. These include hospital and ambulatory center administrators

and employees, insurance providers, as well as information technology experts who are responsible for monitoring and maintaining the operability of our health records. As we will see in future sections, the scope of physician communication skills continues to expand, and is not limited to provider-patient communications. Mastering these inter-professional and intra-professional communication skills are essential in preventing medical errors, minimizing the impact of transitions in patient care, and helping to avoid contradictory strategies to patient care.

# 3. Essential Communication Skills

The four specific communications skills that will be addressed in this chapter include: 1) developing a successful physician- patient partnership from the beginning, 2) obtaining informed consent, 3) delivering bad news, and 4) disclosing a medical error. It is our belief that by developing mastery over these skill sets, the Urologist in training will be able to deliver more personalized care that is balanced, honest, and more receptive to the needs of the individual patient.

## 3.1 Communication Skill #1: Developing a Successful Physician– Patient Partnership from the First Visit

Patient ratings of health care providers are quality reporting measures that are increasingly being used by health care institutions, insurance providers, and internet-savvy patients seeking physicians.[14,15,16] Survey data suggest that physician communication skills are more closely aligned with patient satisfaction than is technical proficiency in treating illness.[8,17,18] Other studies suggest that provider communication skills, along with office- staff interactions, and patient access are the three most important determinants for a satisfactory healthcare experience.[19] Therefore it is absolutely essential that the physician-patient relationship get off on the right track.

The medical interview represents the gateway for many patients into a particular medical system or provider. Fostering a patient- centered approach to medical care, which emphasizes both the patient's disease and his or her perspective about their illness is an essential tenet to the establishment of a successful physician-patient relationship.[20,21] It acknowledges that this relationship is a partnership in which ideas, feelings, and values of both parties influence the manner in which medical decisions are made and implemented.

In order for physicians to be successful in upholding their part of the partnership, patients have expressed their preferences. The physician must be able to engage the patient and promote participation in care with a nondirective, nonjudgmental communication style that allows the patient to feel comfortable in expressing their unabashed understanding and emotional concerns.[8] The use of open- ended questions, a communication style that conveys empathy and caring, listening to patients' concerns, and speaking in a language that is clear, and avoids medical jargon are several tools that are consistently rated by patients among the most important determinants of satisfaction with the provider.[22,23,24]

### 3.1.1 The Four Habits Model

(See Reference **25**)

The Four Habits Model is one communication template that breaks down the medical interview into four interrelated tasks, which are summarized in **Table 1**.

*1. Investing in the beginning.* The beginning of the interview is important in setting goals and the overall tone of the rest of the encounter. Some physicians consider the first few moments of a medical encounter as pleasantry or preliminary to the clinical business of the interview. The Four Habits Model argues that these humanistic moments are among the most important for the encounter. Consider how you would feel if you were a patient anxious to see a new doctor about a medical condition that may alter your entire life. It may be a life- threatening disorder or not. Nevertheless, it is important enough that you wish to see a doctor about it. In all honesty, you have likely waited to get an appointment with the doctor, and will probably be in the waiting room for a considerable amount of time prior to being called into the examination room. Imagine the disappointment and even anger that you would feel when the exam room door opens and your doctor appears disheveled, hurried and disinterested. Your perception is that the physician has no sign of emotion, and there is no interest in hearing about your concerns.

There is absolutely no substitute for greeting a patient with a smile, and establishing a welcoming environment that gives

the patient a sense of confidence, safety, and supports an egalitarian stance. When entering the exam room with a new patient, introduce yourself by name. A handshake immediately establishes a sense of mutual respect and provides a symbolic gesture of equality, trust, and partnership. In addition to the suggestions provided in **Table 1**, other investments include reviewing the patient's history prior to the encounter. When you are aware that the patient has been waiting, it is courteous to recognize this, and make a comment like "thank you for waiting" or "I apologize that you have been waiting so long." Often patients are agitated. Unless you feel that they pose a physical threat, try to maintain your composure and respond to their issues with respect. Statements such as "I apologize for your delay. I am here now and you have my full attention." may help diffuse a difficult and uncomfortable situation. Remind the patient that you are their advocate, particularly when patients are angry. Above all, try and empathize with the patient; there is no role for accusatory or argumentative discussions in a medical encounter.

After the preliminaries have been completed, the next steps to the medical evaluation include: eliciting the patient's concerns and setting the agenda for the visit. See **Table 1** for additional notes on these aspects of the visit.

*2. Eliciting the patient's perspective* is critical to developing a patient-centric approach to care. By using open-ended questions, the physician enables the patient to demonstrate perceived attribution of the problem, what concerns they have, specific goals that they may have for the encounter, and how they believe their problem may impact them or their psycho-social well-being. For instance, a patient who comes in for evaluation of lower urinary tract symptoms may admit to being concerned about having bladder cancer, which his mother recently died from. They will feel much better if the discussion includes consideration of bladder cancer.

By eliciting the patient's perspective, the physician may determine the impact of the patient's concerns on their daily activities, family and work. Eliciting their perspective may also lead to a more focused and accurate diagnostic strategy. For instance, a happily married male patient whose diagnostic testing has proven inconclusive for chronic bacterial prostatitis may disclose that he had an unprotected sex with someone other than his wife. Without eliciting this information, the clinician may have failed to perform the necessary urethral swab to diagnose a sexually transmitted infection.

Pay attention to the verbal and non-verbal cues that the patient uses in communicating their perspective. This will give you some clues as to their emotional condition, the urgency of the problem, and their educational level. This will also help you determine how you will verbally communicate later to each of their concerns.

*3. Demonstrating Empathy.* Demonstrating empathy is ranked as one of the most important attributes that patients want in their doctors. [7,8,22,23,24] Physicians need to be very conscious about non-verbal cues, which may indicate a patient's psychosocial and emotional state. Careful observation of non-verbal gestures, such as looking down, expressions of sadness or joy, or pauses may all be subtle clues to the patient's emotions. It is often helpful to validate these emotions with statements such as "it must be hard to think of living with an ostomy" or "I can see how your father's death from prostate cancer would cause you to be concerned that you may get it in the future." Sometimes when the physician is not sure about the actual emotion that a patient is experiencing, it is not wrong to ask the patient. Saying something like "I am not sure if you are expressing sadness or tears of joy after being cured with a radical cystectomy. Please help me so that I can help you" is a statement that can be made under these circumstances, which offers the patient an opportunity to indicate what their emotional state is.

Similarly, non-verbal cues may be used by the physician in order to convey a sense of empathy. Pauses, speaking softly and in a caring manner, and in some cases, touching the patient on their arm or hand, may be acceptable. The clinician must use discretion here, in order to know when this is appropriate.

*4.Invest in the End.* Unlike the prior tasks, the fourth habit involves sharing medical information, while engaging the patient to participate in a shared-decision making process. It is during this portion of the encounter, that the clinician renders their opinion regarding the patient's health issue, and then discusses potential implications on the diagnosis, prognosis and further interventions. It is also during this portion of the encounter that the physician must include a sufficient quantity and specificity of information in order for the patient to develop an understanding of the disease process and any the choices that will need to be made regarding future diagnostic studies or interventions.

As will be discussed in the *informed consent* subsection, a critical goal of the clinician-patient relationship is to build a partnership that respects a patient's preferences, perspectives, and needs.[26] For many decisions, there is clearly a superior path, in which patient preferences have little impact.[27] However, in other decisions, such as treatment options for prostate or bladder cancer, there are several options in which patient preference may strongly influence the decisions that are made[28,29] We will discuss much more about shared- decision making in *Section 3.3.2*.

At the end of the visit, the patient should receive a clear and concise written summary of what was discussed during the visit, as well as delineation of future diagnostic studies, treatments, and a follow up plan. The provider should go over this printed summary with the patient in order to ensure clarity. This written summary provides closure to the encounter.

## Table 1: The Four Habits Model for patient engagement

| Habit | Skills | Techniques |
|-------|--------|-----------|
| **Invest in the beginning** | • Develop rapport quickly<br>• Elicit patient's concerns<br>• Plan the visit with the patient | Smile, Introductions to all in the room, shake hands. Make a social comment/ non-medical question that puts the patient at ease.<br>Convey knowledge of patient's history by commenting on prior visit or problem.<br><br>Open-ended Questions:<br><br>• "What would you like help with today?"<br>• "I understand that you're here for…could you tell me more about that?"<br><br>Speak directly to the patient when using an interpreter. Repeat concerns back to check understanding<br><br>Let patient know what to expect:<br><br>• "How about if we start with talking more about… then I'll do an exam and we'll go over ways to approach this issue"<br><br>Prioritize when necessary:<br><br>• "Lets make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we cannot get to it, lets plan to do it next time.." |
| **Eliciting the patient's perspective** | • Ask for the patient's ideas<br>• Elicit specific request<br>• Explore the impact on the patient's life | Assess patients' point of view:<br><br>• "What do you think might be causing your problem?"<br>• "What worries or concerns you most about this problem?"<br>• "What have you done to treat your illness so far?"<br><br>Determine patient's goal(s) in seeking care<br><br>• "How were you hoping that I could help?"<br><br>Check context<br><br>• "How has the illness affected your daily activities/work/family?" |

| Demonstrate Empathy | • Be open to the patient's emotions<br>• Make an empathetic statement<br>• Convey empathy nonverbally | Respond in a culturally appropriate manner to changes in body language and voice tone<br><br>Look for opportunities to use brief empathetic comments such as *"...you seem really worried"* Compliment patient on efforts to address problem<br><br>Use a pause, touch, or facial expression |
|---|---|---|
| Invest in the End | • Deliver diagnostic information/ provide education<br>• Involve the patient in decision making (Shared Decision Model)<br>• Complete the visit | Frame diagnosis in terms of patient's concerns<br>Explain rational use of tests and treatments<br>Review possible side effects and expected course of recovery<br>Discuss options and provide resources for patient to review<br>Discuss treatment goals<br><br>Assess patient's capacity and their values and perspectives<br>Assess comprehension<br>Summarize visit and review next steps, appointments<br><br>Ask patient if they have any additional questions or concerns<br><br>    • "did we cover all of the problems that you were concerned about."<br><br>Close the visit in a positive way:<br><br>    • "it has been nice meeting with you, thanks for coming in today." |
| View Image. | | |

## 3.2 Communication Skill 2: Delivering Bad News (DBN)

Bad news is defined as any information that may negatively impact an individual's expectations about their present and future circumstances.[30] It pertains to situations where there is either a feeling of no hope, a threat to a person's mental or physical well-being, a risk of upsetting an established lifestyle, or where a message is given which conveys to an individual fewer choices in his or her life. [31]

Surveys of practicing physicians from the 1950s and 1960s indicated that disclosing bad news to a patient was generally felt to be unnecessarily demoralizing, particularly when disclosing a cancer diagnosis in which there was little hope for a cure.[32,33] Over the last 25 years, there has been a reassessment of this approach. Patients desire honesty; studies have shown that patients who are given bad but honest prognostic information from a physician remain equally hopeful about their future. [34] Other studies have shown that patients who engage in end-of-life discussions with their physicians have no higher rates of depression or anxiety, have lower rates of ventilator dependency and undesirable resuscitation efforts, and have both earlier and higher rates of hospice enrollment. [35] Finally, other studies have suggested that reduced anxiety[36] and better adjustment[37] often accompany an honest, yet empathetic disclosure of a cancer diagnosis.

While bad news is often perceived in the context of the black and white of a terminal illness, in reality there exists a spectrum of gradations[4] that must be approached in the context of the patient's perspective. Consider the following examples: 1) delivering a diagnosis of muscle invasive bladder cancer to a male who was scheduled for a 50$^{th}$ anniversary European cruise with his wife; 2) diagnosing a kidney stone in an airline pilot who is scheduled to fly a transcontinental flight to see his dying mother in the next 24 hours; 3) having to tell a diabetic male who cannot afford medical therapy that his penile implant will not be covered by insurance. While each of these scenarios differs considerably along the spectrum of bad news, they equally may have a devastating emotional impact on the patient. Health-care professionals often find it hard to step back and take into account the spectrum of physical, social, occupational, and emotional issues that may affect what information is classified as bad news by the recipient.[4]

### 3.2.1 Barriers to DBN

From the vantage point of the medical professional, DBN is one of the most difficult communication skills to master. It is often perceived as unpleasant and stressful. [11,13,36,37,38]

Healthcare providers are accustomed to providing effectual treatment that either cures or arrests various medical conditions. When they cannot perform in this capacity, there is often a sense of uneasiness and lack of familiarity with the feelings of being powerless in impacting the disease outcome.[11,39] In other instances, DBN places the provider in an awkward position, not knowing how a patient or family will react to a particular circumstance[11] and often not knowing how to react to the patient's emotions. Finally, some providers relate from personal experience to bad news (i.e. death of a loved one, being diagnosed with cancer, etc.) that they are delivering to a patient. [11] These may pose additional emotional challenges for the provider.

The various delivery styles that physicians take in approaching DBN have been described in different terms within the literature. In one series, the manner in which physicians delivered bad news was characterized by the rapidity in which the bad news was delivered. A *blunt* style was characterized by the rapid delivery of bad news within 30 seconds of the start of the interaction. *Forecasting*, or a staged delivery of news occurred within the first 2 minutes. Finally, *stalling*, which delayed bad news delivery for more than 2 minutes often resulted in failure of the doctor to explicitly convey the news.[40] Another study evaluated 30 Swedish cancer patients who were being given the news that curative treatment was no longer possible. The physicians, all of whom were experts in the field, were categorized as: the *inexperienced messenger*, the *emotionally burdened,* the *rough and ready, the benevolent but tactless,* the *distanced doctor,* and the *empathetic physician.[41]* The empathetic physician is the model that we should be striving for.

In addition to desiring full disclosure, patients also want their physicians to be honest, empathetic, encouraging, hopeful and supportive.[4,39,42] It is often a very fine line that physicians need to tread. Softening the impact of bad news too much may create overly optimistic expectations. Additionally, censuring information to patients, even with good intentions, undermines the doctor- patient relationship and directly violates patients' rights to autonomy. [39,43] While euphemisms are

often used to soften the blow[4] patients want their doctors to convey the information in simple, compassionate, and unambiguous terms.[42,44] Failure to accomplish this has been found to lead to patients with advanced malignancy remaining unaware of their diagnosis and prognosis.[38,40,42,45,46,47,48] Despite the good intentions of a physician who is trying to protect the emotions of the patient by sugar coating the delivery of bad news, there may be a significant negative impact, that may ultimately lead to large costs of medical care during the end of life.[49]

Teaching medical personnel how to DBN is an extremely important component of healthcare education. A survey of American Society of Clinical Oncology (ASCO) attendees in 1998 indicated that only 6% had any formal training in DBN, 9% had formal training in responding to patients' emotions and less than 15% felt very good about their ability to break bad news.[50] Since that time, most medical school curricula have adopted generic programs in teaching medical students difficult communication skills. Yet at the post- graduate level, institutional constraints, and in particular, a lack of time to learn difficult communication skills remain problematic.[11,13] As a result, most of the communication skills training is from direct observation, or "on the job training." This is often subject to trial and error.

There is a glimmer of hope, however. A recent survey of oncology fellowship program directors reported that 63% of their fellows are currently receiving at least some training in DBNs, yet 76% believed that improvements in this area were still necessary. [12] The need transcends medical specialties. One survey of pediatricians revealed that 75% of pediatric residents, 60% of fellows and 40% of faculty graded their knowledge as less than sufficient for DBNs.[13]

General guidelines have been developed over how physicians should approach delivering bad news.[4,13,39,48,49,50] The actual framework is built upon three basic steps, which in many ways is similar to the other communication skills within this chapter. These steps include: 1) **assessing the patient's understanding about their disease as well as the emotional and physical perceptions** that they have, 2) **delivering the bad news honestly and empathetically**, and 3) **providing knowledge and emotional support** to the patient moving forward.

### 3.2.2 SPIKES Protocol for DBN

(See Reference **48**)

**Table 2** summarizes the SPIKES protocol for DBN.[48] This is one of the most widely used techniques which breaks down the principles delineated above into six specific steps.

**1. Setting up the Interview.** There are very important points that must be conveyed to the patient during the meeting. Mentally preparing for this is essential, and a list should be generated of the salient points that must be conveyed during the discussion. Distractions such as busy clinics, pagers, cell phones, and communications from ancillary staff may disrupt the flow of the discussion. Always arrange for some degree of privacy and have tissues and/or some water available.

**2. Assessing the patient's perception.** At the very outset, the physician should assess the patient's current understanding and emotional state related to the medical issue at hand. For instance, in the case of a newly diagnosed prostate cancer patient, many patients may have misconceptions, which reflect their educational and socioeconomic background, as well as their personal life experiences. Probe the patient at the beginning to determine what they know about prostate cancer, its natural history, treatments, and the potential impact on quality of life. Don't forget to use open-ended questions such as, "So what is your understanding about why we did the biopsy?" Pay attention to the verbiage that they use, misconceptions that they have, and how their illness may impact other aspects of their life such as their marital partner, employment, and family obligations.

**3. Obtaining the patient's invitation to disclose the bad news.** While the majority of patients express a desire for full disclosure regarding a diagnosis, prognosis, details of their illness and the treatment options available for it, many cannot process all of this information at one visit. With respect to prostate cancer, most patients will want to hear the results of their biopsy up front. A warning statement such as "I have some bad news to tell you" can usually reduce the impact of the bad news and may allow the patient to focus better on the discussion that ensues. After a pause, the physician can then say, "I am sorry to tell you that the biopsies did show that there was cancer in the prostate" is a reasonable starting point. At that the point, the patient will usually pause; it is a good idea to let them reflect for a moment and during that time

you should prepare for the next part of the conversation, which is to help the patient better understand the disease and treatments.

**4. Providing knowledge and information to the patient.** Continuing the clinical scenario in which a patient is being told he has prostate cancer, it is often useful to start this discussion with an impartial statement regarding the high incidence and low mortality associated with this disease. In reality, most contemporary patients die with their prostate cancer rather than from it. This can immediately set the tone for the discussion and avoids a situation where the patient has been overwhelmed with anxiety, and can no longer process anything that is being stated. During the course of the discussion, many patients become agitated, depressed, or overwhelmed, and can no longer process information that they are receiving. It is important to recognize when this occurs and perhaps ask them if they would like to take a break or reconvene at another time once they can gather their thoughts and questions. During this initial information portion of the meeting, it is important to remember to avoid the use of medical jargon, which may be very confusing to an already anxious patient. During the discussion, speak slowly, stop often to ask the patient if they understand what you are saying, and encourage questions.

**5. Addressing the patient's emotions with empathetic responses**. Responding to the patient's emotional reaction is one of the most difficult challenges of breaking bad news. These may vary from silence to disbelief, sadness, crying, denial, or anger. It is helpful to recognize the emotional reaction that the patient is experiencing. Several empathetic statements that can be used in order to name the emotion and validate it: 1) I see how upsetting this is to you; 2) I can tell you weren't expecting to hear this; 3) I know that this is not good news for you; 4) I am sorry that I have to tell you this, but…; 5) I was also hoping for a better result; 6) This is difficult for me too.

**6. Strategy and summary.** The final step in the delivery of bad news is to summarize and provide the patient with a clear message on what will be the next steps. It is important that the patient share responsibility for decision-making, as we will discuss in the next section. Often the decision for treatment will need to be made at a later date, after the patient has processed the information from the meeting. It is important to assess and if needed, adjust the patient's expectations as well as their understanding of the condition, treatment and outcomes. Finally, it is important to propose and develop a treatment strategy or a follow up appointment during which treatment can once again be discussed that is mutually agreeable and reasonable.

## Table 2: SPIKES protocol for delivering bad news.

| Steps | Steps | Technique |
|---|---|---|
| **S:** Setting up the interview | Review the medical record, understand the current issues and how they evolved.<br><br>Mentally rehearse. | • Arrange for privacy<br>• Be seated during the discussion<br>• Maintain eye contact<br>• Use non-verbal cues to convey empathy<br>• Manage time constraints or distractions |
| **P**: Assessing the patient's perception of the problem | Use open ended questions to develop an understanding of the patients or their relatives perception of the medical condition | Using questions such as:<br><br>What is your current understanding of your medical condition?<br><br>Let the patient speak uninterrupted.<br><br>Correct any misunderstandings after the patient or their representative has completed their statement.<br><br>Use language that is appropriate based upon the patient/relatives responses.<br><br>Develop an understanding of how much information the patient can digest at one sitting |
| **I:** Obtaining the patient's Invitation | Finding out how much information that the patient can and wants to understand.<br><br>Give a warning shot. | Ask the patient how much information and to what extent the detail of the information should be presented.<br><br>Give the patient a "warning shot" in which they can be prepared for bad news that you will be giving them: i.e. "I am sorry that I have some bad news that I would like to discuss about your biopsy results." |
| **K:** Providing Knowledge and Information | Giving the medical facts: "the one way part of the physician dialogue." | Tailor the conversation to the patient's educational level.<br><br>Avoid technical jargon (i.e. use "spread" instead of "metastasized").<br><br>Avoid excess bluntness, but do not withhold information.<br><br>Give information in small chunks and constantly reassess patient's understanding<br><br>When prognosis is poor, make sure that the patient is aware that there are things that can be accomplished, such as adequate pain control and symptom relief. |

| | | |
|---|---|---|
| **E:** Addressing the patient's emotions with empathy | Provide support and solidarity with an empathetic response | Steps to demonstrating an empathetic response: <br><br> 1. Observe for the patient's emotional response <br> 2. Identify the emotion experienced by the patient by naming it. If not sure, ask the patient what they are feeling. <br> 3. Identify the reason for the specific emotion (i.e. sadness from bad news, but may be other issues such as how their partner may survive without them) <br> 4. Let the patient know that you understand their emotion, react to it (i.e. move closer to the patient, pause, provide a tissue, etc) <br> 5. Allow the emotions to clear by providing empathetic responses |
| **S:** Strategy and Summary | Discussing the prognosis and treatment options | Use your understanding of the patient's perceptions, and develop an individualized, shared decision making plan. <br><br> If the prognosis is poor, indicate this, but in a respectful and realistic manner. <br><br> Frame the prognosis and plans so that the patient has a realistic understanding of what to expect. |
| View Image. | | |

## 3.3 Communication Skill #3: Informed Consent

Providing a patient with informed consent has evolved into one of the most important communication processes implemented by physicians today. The underlying goal is to empower patients to make a willful and knowledgeable decision about whether or not to authorize a specified medical treatment. In order for this to occur, the patient needs to understand the proposed intervention, as well as its indications, attendant risks, benefits, and possible alternatives.

### 3.3.1 Central Tenets to the Informed Consent

Three specific criteria are inherent to the informed consent process include: disclosure, capacity, and voluntariness.[51,52,53] Disclosure requires that the patient is apprised of critical information that pertains to the specific therapeutic option(s) being proposed. Capacity refers to the patient's ability to comprehend the information provided, and voluntariness refers to the subject's right to freely exercise decision-making without being subjected to coercion, manipulation, or undue influence. [52]

While these tenets would seem intuitive, they pose several challenges for the clinician. On a fundamental level, patient capacity directly ties into deficiencies in health literacy, which may be accentuated by cultural, socioeconomic, gender, and racial disparities. [54,55] In one study evaluating inner city patients of whom 80% had completed a high school education, the actual literacy was on par with a 9th grade level and fewer than 30% could calculate a fraction or a percentage. [56] Moreover, only 15%, 29%, and 32% understood the words "incontinence," "urinary function," and "bowel function," respectively.

A contemporary review of studies evaluating patient comprehension during informed consent for surgery showed that the overwhelming majority of patients do not comprehend much of the information presented to them, or the specific risks associated with the intervention being recommended. [57] This applies to cancer screenings, in which few patients actually recall discussing risks associated with a particular screening test.[58,59,60] Consider the implications of this in trying to carry on a discussion about the risks and benefits associated with PSA- screening and then expecting a patient to be able to process this information in determining whether it is right for them. It is no wonder that despite US Preventative Task Force recommendations discouraging PSA screening in men 75 years and older, more than 75% of men in this age group cannot recall discussing the potential risks of testing with their physicians. [59,60]

While capacity is one barrier to the informed consent process, determining the extent of disclosure that will allow the patient to develop autonomy poses additional challenges. Knowledge is an essential element for informed decision-making, but there must be balance in the amount of information presented. On the one hand, it is impractical and often detrimental to administer a laundry list of every potential risk associated with a particular intervention. Patients recall less than 20% of the verbal information given to them[61,62,63] Even when written in an informed consent document, less than 30% of patients will actually read it through before signing it.[62,63,64] Informed consent processes in which patients are encouraged to read back the information presented or receive intensive educational training by physician extenders may enhance patient retention and understanding.[64,65,66]

While too much information may prove to be overwhelming and anxiety-provoking, deficiencies in informed consent are often what patients complain about, particularly when an adverse outcome occurs. In a retrospective study of 204 informed consents for radical prostatectomy obtained by house-staff, 50% were deficient in documenting one or more basic risks, benefits and alternatives to the proposed procedure.[64] In another study, deficiencies in the informed consent process factored into 32% of malpractice claims related to penile implant surgery[67]

Table 3 provides a template for how to proceed with a traditional informed consent.[68] The essential goals are to provide the patient with a sensible quantity of information with a degree of specificity that is tailored to the individual preferences and needs of the patient.[52,68,69] For all intents and purposes, the patient should have reasonable expectations regarding at the least, the most common and the most dangerous risks associated with a particular intervention. This should be delivered with an honest and reasonable assessment of the risk that one of these adverse events will actually occur. From a legal standpoint, many institutional regulations rely on the overarching concepts of what a "reasonable physician" should provide and what a "reasonable patient" would need, leaving a wide range for individual and institutional

interpretation. [52] Given the vast amount of differences between individual patients with regard to their capacity, as well as other co-morbid conditions, this "one size-fits all" approach is flawed from several vantage points.[52]

## Table 3: Essential elements of an informed consent

| Steps | Qualifier | The following should be included |
|---|---|---|
| 1. Defining the nature of the specific intervention | Using language that the patient can understand, the physician should provide the basic facts regarding the disease and how the proposed treatment will attempt to halt or reverse the disease process. | • Describe the malady and broadly discuss what we know about its etiology<br>• Give the specific name of the treatment being recommended and provide a description of its general approach.<br>• For a specific medical therapy provide a basic understanding of the pharmacokinetic principles underlying the therapy. For procedural interventions, use diagrams to indicate how the proposed intervention will provide therapy for the illness. |
| 2a. Provide a list of risks related to not performing the intervention | What happens if the intervention is not performed. | • Should provide reasonable expectations for the immediate and long term disease course if the treatment is declined or accepted. When applicable, the physician should make every effort to discuss how long the untreated and treated disease course, as well as life expectancy will be.<br>• Should include a discussion about health-related quality of life. Specifically, the physician should provide reasonable expectations so that the patient can prepare the appropriate support network, including family, friends, and a team of healthcare organizations (i.e. hospice, rehabilitation services and visiting nurse services). |
| 2b. Provide a list of potential benefits of the intervention | What happens if the intervention is performed. | • Should provide reasonable expectations for the immediate and long term disease course if the treatment is declined or accepted. When applicable, the physician should make every effort to discuss how long the untreated and treated disease course, as well as life expectancy will be.<br>• Should include a discussion about health-related quality of life. Specifically, the physician should provide reasonable expectations so that the patient can prepare the appropriate support network, including family, friends, and a team of healthcare |

| | | organizations (i.e. hospice, rehabilitation services and visiting nurse services). |
|---|---|---|
| 3. Provide a list of reasonable alternatives to the intervention | If alternative therapeutic options are available, discuss each of these, as well as their potential risks and benefits. | • Should provide reasonable expectations for the immediate and long term disease course if the alternative treatment is selected. Should discuss the disease course and life expectancy, based upon what is known about alternative options.<br>• Should include a discussion about health-related quality of life based upon the available evidence about the alternative treatment |
| 4. Feedback | Does the patient have an understanding of the treatment and alternatives, and the attendant risks and benefits. | • Start by asking the patient to describe the procedure and what it hopes to accomplish.<br>• Ask the patient if they understand that there are other options, and each of these has their own risks and benefits.<br>• Ask the patient if they believe that they have enough information to make an informed choice and decision. |
| 5. Documentation of the encounter | Discussion and specific procedural risks that were discussed | • Can include a list of the various treatment options and the details of the discussion.<br>• From a medical documentation standpoint, it helps to list some specific details that were covered (i.e. during our discussion about the treatment options for prostate cancer, the patient indicated a preference to having HIFU, despite the fact that I indicated that there has not been a large amount of peer reviewed randomized clinical trials comparing outcome data with that of surgery or radiation therapy). |
| 6. Patient and physician sign informed consent | The patient and physician confirm that a comprehensive and understandable discussion took place and the patient has made a willful and knowledgeable choice. | Ideally should be witnessed by a third party, in order to confirm that the physician is carrying out the patients will.<br><br>Should be signed within a specified time frame. Some institutions set their own time frame, but in general, the discussion and the consent should be performed within 30 days of implementation of the specified treatment. |
| View Image. | | |

### 3.3.2 Shared Decision Making (SDM)

With the contemporary shift towards patient-centered care, medicine has moved away from the traditional paternalistic view of medical decision-making. The underlying goal is for the patient to achieve relational autonomy and self-determination.[70,71] Shared Decision Making (SDM), as its name implies, is a collaborative process which allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences.[71] What distinguishes SDM from the traditional concept of an informed consent is that it is a bidirectional process. At its core is the recognition that most medical decisions have diagnostic and therapeutic options, in which there are choices that can be made. It establishes that there is a partnership between patients and physicians, who have different levels of knowledge and expertise to these healthcare options. Clinicians are knowledgeable about disease states, diagnostics and treatment options. Patients harbor knowledge about their own body, their circumstances, and their goals for life and healthcare. [72] Under SDM, the provider and the patients relate to and influence each other as they collaborate in making the healthcare decision, which is patient-specific, and relies on the best medical evidence.

Not all medical decisions are suited for the SDM process. In situations in which an intervention is based upon clear, evidence-based standards or guidelines, the process of informed decision making is a more accurate depiction of the process. More often than not, medical decisions are not based upon these stringent criteria, and are considered *preference-sensitive*. Preference-sensitive decisions are made when there is uncertainty regarding a particular intervention.[73] This uncertainty occurs when there are questions regarding the scientific rationale of an intervention, conflicting medical evidence surrounding an intervention, or difficulty in applying the population probabilities from a study to the particular individual's situation.

Decision aids are often used to assist patients in obtaining an awareness and knowledge of the critical information that they need to deliberate with health care providers about their options. They provide information about the various options and help patients to construct, clarify, and communicate the personal values that they associate with different features of the options.[74,75,76] Decision aids may include printed material, web-based material, videos, and a variety of other informational resources spanning the gamut of communication media. Current quality standards for patient decision aids require that they present the information and options in a balanced manner that provides structured guidance in the steps of decision making. [77]

The concept of decision aids is supported by evidence from 86 randomized trials showing that they are associated with increased knowledge, more accurate risk perceptions, a greater number of decisions consistent with patients' values, a reduced level of internal decisional conflict for patients, and fewer patients remaining passive or undecided. [78] Recently, there has been growing evidence supporting that patients who receive unbiased information about their treatment options choose more conservative therapies over surgery for several disorders.[78,79] Other studies have found that when decision aids are used, patients are also less likely to undergo indiscriminant PSA screening. [80] As this data matures, there is now preliminary evidence that enhancing the support tools accessible to patients may translate into a reduction in health care costs.[79]

### 3.3.3 Implementing SDM

There remain several barriers to the widespread adoption of SDM strategies. Time constraints, perceptions that SDM cannot be applied because of patients' characteristics, and the nature of the clinical situations are the most common reasons for not using SDM.[73,81] Other barriers include a lack of formal healthcare training in SDM, healthcare disparities, cost, and lack of physician enthusiasm with the process.[81]

Another problem with SDM is that while physicians are often in agreement with its underlying principles, the methodology in enacting SDM remains poorly defined. Eldwyn et al.[70] describe a multi-step process in which options are offered using the following three techniques: 1) **Choice talk**: making the patient aware that reasonable options exist, 2) **Option talk**: providing more detailed information about options, and 3) **Decision talk**: considering preferences and deciding what is best.

Another six-step technique is outlined in **Table 4**,[76] and has undergone preliminary evaluations using a case-based model which teaches SDM skills to primary care physicians. The case involved a 60 year old male patient who presented for an annual physical exam in which a shared decision making process was implemented to discuss whether he should undergo PSA screening for prostate cancer. The case was rated favorably by the clinicians as a teaching tool for SDM, and approximately 2/3 of study participants indicated that they became more confident in understanding how to implement SDM as a result.

## Table 4: Shared Decision Making

| Steps | Qualifier | The following should be included |
|---|---|---|
| 1. Invite the patient to participate | • Describe the health issue or decision<br>• Communicate uncertainty<br>• Emphasize the need for a decision | There's a decision to make about your treatment (or testing) and I'd like to make it with you. Knowing what's important to you will help us make a better decision.<br><br>*OR*<br><br>Sometimes things in medicine aren't as clear as most people think. Let's work together so that we can come up with a decision that is right for you. |
| 2. Present options | • Discuss the options<br>• Provide a balanced explanation of the pros and cons of each option<br>• Provide probabilities using accepted principles of risk communication<br>• Assess the patient's comprehension | Before making an informed decision, patients need to know that there are options available to them:<br><br><u>When not using a decision aid:</u><br>Here are some choices that we can consider.<br>*OR*<br>Here are your options.<br><br><u>When using a decision aid:</u><br>Did you have a chance to read or watch the material about your options? Which of the treatments or tests would you like to discuss?<br>*OR*<br>Let's take a few minutes to review the options that you have. |
| 3. Provide information on benefits and risks | • Discuss the patient's views of the options<br>• Explore the patient's values | Provide balanced information on benefits and risks. Use numbers rather than words when you can. Without them, patients tend to overestimate the benefits and underestimate the risks and have less realistic expectations?<br><br>It is also important to check in with the patients to ensure that they correctly understand the benefits and harms. |

| | | |
|---|---|---|
| 4. Assist patients in evaluating options based upon their goals/concerns | • Assess the patient's preferred role in making the decision | Patients may not be comfortable raising their personal goals and concerns. By actively inquiring, you are giving them permission to speak about what is important to them. Once you have elicited this information, you can assist them in evaluating their options base d upon their preferences.<br><br>Simple language:<br>Just as people are different no one decision is right for everyone. As you think about your options, what's important to you?<br>OR<br>People have different goals and concerns. As you think about your options what's important to you? |
| 5. Facilitate deliberation and decision making | • Assess the patient's readiness to make a decision<br>• Elicit the patient's initial preferences for the options<br>• If the patient prefers, provide a recommendation about which option(s) seems the best for the patient<br>• Negotiate with the patient a mutually agreed upon course of action | Patients may not be ready to make a decision immediately. Probing for what else they need to know or do prior to making the decision can be helpful. If they are ready to decide, you can help facilitate a final decision.<br><br>Considering what we've discussed do you have a preference about the direction that we can take?<br><br>You have time to think things over.<br><br>Is there any more information that you need?<br><br>What the hardest part about deciding?<br><br>From what I hear you saying here is what I suggest….How does that sound to you? |
| 6. Assist with the implementation | • Help undecided patients access additional support and other resources to make the decision<br>• Make a plan to review the decision or deferment<br>• Document in the medical record that a discussion about the problem occurred, whether a patient decision aid was used and what decision was made | Close the conversation by laying out the next steps for the patient.<br><br>Let's take a moment to talk about the next steps |

View Image.

### 3.4 Communication Skill #4: Disclosure of medical errors

#### 3.4.1 Incidence of medical errors

It has been 15 years since the Institute of Medicine released its historical report, "To Err is Human," which estimated that medical errors account for between 44,000 and 98,000 deaths each year in United States hospitals.[82] The report elucidated a number of preventable, adverse events, which result in harm to more than 1.5 million patients annually. These include: adverse drug events, improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries, falls, burns, pressure ulcers, and mistaken patient identities. A disproportionate share of adverse events occurring in hospitals occur in operating rooms, [83,84] with some surgical specialties having higher rates of adverse events than others. [85]

Medical errors are not limited to the hospital setting. In fact, most medical care is delivered through private physician offices, outpatient clinics, ambulatory care centers, and other outpatient care facilities. Studies have shown that 25-40% of these patients may be impacted by a medical error, [86] many of which are either not recognized or remain undisclosed.[87,88]

#### 3.4.2 Purposes of Error Disclosure

When a medical error occurs, physicians have ethical and professional obligations to inform the patient.[89] Disclosure is a critical communication skill, which serves four purposes:[90,91,92]

1. **Patient autonomy**. By understanding what adverse event transpired and the efforts that were taken to avoid and mitigate its effects, patients are empowered to make more informed decisions about their future care.
2. **Accountability**. By recognizing and disclosing a medical error to the patient, the institution and its providers demonstrate accountability for both the error and the environment which fostered the error to occur.
3. **Quality and safety improvements**. An essential component of medical error disclosure is the development of plans and processes to prevent future medical errors from occurring.
4. **Trust**. Disclosure fosters a medical culture that promotes greater patient trust through transparency.

#### 3.4.3 The Disclosure Gap

Research has shown that patients desire absolute transparency when harmful medical errors occur. They desire an explanation of why the error occurred, how it impacts their care, how the problem will be corrected, and how future errors can be prevented.[93] Following a medical error, patients may experience feelings of anger, mistrust, and resignation.[94] Disclosing the medical error in a manner in which these feelings are addressed may be just as important as the actual facts surrounding the medical error. [93,94,95,96,97,98] Patients want providers who demonstrate honesty, compassion, and remorse for the error that occurred.[93,94,96,97,98] Moreover, many patients wish to hear an actual apology from their healthcare provider.[93,99]

While physicians agree in principle with the need for transparency regarding medical error disclosure,[93,,100,101,102,103,104] in practice, they have traditionally struggled with this communication skill. Barriers to disclosure include fear of subsequent medical litigation[105] and fear of public and personal humiliation associated with the admission of a medical error.[106] This fear of public and professional criticism is extremely powerful, and seems to be engrained in the culture of modern medicine. In fact, studies have shown that even at the beginning of their careers, medical trainees withhold data regarding medical errors due to fears of being treated harshly (with verbal or other forms of public humiliation) and feel that these mishaps may place their future careers in jeopardy. [101] The final barrier to disclosure of medical errors is that many clinicians simply lack familiarity with the communication skills necessary to disclose a medical error.[93,100,101,102,105]

Recent studies have begun to bring clarity to several of these issues. With respect to medical litigation, the general opinion is that disclosure can actually strengthen the trust between patients and physicians. In order to facilitate this process, the majority of states have now passed legislation limiting the liability directly related to an apology following medical errors. [107,108,109] National organizations such as the National Quality Forum and the Joint Commission have developed guidelines supporting and facilitating disclosure of medical errors. Finally, the Department of Health and

Human Services has released the Patient Safety and Quality Improvement Act, establishing additional confidentiality protections for patient safety information reported by providers.

Several widely referenced programs have demonstrated that disclosure policies may actually reduce the burden of malpractice litigation. The first is the Lexington VA Medical center in which a transparent error disclosure policy compared favorably with 35 other VA Medical Centers in terms of the complexity-adjusted workload and malpractice payments made from 1990-1996.[110] The second is the University of Michigan Health System,[111] which implemented a disclosure-with-offer, comprehensive claims management model in 2001. The model emphasized transparent communications with patients and their families, and offered a rapid internal investigation of the alleged error. When the investigation revealed a medical error, compensation was immediately offered. If the adverse outcome was not believed to be a result of medical error, they disclosed the results of the investigation and would vigorously defend the claim, if needed. The disclosure policy resulted in a 35% reduction in the number of monthly claims, a 65% reduction in the number of lawsuits, as well as significant reduction in the median time from claim reporting to resolution. This reduced the monthly liability costs, patent compensation, and non-compensated legal costs.

Studies have found that many patients associate a physician's propensity to disclose a medical error with good quality of care. In a random sample of patients incurring a medical error in Massachusetts' hospitals over a 7 month period, Lopez and colleagues [112] found that when there was disclosure of the adverse event patients consistently gave higher rankings for the quality of the care received. In another representative sample of inpatients discharged from Illinois hospitals, 41% admitted to incurring a medical error at some time during their hospitalization. It was the group of patients who were confident that their providers would disclose an error that were less likely to sue, and substantially more likely to recommend their provider and the hospital.[113]

Many countries have established standards of practice or legislation that mandates disclosure. In Canada, the Canadian Patient Safety Institute has developed guidelines for disclosure that include a statement of the facts, information about the ongoing care, and expression of sympathy or regret, an overview of the investigative process that will occur, an offer of future meetings, offers of support, and a follow up plan. In the United States much of the jurisdiction for disclosure falls under state and local levels, with oversight by the Agency for Healthcare Research and Quality.

### 3.4.4 Disclosing a Medical Error

Table 5 provides an outline of the steps that should be untaken in disclosing a medical error, based upon the recommendations of the National Quality Forum.[114]

### 3.4.5 Preliminary to the Conversation

**Setting the scene.** It is important to schedule a disclosure meeting at a time in which all stakeholders can be present. Timeliness is essential; the NQF suggests that the initial conversation with the patient and or family should occur within 24 hours of the error, with additional follow up discussions occurring to provide information as it becomes available. The setting for the meeting should provide for some sense of privacy, which will foster an undistracted and an interactive discussion.

**Preparing for the meeting.** Prior to the meeting, the physician should develop an accurate understanding of the error, why it occurred, and its impact on the patient and the patient's family. Discussing the circumstances surrounding the error with hospital administration and with institutional representatives from risk management is an essential component to this. They will assist the physician in determining whether legal counsel is needed, and also will help determine which, if any institutional representatives should be present during the disclosure meeting. The physician may use this pre-meeting period to clarify any medical circumstances that are outside of their realm of expertise. Talking with colleagues from the center and from other institutions may provide some additional clarification.

**Practice the delivery of information.** A clear and transparent message needs to be conveyed to the patient and their family. As with any other technical and communication skills, there is no substitute for practice and experience. This may require that the physician practice communicating the message, either alone or with the hospital risk manager.

**Basic communication skills.** The rules that apply to disclosing medical errors are no different than those that surround other physician–patient communication: 1) there should be direct eye contact between the physician and others in the room, 2) the physician should not appear rushed, and should allocate enough time for the activity, 3) the caregiver should act in a courteous, respectful, and empathetic fashion, and 4) The physician should periodically pause, and assess whether the patient and others in the room are able to understand the discussion.

**Table 5: Essential components of a medical disclosure**

| Steps | Qualifier | Should include |
|-------|-----------|----------------|
| 1. Facts | Explicit statement about what happened. | • Explain what and why the event occurred<br>• Implications on the patients future health<br>• Discuss measures taken for preventability<br>• Delivery style should demonstrate empathy |
| 2. Regret | Regret that the outcome was not as expected. | • Explicit and empathetic expression<br>• "I am sorry that this has happened" |
| 3. Apology | From the patient's licensed independent practitioner (LIP) or administrative leader. | Should be offered if the investigation reveals that the adverse outcome was caused by unambiguous errors or system failures |
| 4. Commitment | To investigate and as possible, prevent future occurrences. | Reassurance to deliver the facts to the organization's safety leaders, including those in governance positions |
| 5. Feedback | Was the unanticipated event an error or systems failure. | • Provide the current status of the investigation into the error/unanticipated event.<br>• Provide sufficient detail to support informed decision making by the patient. |

See Reference **114**

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## 3.4.6 The Conversation

**Facts**. The first step in the conversation involves a simple statement of the actual medical error that occurred, and will set the tone for the remainder of the discussion. The caregiver should limit the use of medical terminology, and use language that the patient and others present can understand. The actual error and why the error occurred are two crucial components of the statement of the medical facts. How the error impacted the patient's health and how it will be corrected are additional issues that need to be addressed.

The verbal and nonverbal cues that the physician displays should be thoughtful, respectful, professional, and empathetic. The physician needs to understand that the patient and their family are listening to the actual facts, and are deciding on whether he or she is being honest, forthright and transparent. The statement must be direct, and should not require a litany of probing questions to get the further details of the error, and why it occurred. [101] The physician should not be perceived as withholding details of the error, and should not evade questions that the patient or his family may have.

**Regret.** The second element of the physician's disclosure statement includes a direct statement of regret. An explicit statement such as "I am sorry that this has happened" goes a long way in making the patient and their family believe that you are human, and that you can identify and empathize with their misfortune. It also demonstrates that above all, you remain an advocate for rectifying the situation. The caregiver must appear sincere, and allow the patient or family members to express their emotions regarding the error. These are often negative, [102] and at times can escalate into angry accusations. The physician must be able to listen, not become confrontational, and must exude the sense that they are advocating for the patients' health and welfare. When dealing with an irate patient or family, it is helpful to reassure the patient that you are on their team, and constantly remind them that you will do your very best in helping them achieve resolution to the problem.

In cases in which an adverse outcome clearly was caused by unambiguous errors or systems failures, the National Quality Forum recommends that an apology be given from the patient's licensed independent practitioner and or an administrative leader. An apology serves as a sign of admission of responsibility, a desire to reverse what has happened, and seems to confer a sense of honesty and integrity. In a survey of viewers who were randomized to watch a series of video disclosures of adverse events, Wu et al. [100] found that not only did a physician need to accept responsibility for an event, but also needed to apologize in order for patients to maintain a positive image of the physician.

**Commitment.** In cases in which the error occurred as a result of a system failure or there are unclear reasons why it occurred, the physician needs to demonstrate that they are committed to determining the cause and preventing it from occurring again. This third element of the disclosure statement should include a detailed plan for any investigation that will take place. If the caregiver is partly or entirely at fault for the error, they should also indicate what they would have done differently if they could have the opportunity.

**Feedback.** The physician needs provide reassurance to the patient that they will continue to communicate with them as new information becomes available from the investigation. They need to portray themselves as advocates for the truth and for prevention of future errors. Reassurances should be provided that the patient and their family will be notified about the results of any investigation into the causes for the medical error. Specifically, the caregiver needs to provide feedback as to whether or not the adverse event resulted from an error or a systems failure. This feedback can be given as the results of various aspects of the investigation are completed, or can be delivered at a single time point in the future. The patient and the family should decide about how they would like to receive this notification, and whether a follow up meeting should be arranged.

**Additional efforts.** Beyond the direct communications with the patient and their family, the National Quality Forum recommends the establishment of a disclosure and improvement support system to provide emotional support for caregivers and administrators in the period, following an adverse event. They recommend the establishment of advisory support teams that are available 24 hours a day to caregivers and staff to facilitate rapid responses to serious unanticipated outcomes. Finally, they prioritize the education of caregivers in the importance and techniques of disclosure and recommend a focus on systems improvement rather than blame, with a special emphasis on creating a just

culture. [115,116,117]

# 4. Conclusion

There is growing recognition that effective communication skills translate into higher patient satisfaction and better quality of medical care. While communication skills are designated as core competencies by the ACGME, there is little guidance provided in the manner in which they are taught or learned during residency training. We hope that this lesson provides a start.

The Urologist needs to have at their disposal a toolbox of communication skills which may be utilized at any time, in order to deliver the best quality, patient- centered care. In this lesson we considered four communication skill sets which include; initiating a partnership with the patient from the first visit, delivering bad news, providing an informed consent, and disclosing a medical error. While the comments and the recommendations that were provided in each section provide a basic framework for accomplishing each of these tasks, we believe that there is no substitute for practice and repetition in learning difficult communication skills. We would encourage you to use the information that you have taken from this lesson and attempt to institute some of our suggestions as you communicate with patients in the future.

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