มหาวิทยาลัยมหิดล
คณะแพทยศาสตร์
ศิริราชพยาบาล

ศูนย์ความเป็นเลิศด้านการศึกษาวิทยาศาสตร์สุขภาพ
คณะแพทยศาสตร์ศิริราชพยาบาล มหาวิทยาลัยมหิดล

Teaching doctor-patient communication

การสื่อสารที่ดี มีวิธีอย่างไร
และสอนแพทย์อย่างไร ให้สื่อสารกับผู้ป่วยแล้วเกิดผลดีที่สุด

เอกสารประกอบการอบรม

ระหว่างวันที่ พ. 17 - ศ. 19 ตุลาคม 2561
ณ ห้องประชุมสิรินธร อาคารเฉลิมพระเกียรติ ชั้น G
คณะแพทยศาสตร์ศิริราชพยาบาล

SHEE
Siriraj Health science Education Excellence center

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กำหนดการ

โครงการอบรมเชิงปฏิบัติ เรื่อง “Teaching doctor-patient communication”

ระหว่างวันที่ 17 – 19 **ตุลาคม พ.ศ.** 2561

ณ ห้องประชุมสิรินธร อาคารเฉลิมพระเกียรติ ชั้น G **คณะแพทยศาสตร์ศิริราชพยาบาล**

Part I : Essential doctor-patient communication skills

วันพุธที่ 17 ตุลาคม พ.ศ. 2561		**วิทยากรหลัก**	**วิทยากรร่วม**
08.00 - 08.30 น.	ลงทะเบียนภาคเช้า		
08.30 – 10.00 น.	Principles of communication	อ. นพ. ชนินทร์ ลิ่มวงศ์	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์
10.00 – 10.15 น.	*พักรับประทานอาหารว่าง*		
10.15 - 12.00 น.	Active listening	ผศ. พญ.ธัชวรรณ จิระติวานนท์	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์ รศ. นพ.สุพจน์ พงศ์ประสบชัย
12.00 – 13.00 น.	*พักรับประทานอาหารกลางวัน*		
13.00 - 14.30 น.	Informative counseling	รศ.ดร. นพ. สืบวงศ์ จุฑาภิสิทธิ์	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์ อ. นพ.ศิรส จิตประไพ
14.30 - 14.45 น.	*พักรับประทานอาหารว่าง*		
14.45 - 16.00 น.	Breaking bad news	รศ. นพ.สุพจน์ พงศ์ประสบชัย	อ. นพ.ศิรส จิตประไพ
วันพฤหัสบดีที่ 18 ตุลาคม พ.ศ. 2561			
08.00 - 08.30 น.	ลงทะเบียนภาคเช้า		
08.30 - 10.30 น.	Disclosure of medical errors negligence, and complications	ผศ. นพ.ตรีภพ เลิศบรรณพงษ์ ผศ. พญ.ธัชวรรณ จิระติวานนท์	ศ. แสวง บุญเฉลิมวิภาส รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์ อ. นพ.ศิรส จิตประไพ ผศ. พญ.สหัสา หมั่นดี
10.30 - 10.45 น.	*พักรับประทานอาหารว่าง*		
10.45 - 12.00 น.	Advanced care planning	รศ. นพ.รุ่งนิรันดร์ ประดิษฐสุวรรณ รศ. นพ.สุพจน์ พงศ์ประสบชัย	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์ ผศ. พญ.ธัชวรรณ จิระติวานนท์
12.00 – 13.00 น.	*พักรับประทานอาหารกลางวัน*		
13.00 - 14.30 น.	End-of-life discussion	รศ. นพ.สุพจน์ พงศ์ประสบชัย ผศ. พญ.บุณฑริกา สุวรรณวิบูลย์	อ. นพ.ศิรส จิตประไพ
14.30 - 14.45 น.	*พักรับประทานอาหารว่าง*		
14.45 - 16.00 น.	communication with relatives with bereavement	อ. นพ. ปเนต ผู้กฤตยาคามี	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์ รศ. นพ.สุพจน์ พงศ์ประสบชัย
16.00 –16.30 น.	Summary	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์	

Part II: How to teach communication skills

วันศุกร์ที่ 19 ตุลาคม พ.ศ. 2561		วิทยากรหลัก	วิทยากรร่วม
08.00 - 08.30 น.	ลงทะเบียนภาคเช้า		
08.30 – 09.45 น.	Basic principles of communication skills teaching	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์	ผศ. พญ.กษณา รักษมณี
09.45 – 10.00 น.	*พักรับประทานอาหารว่าง*		
10.00 – 11.00 น.	How to teach communication in everyday practice	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์	รศ. นพ.สุพจน์ พงศ์ประสบชัย ผศ. พญ.ธัชวรรณ จิระติวานนท์ อ. นพ. ปเนต ผู้กฤตยาคามี
11.00 - 12.00 น.	How to assess communication Skills	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์	รศ.ดร. นพ. สืบวงศ์ จุฑาภิสิทธิ์
12.00 – 13.00 น.	*พักรับประทานอาหารกลางวัน*		
13.00 - 14.00 น.	Group activity: Designing a lesson	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์	อ. นพ.ศิรส จิตประไพ
14.00 - 14.45 น.	Presentation of communication lessons I	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์	รศ. นพ.สุพจน์ พงศ์ประสบชัย
14.45 - 15.00 น.	พักรับประทานอาหารว่าง		
15.00 - 15.45 น.	Presentation of communication lessons II	รศ.ดร. นพ. สืบวงศ์ จุฑาภิสิทธิ์	อ. นพ.ศิรส จิตประไพ
15.45 - 16.00 น.	Summary	รศ.ดร. นพ.เชิดศักดิ์ ไอรมณีรัตน์	

หมายเหตุ *กำหนดการอาจมีการเปลี่ยนแปลงตามความเหมาะสม*

รายชื่อผู้ร่วมอบรม

Part I : Essential doctor-patient communication skills 17-18 Oct 2018

กลุ่มที่ 1					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	รศ. นพ.	วิสูตร	ฟองศิริไพบูลย์	คณะแพทยศาสตร์ศิริราชพยาบาล	ภาควิชานิติเวชศาสตร์
2	พญ.	ปฐมา	นาคเจือ	โรงพยาบาลเจริญกรุงประชารักษ์	เวชศาสตร์ฉุกเฉินและนิติเวชวิทยา
3	นพ.	เปศล	โกศัลลกูฏ	คณะแพทยศาสตร์วชิรพยาบาล มหาวิทยาลัยนวมินทราธิราช	ภาควิชานิติเวชศาสตร์
4	นพ.	สรณ	สุทธิวานิช	โรงพยาบาลพหลพลพยุหเสนา	กลุ่มงานอุบัติเหตุฉุกเฉินและนิติเวช
5	อ.ดร.	สุกก์สลิล	บูรณะทรัพย์ขจร	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์
6	อ.	ทัพพ์เทพ	ทิพยเจริญธัม	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์
กลุ่มที่ 2					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	นพ.	กวี	อนันต์นับ	โรงพยาบาลสุรินทร์	กลุ่มงานเวชกรรมฟื้นฟู
2	พญ.	ขวัญศิริ	นราจีนรณ	โรงพยาบาลจุฬาลงกรณ์	ฝ่ายเวชศาสตร์ฉุกเฉิน
3	นางสาว	สุฎาภรณ์	ฆารเจริญ	โรงพยาบาลกรุงเทพหัวหิน	แผนกเวชศาสตร์ฟื้นฟู
4	นพ.	วทัญญู	พาราพิบูลย์	โรงพยาบาลมหาราชนครราชสีมา	งานอายุรกรรม
5	ดร.	อดิณัฐ	อำนวยพรเลิศ	คณะเภสัชศาสตร์ มหาวิทยาลัยพะเยา	บริบาลเภสัชกรรม
6	นางสาว	ขวัญนรา	นราจีนรณ	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์
กลุ่มที่ 3					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	พญ.	กนกลักษณ์	ศิริรุ่งวัฒนากุล	โรงพยาบาลสวรรค์ประชารักษ์	แผนกจิตเวช
2	ผศ. พญ.	รัตนาวลัย	นิติยารมย์	คณะแพทยศาสตร์ศิริราชพยาบาล	ภาควิชากุมารเวชศาสตร์
3	นพ.	อุดมโชค	อินทรโชติ	โรงพยาบาลชัยภูมิ	กลุ่มงานเวชกรรมสังคม
4	พญ.	ประภาศรี	วงษ์สุวรรณ	โรงพยาบาลเลิดสิน	จิตเวชศาสตร์
5	อ. พญ.	ศศิธร	จันทรทิณ	คณะแพทยศาสตร์ศิริราชพยาบาล	ภาควิชากุมารเวชศาสตร์
6	นางสาว	พัสราภรณ์	ศุภวงศ์วรรธนะ	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์
กลุ่มที่ 4					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	นพ.	กฤช	หาญชาญชัยกุล	โรงพยาบาลสรรพสิทธิ์ประสงค์	ภาควิชาสูติศาสตร์-นรีเวชวิทยา
2	พญ.	อินทุอร	สง่าศิลป์	คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล	ภาควิชาวิสัญญีวิทยา
3	พญ.	นฤมล	ประจันพาณิชย์	คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล	ภาควิชาวิสัญญีวิทยา
4	นพ.	โกสินทร์	วิระษร	โรงพยาบาลศรีนครินทร์	อายุรศาสตร์
5	นพ.	ธีระพล	สมหมายไชยา	โรงพยาบาลเลิดสิน	ภาควิชาวิสัญญีวิทยา
6	นพ.	ณชารินทร์	พิภพทรรศนีย์	คณะแพทยศาสตร์ สถาบันเทคโนโลยีพระจอมเกล้าเจ้าคุณทหารลาดกระบัง	
กลุ่มที่ 5					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	พญ.	วรินทร์	สมิทธิเมธินทร์	โรงพยาบาลเมตตาประชารักษ์ (วัดไร่ขิง)	จักษุวิทยา
2	นพ.	ปิติพงศ์	สุรเมธากุล	โรงพยาบาลเมตตาประชารักษ์ (วัดไร่ขิง)	จักษุวิทยา
3	พญ.	สุพัตรา	จามรสุวรรณ	โรงพยาบาลเมตตาประชารักษ์ (วัดไร่ขิง)	ภาควิชาจักษุวิทยา
4	พญ.	สรินยา	บวรภัทรปกรณ์	โรงพยาบาลจุฬาภรณ์	สาขารังสีรักษาและมะเร็งวิทยา
5	นพ.	นำชัย	ด่านผดุงธรรม	โรงพยาบาลกระทุ่มแบน	สาขา รังสีวิทยาทั่วไป
6	นางสาว	นาริชาติ	ชื่นสกุล	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์

รายชื่อผู้ร่วมอบรม

Part II : How to teach communication skills 19 Oct 2018

กลุ่มที่ 1					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	รศ. นพ.	วิสูตร	ฟองศิริไพบูลย์	คณะแพทยศาสตร์ศิริราชพยาบาล	ภาควิชานิติเวชศาสตร์
2	พญ.	ขวัญศิริ	นราจีนรณ	โรงพยาบาลจุฬาลงกรณ์	ฝ่ายเวชศาสตร์ฉุกเฉิน
3	นพ.	เปศล	โกศัลลกูฏ	คณะแพทยศาสตร์วชิรพยาบาล มหาวิทยาลัยนวมินทราธิราช	ภาควิชานิติเวชศาสตร์
4	พญ.	ปฐมา	นาคเจือ	โรงพยาบาลเจริญกรุงประชารักษ์	เวชศาสตร์ฉุกเฉินและนิติเวชวิทยา
5	นพ.	สรณ	สุทธิวานิช	โรงพยาบาลพหลพลพยุหเสนา	กลุ่มงานอุบัติเหตุฉุกเฉินและนิติเวช
6	อ.	พนิตสุภา	เชื้อชั่ง	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์
กลุ่มที่ 2					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	พญ.	กนกลักษณ์	ศิริรุ่งวัฒนากุล	โรงพยาบาลสวรรค์ประชารักษ์	แผนกจิตเวช
2	นพ.	กวี	อนันต์นับ	โรงพยาบาลสุรินทร์	กลุ่มงานเวชกรรมฟื้นฟู
3	นพ.	อุดมโชค	อินทรโชติ	โรงพยาบาลชัยภูมิ	กลุ่มงานเวชกรรมสังคม
4	นางสาว	สุฏาภรณ์	ฆารเจริญ	โรงพยาบาลกรุงเทพหัวหิน	แผนกเวชศาสตร์ฟื้นฟู
5	ดร.	อดิณัฐ	อำนวยพรเลิศ	คณะเภสัชศาสตร์ มหาวิทยาลัยพะเยา	บริบาลเภสัชกรรม
6	นางสาว	นาริชาติ	ชื่นสกุล	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์
กลุ่มที่ 3					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	พญ.	วรินทร์	สมิทธิเมธินทร์	โรงพยาบาลเมตตาประชารักษ์ (วัดไร่ขิง)	จักษุวิทยา
2	นพ.	ปิติพงศ์	สุรเมธากุล	โรงพยาบาลเมตตาประชารักษ์ (วัดไร่ขิง)	จักษุวิทยา
3	พญ.	สุพัตรา	จามรสุวรรณ	โรงพยาบาลเมตตาประชารักษ์ (วัดไร่ขิง)	ภาควิชาจักษุวิทยา
4	พญ.	สรินยา	บวรภัทรปกรณ์	โรงพยาบาลจุฬาภรณ์	สาขารังสีรักษาและมะเร็งวิทยา
5	นพ.	นำชัย	ด่านผดุงธรรม	โรงพยาบาลกระทุ่มแบน	สาขา รังสีวิทยาทั่วไป
6	อ.	ฉันทณัฏฐ์	ทิพยเจริญธัม	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์
กลุ่มที่ 4					
ลำดับ	คำนำหน้า	ชื่อ	สกุล	สังกัด	หน่วยงาน/ภาควิชา
1	นพ.	กฤช	หาญชาญชัยกุล	โรงพยาบาลสรรพสิทธิ์ประสงค์	ภาควิชาสูติศาสตร์-นรีเวชวิทยา
2	ผศ. พญ.	รัตนาวลัย	นิติยารมย์	คณะแพทยศาสตร์ศิริราชพยาบาล	ภาควิชากุมารเวชศาสตร์
3	พญ.	อินทุอร	สง่าศิลป์	คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล	ภาควิชาวิสัญญีวิทยา
4	พญ.	นฤมล	ประจันพาณิชย์	คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล	ภาควิชาวิสัญญีวิทยา
5	นพ.	โกสินทร์	วิระษร	โรงพยาบาลศรีนครินทร์	อายุรศาสตร์
6	อ. พญ.	ศศิธร	จันทรทิณ	คณะแพทยศาสตร์ศิริราชพยาบาล	ภาควิชากุมารเวชศาสตร์
7	อ.	ทัพพ์เทพ	ทิพยเจริญธัม	คณะแพทยศาสตร์ศิริราชพยาบาล	สถานการแพทย์แผนไทยประยุกต์

เอกสารประกอบการอบรม

17 Oct 2018

17 Oct 2018

หัวข้อ : Principles of communication

Principles of Communication

นพ. ชนินทร์ ลิ่มวงศ์

ภาควิชาอายุรศาสตร์ คณะแพทยศาสตร์ศิริราชพยาบาล

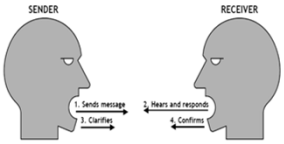
Common problems in counseling

- "Listening but do not hear"
- Bad news are always difficult
- Enough time should be given but counselor's time is of the essence
- A problem of too many people
- How much is sufficient information ?
- To know when not to answer
- How to avoid informative counseling without support ?
- How to learn to direct the situation ?

Fact about communication time

- Writing
- Reading
- Listening
- Talking
- Acting

An Effective Communications Model



Communication vs. Counseling

- Common Goal : Problem solving
- Clear role : counselor vs counselee
- Certain different rules
  - Frequently non-directive
  - Non-judgemental
  - Providing empathy and support

Different Types of Counseling

- Directive counseling
- Advocacy counseling
- Informative counseling
- Supportive counseling

Riccardi VM, Kurtz SM. Communication and counseling in health care. Springfield. Illinois 1983.

Components of an effective counseling

- Counselor
- Counselee
- Content
- Circumstance

A. Counselor

- I. Attitude
- II. Skills
- III. Manner / charisma

Counselor (1) -Attitude

- Attitude
  - Faith
  - Empathy
  - Optimism
  - Realistic understanding
  - Unbiased view

Counselor (2) - Skills

- Verbal communication skills
- Non-verbal communication skills

Verbal skills

- Questioning
- Probing
- Repeating (Reiterating)
- Paraphrasing
- Reflection (Interpreting)
- Reframing
- Summarizing
- Encouraging

Non-Verbal skills

- Vocal quality
- Speed of voice
- Volume of voice
- Listening
- Silencing
- Touching
- Refraining
- Interrupting
- Observing
- Facial expression

Listening Bad Habits

- ขาดความอดทน
- พูดแทรกขณะฟัง
- รีบด่วนสรุป ตัดสินใจโดยฟังไม่ครบถ้วน
- ให้คำแนะนำเหมือนเป็นผู้รู้ ลูกหลาน
- จดบันทึกอย่างตั้งใจ แต่ไม่แสดงว่าตั้งใจฟัง
- ฟังแล้วไม่มีการแสดงออกตอบสนอง
- อารมณ์เสีย เมื่อข้อมูลไม่ตรงใจ ไม่พอใจ
- เปลี่ยนเรื่องไปมาขณะสนทนา

Counselor (3) - Manner/Charisma

- Maturity
- Politeness
- Courtesy
- Sensitivity
- Respect

B. Content (1)

- Medical
  - information
  - diagnosis, burden
  - prognosis
  - options
- Psychological
  - normal coping mechanism
  - help / service

B. Content (2)

- Contents vary depending upon the types of counseling for each session / moment
- Consider how much to give and how many times “give small bites if you can”
- Frequently what you plan to do is not what is eventually done !

How to Inform ?

- Verbal skills
  - พูดภาษาเดียวกัน
  - พูดหรือบอกความจริงที่จำเป็น อาจจะไม่ทั้งหมด
  - พูดให้เข้าใจง่าย
  - พูดหรือบอกทีละน้อย ในเรื่องที่ยาก
  - พูดให้สบายใจ สบายใจขึ้น สบายใจที่สุดที่จะเป็นไปได้
  - พูดจากเรื่องใกล้ตัวไปสู่ไกลตัว
  - พูดสารที่มีความหมายเชิงบวกนำลบ

B. Content (3)

- Keep in mind of the following

  Always tell the truth
  Use language patient understands
  Prioritize what you will say
  Use wording that minimizes reaction but convey similar meaning
  Give time period in range

B. Content (4)

- Keep in mind of the following

  Make use of inference not personalized opinion
  Avoid blaming
  Assess understanding periodically
  Allow questions at appropriate times

C. Counselee

- Difficult patients
- Family counseling
- Barriers to understanding
- Unexpected circumstances
- Terminally-illed and end-of-life situations

When is it appropriate to counsel ?

- Patient's right to know
- Patient's desire to know
- Patient's need to know
- Patient's readiness to know

	Right	Need	Desire	Ready
Counsel now	Y	Y	Y	Y
Counsel later or withhold	Y	N	Y	N
Counsel anyway or withhold	Y	Y	N	Y/N
Withhold	N	Y/N	Y/N	Y/N
Withhold	Y	N	N	Y/N

Withholding bad news

- Pt with unstable psychiatric condition
- Pt with active suicidal idea
- Pt with no family support
- Pt with imminent death
- Pt with comprehension difficulties : dementia, delirium, under influence of drugs/chemicals
- None of these is, by no means,an absolute contraindication

D. Circumstance (1)

- Place
  - privacy and quietness
  - avoid bedside for advocacy / supportive counseling
  - sitting down always
  - avoid confrontation
  - be prepared for emotional session
  - avoid interruption

D. Circumstance (2)

- Opening
  - greeting
  - introduction
  - set agreement/rules
  - refer to pt by name
  - small talk first
  - assess what he/she knows
  - assess what he/she wants
  - goal setting

D. Circumstance (3)

- Middle part (body)
  - two-way communication
  - use skills to convey contents
  - interrupt as minimal as possible
  - redirection if needed
  - responding to concerns / feeling

D. Circumstance (4)

- Closing
  - Summarizing
  - Emphasizing what need to be decided and when (if apply)
  - Allow questioning
  - Assess feeling
  - Show appreciation
  - Make follow up plan

17 Oct 2018

หัวข้อ : Active listening

ทักษะการฟังในการสื่อสารทางการแพทย์

(Listening Skill in Medical Communication)

ผศ.พญ. ธัชวรรณ จิระติวานนท์

ทักษะการฟังเป็นทักษะที่สำคัญ และเป็นทักษะพื้นฐานสำหรับการสื่อสาร หากแต่เป็นทักษะที่มักถูกละเลย ไม่ได้รับความสำคัญ และขาดการฝึกฝน ในบทบาทของแพทย์ที่ดูแลผู้ป่วย จำเป็นอย่างยิ่งที่ต้องทำความเข้าใจกับทักษะนี้ เพื่อการดูแลผู้ป่วยที่มีประสิทธิภาพต่อไป

ทักษะการฟังเป็นทักษะที่มนุษย์ใช้มากที่สุดเมื่อเทียบกับการสื่อสารอื่นในชีวิตประจำวัน คือ ประมาณ 45% ในขณะที่การพูดใช้เวลาไป 30%, การอ่าน 16% และเขียน 9%[1] แต่เป็นเรื่องน่าเสียดายที่มีผู้ที่เข้าใจการเป็นผู้ฟังที่ดีไม่มากนัก แม้การฟังนั้นจะเป็นเพียงการฟังเพื่อให้ได้ข้อมูล (informational listening) แต่ข้อมูลที่ผู้พูดส่งไปมักถูกละเลย เข้าใจผิด และถูกลืมอย่างรวดเร็ว

ในภาษาอังกฤษ คำว่าฟัง ตรงกับคำว่า listen ซึ่งต่างจากคำว่าได้ยิน ซึ่งตรงกับคำว่า hear การฟังเป็นทักษะที่ลึกซึ้งกว่าการได้ยินมากนัก เพราะเป็นกระบวนการที่ซับซ้อนที่ต้องอาศัยการตีความและความเข้าใจในเนื้อความที่ได้รับ ในขณะที่การได้ยิน เป็นเพียงการรับรู้ทางประสาทสัมผัสการได้ยิน (auditory sensation) ไปยังสมองเท่านั้น เราอาจจะสามารถโต้ตอบหรือพูดตามคำพูดของผู้พูดได้ แต่หากเราไม่ได้เข้าใจเรื่องที่ผู้พูดกำลังพูด ก็ไม่ใช่การฟังที่แท้จริง

ในการสื่อสารกับผู้ป่วย การฟังเป็นทักษะพื้นฐานของการดูแลผู้ป่วยโดยมีผู้ป่วยเป็นศูนย์กลาง (patient centered model) เราใช้การฟังเพื่อให้ได้ข้อมูลเพื่อการวินิจฉัย เพื่อการตัดสินใจเลือกการรักษา เพื่อการเข้าใจผู้ป่วยแบบเป็นองค์รวม และที่สำคัญ เพื่อการสร้างความสัมพันธ์ระหว่างแพทย์และผู้ป่วย (doctor-patient relationship) การไม่รับฟังของแพทย์เป็นเหตุผลหลัก ที่ทำให้ผู้ป่วยเกิดความไม่พึงพอใจในทางการแพทย์ และส่งผลต่อการรักษาผู้ป่วยได้

อ็อตโต ชาเมอร์ (Otto Scharmer) นักคิดชาวเยอรมัน ได้นำเสนอทฤษฎีที่น่าสนใจอย่างมากเกี่ยวกับวิธีการเรียนรู้ของมนุษย์ ที่เรียกว่าทฤษฎีตัวยู (U Theory)[2] ว่า โดยทั่วไปเมื่อมนุษย์รับรู้ข้อมูลอะไรบางอย่าง เรามักจะตอบโต้โดยทันทีในลักษณะ action = reaction แต่ใน U theory ได้เสนอให้มีการห้อยแขวนความคิด มองลงลึกไปในความแตกต่าง โดยการเปิดจิต (open mind) เปิดใจ (open heart) และเปิดเจตน์จำนง (open will) ถึงเหตุผลของการนำเสนอข้อมูลนั้นก่อนที่จะตอบสนองข้อมูลนั้นๆออกไป

ชาเมอร์ ได้แบ่งประเภทของการฟังออกเป็น 4 ระดับตาม U theory ดังนี้

1. *ฟังแบบน้ำเต็มแก้ว* (downloading listening) เป็นการฟังที่พบได้บ่อย โดยจะตอบสนองเฉพาะสิ่งที่ตนมีข้อมูลอยู่เดิม มักคิดอยู่ในใจว่า “รู้แล้ว” ตอบสนองต่อการฟังโดยทันที
2. *ฟังแบบเอะใจ* (factual listening) เป็นการฟังในสิ่งที่ต่างจากที่เคยรู้มาก่อน ไม่ตรงกับข้อมูลที่มีอยู่เดิม เป็นพื้นฐานของการตรวจสอบทางวิทยาศาสตร์ หรือเป็นการฟังเพื่อจับประเด็น
3. *ฟังด้วยความเข้าใจ* (empathic listening) เป็นการฟังที่ผู้ฟังเปิดใจรับฟังและรับรู้ข้อมูลในแง่มุมอื่นที่ไม่เคยรู้ รวมถึงรับรู้ความรู้สึกของผู้พูด เป็นการฟังที่สูงขึ้นเพื่อสร้างความเข้าใจกัน
4. *ฟังด้วยปัญญา* (generative listening) เป็นการฟังในขั้นสูงสุด โดยปล่อยวางความเชื่อเดิมและเหตุผลที่ตนเอง

เคยมี และพร้อมจะก้าวข้ามไปสู่การเปลี่ยนแปลง

คงเป็นการยากที่จะบอกว่าผู้ฟังที่ดีอยู่ในระดับใด หากขึ้นอยู่กับบริบทและโอกาส โดยการฟังที่ดี ควรเป็นการฟังอย่างตั้งใจ เป็นการฟังเพื่อการเข้าใจความหมายที่แท้จริงของการสื่อสารนั้น ทั้งความหมายของคำ และความรู้สึกของผู้พูด

เราเป็นผู้ฟังที่ดีแล้วหรือยัง[3]

การเป็นผู้ฟังที่ดีนอกจากข้อมูลที่เราได้รับจากการสนทนาแล้ว เรายังทำหน้าที่เป็นเหมือนพยานในเหตุการณ์ที่ผู้พูดเล่าให้เราฟัง โดยไม่มีการตัดสิน เราสามารถเริ่มต้นการเป็นผู้ฟังที่ดีได้ ดังนี้

1. สังเกตตัวเองและบอกตัวเองว่าเราจะเป็นผู้ฟังที่ดี
2. ขณะที่ฟังให้ระลึกว่าเรากำลังฟังสิ่งที่ผู้พูดต้องการบอกเรา ไม่ใช่นึกว่าจะพูดอะไร
3. อดทนที่จะไม่ขัดจังหวะการพูด หรือพูดตัดบท
4. ระลึกว่าการหยุดและเงียบ เป็นวิธีที่มีประโยชน์
5. มีการสอบถามผู้ป่วยว่าสิ่งที่เราเข้าใจนั้นถูกต้อง รวมถึงสิ่งที่ผู้ป่วยเข้าใจเรานั้นถูกต้อง

รู้ได้อย่างไรว่าการฟังของเรามีประสิทธิภาพ

มี 4 คำถามที่ให้ถามตัวเองในระหว่างการสนทนา เพื่อวิเคราะห์ว่าการฟังมีประสิทธิภาพแล้วหรือไม่ ดังนี้

1. เราได้ยินสิ่งที่ผู้พูด พูดกับเราหรือเปล่า
2. เราเข้าใจสิ่งที่ได้ฟังหรือไม่
3. คนไข้ทราบหรือไม่ว่าเราได้ยินสิ่งที่เขาพูด
4. คนไข้ทราบหรือไม่ว่าเราเข้าใจเขา

ตัวอย่างการฟังที่ไม่มีประสิทธิภาพ

ผู้ป่วย: หมอค่ะ ป้ากลัวมากเลย ไม่อยากผ่าเลยค่ะ

แพทย์: ไม่ต้องกลัวหรอกครับ เดี๋ยวคุณป้าก็หลับไป เค้าผ่ากันเยอะแยะ

การตอบสนองอย่างนี้ ไม่ได้ผิดพลาดแต่ไม่ได้ช่วยให้ผู้ป่วยหายกลัว เป็นการฟังแบบน้ำเต็มแก้ว เอาความรู้สึกและประสบการณ์ของเราตอบสนองต่อคำพูด จะเห็นได้ว่าแพทย์ท่านนี้ได้ยินสิ่งที่ผู้ป่วยพูด แต่ไม่เข้าใจจริงๆสิ่งที่ได้ฟังผู้ป่วยทราบว่าแพทย์ได้ยินสิ่งที่เขาพูด แต่ไม่รู้สึกว่าได้รับการเข้าใจจริงๆ

ตัวอย่างการฟังที่มีประสิทธิภาพ

ผู้ป่วย: หมอค่ะ ป้ากลัวมากเลย ไม่อยากผ่าเลยค่ะ

แพทย์: คุณสมศรีบอกได้ไหมครับว่าที่บอกว่ากลัว กลัวอะไร

ผู้ป่วย: ป้ากลัวเจ็บน่ะ ป้าเคยผ่าคลอดลูกเมื่อ 20 ปีก่อน ป้าปวดแผลมากเลย

แพทย์: คุณสมศรีพอจะเล่าให้ฟังเรื่องการผ่าตัดที่ผ่านมาได้ไหมครับ

ผู้ป่วย: (ผู้ป่วยเล่าเหตุการณ์) .....

แพทย์: หมอพอจะเข้าใจความรู้สึกของคุณสมศรีแล้วครับ หมอจะดูแลเรื่องอาการปวดให้ดีที่สุด เรามียาเพื่อป้องกันและมียาเพื่อรักษาดูแลอาการเพื่อให้คุณสมศรีรู้สึกสบายที่สุดหลังผ่าตัดครับ

จากบทสนทนานี้ จะเห็นว่าแพทย์มีการสอบถามเพื่อวิเคราะห์ลงไปว่าปัญหาคืออะไร และตอบสนองเพื่อให้ผู้ป่วยคลายกังวล ผู้ป่วยรับรู้ว่าแพทย์เข้าใจเขาและรับรู้ความต้องการของเขา ในบางสถานการณ์ การฟังอย่างเดียวโดยไม่ตัดบทหรือโต้ตอบเป็นการตอบสนองที่เหมาะสม แต่ในบางสถานการณ์ผู้ป่วยต้องการการตอบสนองด้วยคำพูด

การฟังอย่างตั้งใจ (active listening)

การฟังอย่างตั้งใจ เป็นทักษะเฉพาะในการสื่อสาร เป็นการฟังเพื่อการเข้าใจความหมายที่แท้จริงของการสื่อสารนั้น ทั้งความหมายของคำ และความรู้สึกของผู้พูด โดยมีทักษะย่อยที่เกี่ยวข้อง ดังนี้ [4,5]

1. ทักษะที่บ่งว่าตั้งใจฟัง (Attending skill)

   การฟังที่ดี นอกจากเราจะต้องตั้งใจ และพยายามเข้าใจความหมายของการสนทนานั้นแล้ว การแสดงออกว่าเราเป็นผู้ฟังที่ดีมีความสำคัญเช่นกัน ส่งผลให้ผู้พูดรู้สึกไว้วางใจ รู้สึกถึงการให้เกียรติ และพร้อมที่จะสนทนาต่อ โดยการสนทนาควรอยู่ในสถานที่ที่ไม่ถูกรบกวน มีการวางท่าทางขณะสนทนาให้เหมาะสม ไม่แสดงออกถึงการไม่ใส่ใจ ระมัดระวังภาษากายที่ทำให้ดูน่ารำคาญ เช่น นั่งเขย่าขา ควงปากกา เอามือเคาะโต๊ะ และที่สำคัญต้องฝึกการสบตาที่สื่อความหมาย (eye contact) การสบตา ไม่จำเป็นต้องมองตาตลอดเวลา หากผู้ฟังเข้าใจเรื่องราวที่ผู้พูดได้พูด รวมถึงมีความปรารถนาดีให้ สายตาที่มองออกไป จะเป็นสิ่งที่บ่งบอกได้เป็นอย่างดี

2. ทักษะการติดตามการฟัง (Following skill)

   ทักษะนี้ เป็นทักษะที่ช่วยให้ผู้พูดสามารถพูดต่อไป ด้วยความสบายใจ ในทิศทางที่เหมาะสม โดยเริ่มจากการสังเกตภาษากายของผู้พูด ว่ามีเรื่องราวที่อยากจะบอกหรือมีอะไรในใจ และเริ่มต้นการสนทนา โดยอาจเริ่มจากการสอบถามจากภาษากายที่เราสังเกตได้ เช่น “วันนี้ดูเครียดนะ มีอะไรอยากจะเล่าให้ฟังไหมคะ” และให้เวลากับผู้พูดสักครู่ เพื่อให้เขาได้ตัดสินใจว่าอยากจะเล่าให้ฟังหรือเปล่า และฟังต่ออย่างตั้งใจ

   ในขณะที่ฟังนั้น เราสามารถทำให้ผู้ฟังเล่าต่อเนื่อง โดยการพูดประโยคสั้นๆที่แสดงให้เห็นว่าเราฟังอยู่ และเข้าใจสิ่งที่พูด เช่น อืม จริงเหรอ เล่าต่อซิ แล้วยังไงต่อ โดยร่วมกับการถามคำถามที่มุ่งเน้นไปในสิ่งที่ผู้พูดกำลังให้ความสำคัญ ถามแต่พอดี การถามที่เยอะเกินไป อาจทำให้ผู้พูดรู้สึกเหมือนถูกควบคุมการสนทนา หรือจ้องจับผิดผู้พูด

   สิ่งที่ขาดไม่ได้ในทักษะนี้คือ การเงียบ (attentive silence) ผู้ฟังส่วนใหญ่มีแนวโน้มที่จะพูด มากกว่าการเงียบฟัง แม้ในขณะที่สนทนา ถ้ามีความเงียบเกิดขึ้น ผู้ฟังหลายคนจะรู้สึกอึดอัด เราเงียบเพื่อแสดงว่าเราตั้งใจคิดตามสิ่งที่พูด และอยากให้ผู้พูดได้พูดต่อ การเงียบนั้นหากทำไปอย่างมีวัตถุประสงค์ จะช่วยให้ความรู้สึกอึดอัดนั้นลดลงได้

3. ทักษะการสะท้อนความรู้สึก (Reflecting skill)

   หลักการสำหรับทักษะนี้ คือ เราจะสะท้อนความรู้สึกโดยไม่ตัดสินผู้พูด ในถ้อยคำที่กระชับ และถูกต้องกับความรู้สึกนั้นจริงๆ โดยมีทักษะที่ควรรู้จัก ดังนี้

   1. Paraphrasing เป็นการตอบสนองสั้นๆเกี่ยวกับข้อความที่ผู้พูดได้ ด้วยคำพูดของเราเอง
   2. การสะท้อนอารมณ์ และความหมาย (reflecting feelings and meaning) โดยการจับความรู้สึกของผู้พูดในขณะนั้น รวมถึงการจับประเด็นที่ได้ แล้วสะท้อนออกมา เช่น “ คุณ...รู้สึกเบื่อหน่ายกับการรักษา เพราะที่ผ่านมาไม่มีวิธีไหนทำให้หายขาดได้ ใช่ไหมคะ”

3. การสรุปประเด็น (summary) การสรุปประเด็นมีความสำคัญ โดยเฉพาะในกรณีที่การสนทนานั้นผู้ฟังมีความสับสนในอะไรบางอย่าง หรือมีปัญหาที่ต้องการการแก้ไข ช่วยในการประมวลความคิด ก่อนจะจบการสนทนา หรือเริ่มหัวข้อใหม่ โดยผู้ฟังจะต้องรวบรวมสิ่งที่ได้ฟังมา เลือกเฉพาะส่วนที่สำคัญ แล้วสรุปจุดหลักๆที่ทำให้ผู้พูดเข้าใจตัวเองได้ดีขึ้น

จะเห็นได้ว่า การฟัง ไม่ได้มีเฉพาะการได้ยินข้อมูลต่างๆเท่านั้น การฟังที่ดี ต้องมีลักษณะของ “active listening” ซึ่งมีองค์ประกอบของ attending, following และ reflecting skill ที่ควรได้รับการฝึกฝนและพัฒนาอย่างต่อเนื่อง

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17 Oct 2018

หัวข้อ : Informative counseling

Informative counseling and informed consent

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17 Oct 2018; 13.00-14.30

Objectives

- เพื่อให้ผู้เข้ารับการอบรมได้เรียนรู้ และ อภิปราย ลักษณะ องค์ประกอบ ความสำคัญ และ ขั้นตอนในการทำ **informed consent**
- เพื่อให้ผู้เข้ารับการอบรมได้เห็น รูปแบบการสอนเรื่อง ทักษะการสื่อสารในเรื่อง **informed consent**

17 Oct 2018; 13.00-14.30

กิจกรรม

ผู้เข้าอบรมร่วมกันอภิปราย

ท่านมีความเข้าใจอย่างไร เกี่ยวกับ

informative counseling and inform consent

17 Oct 2018; 13.00-14.30

กิจกรรม

ผู้เข้าร่วมอบรม ร่วมกิจกรรม **role play** เรื่อง **informative counseling** โดยมีอาสาสมัคร **1** ท่าน แสดงบทบาทเป็นแพทย์ ที่จะให้คำปรึกษากับผู้ป่วยจำลอง (คุณชุติมา)

17 Oct 2018; 13.00-14.30

- ท่านกำลังจะให้คำปรึกษา และ ขอ inform consent กับคุณชุติมา ผู้ป่วยหญิง อายุ 59 ปี
- คุณชุติมา มาพบท่านในครั้งนี้ด้วยเรื่อง ปวดท้องน้อยด้านซ้าย และ ถ่ายอุจจาระปนเลือด มาประมาณ 2 สัปดาห์
- คุณชุติมา ปกติแข็งแรงดี ไม่มีโรคประจำตัวใด ๆ ครั้งนี้ มาพบแพทย์ด้วยอาการปวดท้องน้อยด้านซ้าย และ ถ่ายอุจจาระปนเลือด มาประมาณ 2 สัปดาห์
- ลักษณะอาการปวดท้องจะปวดบริเวณด้านซ้ายล่าง ลักษณะอุจจาระ มีเลือดสดในช่วงแรก และมีมูกปน
- ในช่วง 2 สัปดาห์นี้ มีอาการแบบนี้ทั้งหมด 2 ครั้ง ครั้งแรก เมื่อ 2 สัปดาห์ก่อน แล้วหายไป ครั้งที่สองเป็นอีกที เมื่อ 4 วันก่อน
- ท่านเป็นอายุรแพทย์เฉพาะทาง และ ได้ตรวจร่างกายแล้ว ไม่พบความผิดปกติใด ๆ
- PR: ปกติ ใส่ proctoscope ไปก็ปกติดี
- ท่านจึงแนะนำให้ คุณชุติมา ตรวจเพิ่มเติมด้วยการทำ colonoscope

จงให้ข้อมูลกับคุณชุติมา เพื่อชักชวนให้คุณชุติมา เข้ารับการตรวจเพิ่มเติมด้วย colonoscope

17 Oct 2018; 13.00-14.30

กิจกรรม

ให้ผู้เข้าร่วมอบรม ร่วมกันอภิปราย ประเด็นต่างๆ ในเรื่อง **informative counseling** จาก **role play** ที่ท่านมีประสบการณ์เมื่อสักครู่

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Effective communication process

- Effective opening session
- Effective conversation skill
- Effective closing session skill

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Effective communication process

- Effective opening session
  - Greeting
  - Identify all persons related
  - Small talk
  - Refer to previous related session or previous related treatment

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Effective communication process

- Effective conversation skills
  - Verbal and non-verbal skill
  - What should be used to inform (verbal, document, VDO)?
  - What is proper information to inform and when?
  - How much should we inform: high incidence, significant risk
  - Choosing not to inform some patients or relatives
  - Choosing not to inform some facts
  - Being asked not to inform
  - Too little or too much information
  - Use easy word (language); no medical terms

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Effective communication process

- Effective closing session skill
  - Check understanding
  - Avoid the question "Do you understand?"
  - Offer time to think more to the patient

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Informed consent

- Originally from *research* (from 1900 when Walter Reed did research on yellow fever in Cuba)
- Intend to *protect patient* and *promote ethical issue*
- Main principles:
  - To respect and promote participants' autonomy
  - To protect them from potential harm
- Clinical care vs clinical research
  - Some similar: maximize benefit to the patient
  - Some differences: unknown risk or benefit

Lancet Oncol 2008; 9: 485–93

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Informed consent

- "consent" allows an autonomous patient to *determine what treatments he or she will accept or refuse*
- *Obtaining* consent from a patient *is not* the same as *having the patient sign* a consent form
- The clinician providing treatment is responsible for obtaining consent from the patient
- Consent is legally valid if it is given *voluntarily* by an *appropriately informed* person, who has the requisite *capacity* to exercise an informed choice

Anaesthesia and intensive care medicine 10;3:111-4

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Informed consent

INFORM (give information) ✚ **CONSENT (providing signature)**

Promotion of participants' understanding
Check participants' understanding
Adequate explanation

Lancet Oncol 2008; 9: 485–93

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ถาม และ ตอบคำถาม

เอกสารแนะนำเพิ่มเติม

Silverman J, Kurtz S, Drper J. **Skills for Communicating with patients.** Third Edition 2013.

Improvement of informed consent and the quality of consent documents. *Lancet Oncol* 2008; 9: 485–93

17 Oct 2018; 13.00-14.30

Thank you for your attention

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Giving information

In the last chapter we concentrated on how to gather information from a patient. This, together with the information obtained from the physical examination and investigations, will enable a diagnosis to be made for the majority of patients, and a management plan to be devised for all patients. At some point, perhaps in the same interview or perhaps in a subsequent one, there will be a need to explain and discuss what has been found and what investigations and treatment are planned. It is important to remember that most treatments involve the cooperation of the patient — providing, of course, they are capable of cooperation. The way in which information is given has been shown in a number of studies to have a major effect on several aspects of patient care, including:

- Patients' level of anxiety and stress – This has been shown to decrease if patients are given adequate information prior to investigations and surgical procedures.
- The outcome of these procedures –There is some evidence to suggest that patients who are given a full explanation of the operation they are about to undergo spend less time in hospital and require fewer pain-relieving drugs than patients who have not been fully informed.
- Satisfaction with care – Patients who are given a full explanation of their problem and its management in a way which they understand are more likely to be satisfied with their care: This is desirable in itself, but there is also evidence that a satisfied patient is more likely to comply with advice than someone who is dissatisfied.
- Compliance with treatment – Patients are more likely to comply with their treatment if they are satisfied with their consultation and if they understand why they have to undergo the treatment.

Unfortunately, doctors are not very good at giving information to patients. Failure to give information or adequate explanation is the most common cause of dissatisfaction amongst patients. Here are some quotes from patients included in a report on communication between hospitals and patients:[1]

"You have to fight to be told what's wrong."
(patient who had had a stroke)

"Why is it that no one wants to discuss it? It wouldn't hurt to know the side-effects of drugs."
(patient with rheumatoid arthritis)

"I didn't even know if it was malignant ... perhaps they leave it to your imagination."
(woman with breast cancer)

Think of the possible reasons why these patients did not get the information they wanted.

There is evidence from a number of studies that the way in which doctors give information to patients is inadequate. First, patients often do not remember the information they are given. In one study in an outpatient clinic, it was found that patients had forgotten 40% of the information within 2 hours of seeing the doctor. This rose to 54% when patients were asked to recall the information 1–4 weeks after the consultation. Second, patients often do not follow the advice given. Several studies have found that 30–50% of patients do not take their drugs as prescribed.

An article in the British Medical Journal entitled: 'Most young doctors are bad at giving information', described a study of doctors who had received training in interviewing skills when they were students.[2] Whilst their ability to gather information from the patient remained high, their ability to give information had not, and the majority were thought to have performed inadequately. What are the possible explanations for these findings? The explanations concern the processes involved in exchanging information.

The person giving the information

To give information effectively, you must:

- understand the information and be able to convey it accurately
- use ideas and language that will be comprehensible to the recipient
- be prepared to respond to the recipient's questions and emotional reaction.

The person receiving the information

The recipient should:

- be able to listen to and concentrate on what is said. We are less likely to listen and remember if we are tired, anxious, or have symptoms such as pain or nausea.
- remember the information more easily if they are able to link it to

their existing knowledge, if it has been reinforced during the interview and if they are asked to review what has been said.

Clearly, there are skills involved in giving information that doctors may not be aware of. First, there is more to it than simply telling the patient what is wrong and what they should do. Second, it is often wrongly assumed that patients are not capable of understanding explanations of their medical problems because of lack of knowledge. Third, it is often assumed that patients are made more anxious if the details of their problem and its management are explained to them. There is no evidence that this is so. Lack of information and uncertainty about their diagnosis and treatment is more likely to increase anxiety. There is considerable evidence now that the majority of patients want to know what is wrong with them, even if the news is not good. Giving them this information has a positive effect on the patient — providing, of course, it is given in a manner sensitive to their needs.

How to give information

So what are the skills involved in giving information to patients? First of all, think about the aims you wish to achieve:

- To help the patient understand what is happening.
- To reduce their anxiety and uncertainty as far as possible.
- To gain their cooperation in the management of their problem.

To achieve these aims, you first must find out what the patient understands about their problem and how they think they might be helped. Then, you need to tailor the information you give them accordingly.

Guidelines for giving information to a patient (Table 4.1)

1. Describe what information you plan to give

Clarify in your own mind the information you plan to give. This will probably fall into the following categories:

- results of the physical examination
- results of tests
- diagnosis (or provisional diagnosis)
- cause of the problems
- necessary further investigations
- treatment planned
- prognosis
- advice about lifestyle.

2. Summarise patient's problems

Begin the interview by summarising the patient's problems (the information gathered to date):

DR SMITH *You've told me about the pain in your stomach and the heart burn you've been having after meals and at night. You also mentioned that you've had an ulcer in the past. Is that right?*

MR BARNES *Yes — they found I had an ulcer when I was serving in the army — about 10 years ago.*

3. Find out the patient's understanding of their condition

Assess the patient's understanding of the condition:

DR SMITH *Could you tell me what you think is causing your symptoms?*
or
Most people have some ideas or worries about what is causing the problem. Do you have any ideas?

MR BARNES *Well, I think my ulcer's come back because of my new job — driving a lorry up to Scotland and back. I'm a bit worried because my friend got peritonitis from a burst ulcer.*

4. Outline structure of interview

Outline how you plan to structure the rest of the interview. You may plan to discuss the diagnosis, treatment, future investigations, etc. It has been shown that structuring the interview and explaining what you plan to discuss improves the patient's recall of the information given them:

DR SMITH *Fine, I understand. Now I'm going to discuss several things with you: first, what I think is wrong with you; second, what further investigations you need; and lastly, the treatment I'm going to give you.*

5. Use appropriate language

Describe and explain each part of the information. In doing this, it is important to:

- give the most important information first
- use short words and short sentences
- avoid medical jargon
- be specific — vague information only increases anxiety.

It is all too easy to use words and medical phrases familiar to you but which the patient will not understand. When you use them, ask if the patient understands.

DR SMITH *Well, your barium meal did not show an ulcer. But it did show that you have something we call a hiatus hernia. Do you know what that is?*

MR BARNES *I think my grandmother had one, but I haven't much of a clue, really.*

6. Use drawings

If appropriate, use drawings to supplement the information. In the above case, Dr Smith could explain a hiatus hernia to Mr Barnes much more easily using drawings than using words.

7. Give important information first

Give the most important information first of all. This is particularly necessary when giving advice:

DR SMITH *Now I'm going to explain how we can try to get rid of your symptoms. I think it would help if you were able to lose a bit of weight. You will be less likely to get the pain if you can eat smaller meals regularly — for example, instead of one large meal at night, I suggest you eat a good breakfast (cereal, toast, etc.), perhaps a light lunch, such as sandwiches, and then have your evening meal — which should be smaller than usual. I suggest that you sleep on three pillows because then the acid in your stomach is less likely to come up into your gullet than when you lie flat. Lastly, I'm going to give you some tablets that will stop your stomach producing acid; you should take one each morning.*

8. Explore patient's views

Explore the patient's views on the information they have received. Encourage them to ask questions:

DR SMITH *Perhaps you could say what you feel about that.*

MR BARNES *Well I'm really surprised that I haven't got an ulcer because my pain felt just the same as last time. But yes, I understand what a hiatus hernia is now that you've drawn one. I'm worried that it might be difficult for me to eat the meals you suggest because I'm on the road most of the day, and I'm not sure if I want to take those tablets.*

9. Negotiate management

Negotiate management with the patient. If appropriate, help them to decide between treatment options:

DR SMITH *Yes, I understand you might have some problems with the diet I'm suggesting, especially as road-side cafes usually sell lots of greasy food. However, perhaps you could keep to the fish and chicken and avoid the chips and fried eggs. You say you're not keen on taking tablets — why not?*

MR BARNES *A friend of mine had them and then he got worse, and 6 weeks later they found he had stomach cancer.*

DR SMITH *I see. So are you worried about having cancer?*

MR BARNES *I was a bit. I suppose if my X-ray only showed a hernia, I must be clear. Are there other tests you can do to be absolutely sure?*

DR SMITH *Yes, there are, but I don't think it's necessary to do them at present. We'll want to see how you get on over the next few weeks with a change of diet. What about the tablets I've suggested? I don't think it's possible that they caused your friend's cancer.*

MR BARNES *I think I'd rather try changing my diet first of all and taking the white medicine you prescribed for me last time.*

DR SMITH *Let's try that for the next four weeks, then I'll see you again.*

Note that Dr Smith does not elicit Mr Barnes's fear of cancer until this stage of the interview. Once out in the open, Dr Smith acknowledges Mr Barnes's concerns and takes them into account during the rest of the interview. He also gives Mr Barnes the opportunity to express his treatment preference. Eventually, they decide on a treatment plan that is acceptable to both, and one that Mr Barnes is likely to follow because he was involved in making the decision.

10. Check understanding

Check the patient's understanding of what has been said:

DR SMITH *Well, Mr Barnes, I seem to have given you lots of information. Would you like to just go over what we have said?*

Table 4.1 Giving information to a patient

1. Describe what information you plan to give
2. Summarise your understanding of the patient's problems
3. Find out their understanding of the condition
4. Outline the structure of the rest of the interview
5. Use appropriate language
6. If relevant, use drawings to supplement the information
7. Give the most important piece of information first
8. Explore the patient's views on the information given
9. Negotiate management
10. Check the patient's understanding of what has been said

Giving lifestyle advice

Doctors are being asked increasingly to help patients modify aspects of their lifestyle that may be hazardous to their health. Smoking, excessive drinking, lack of exercise, a high fat diet and unsafe sex are all examples of behaviours that carry a health risk. In the general practice setting, the emphasis is on helping patients to reduce their risks of developing disease, e.g. by stopping smoking. In the hospital setting, the emphasis may be more on helping patients with established disease to adopt behaviours that reduce disability or the chance of a recurrence.

As a medical student, you may be asked by patients, 'How can I give up smoking?' In the past, it was thought that if patients were given information, e.g. about the hazards of smoking and how to stop, then their knowledge about smoking would increase and this would lead to a

change in their attitudes and behaviour. We now realise that helping patients to change involves more than just providing them with information.

Case example 4.1

An habitual smoker with asthma

Mr O'Shea, aged 52, an unemployed man admitted with an acute asthmatic attack.

DR SINGH *Well, Mr O'Shea, you're much better now and it's time to go home. I've seen you a few times in the day room smoking — you shouldn't be doing that with a chest like yours. I think I've told you that before. Make sure you've stopped by the time I see you next in the outpatient clinic. Smoking does terrible things to your chest, you know.*

MR O'SHEA *OK, doctor — I'll try.*

Four weeks later in the outpatient clinic:

DR SINGH *Hello, Mr O'Shea. So how is your asthma? I hope you've given up smoking!*

MR O'SHEA *My asthma's not too bad — except some mornings when my chest feels really tight and I'm up all night coughing sometimes. I sort of tried to give up smoking but didn't manage it.*

DR SINGH *So how many are you smoking?*

MR O'SHEA *Still 20 a day — sometimes a bit less.*

Mr O'Shea did not heed Dr Singh's advice to stop smoking. Are you surprised? Think about other approaches that Dr Singh could have adopted within the interview that might have been more successful.

How to give lifestyle advice

This process can be divided into four stages. We will use the example of advising a patient to give up smoking.

Stage 1: enquire about the patient's attitudes to health

This will help you to understand why they smoke and to tailor your advice accordingly. An American social psychologist has proposed a health belief model that can be summarised as 'the three Ss':

- Susceptibility – How does the person perceive their vulnerability to a particular disease? A person who has a strong family history of smoking and early deaths from cardiovascular disease is likely to view their susceptibility differently, and may be more motivated to give up, compared to someone whose grandparents and parents smoked heavily and lived to a ripe old age.
- Seriousness – How do they perceive the seriousness of the conse-

quences of developing or exacerbating a particular disease? In the case example, to what extent does Mr O'Shea believe that his asthma is made worse by smoking?

- Solutions – How do they weigh the costs and benefits of a particular course of action, such as giving up smoking? A person may want to accept the financial and potential health costs of smoking because they enjoy it and feel that it relieves their stress.

Stage 2: giving information

Having obtained an understanding of the patient's attitudes to their problem, you are in a better position to provide information about smoking and how to stop.

Remember some basic rules about giving information:

- Organise the information into categories and explain what they are.
- Give instruction and advice early in the interview.
- Make the advice specific.
- Use short words and short sentences.
- Avoid medical jargon.
- Repeat the advice during the course of the interview.

Stage 3: negotiating

It is important to negotiate a plan of action with the patient. Find out if they are still firmly committed to stopping smoking; if so, what do they feel is an achievable, realistic target? This should be discussed and a plan of action agreed. Remember to ask the patient to summarise what has been agreed so that you can check their understanding of the plan.

Stage 4: supporting the patient

Changing one's lifestyle — such as giving up a lifelong habit of smoking or drinking — is not easy, and continued support should be given. The plan of action that has been negotiated should be reviewed and may need to be renegotiated at intervals.

Re-read the case example of Mr O'Shea and Dr Singh. How might Dr Singh have conducted the interview more effectively, bearing in mind the guidelines you have just read? You might want to create a role play of Mr O'Shea and Dr Singh.

The use of written information

A number of studies have shown that patients want information in the form of pamphlets or booklets, and that they benefit from written information. Such material can supplement verbal explanation and advice, provide a permanent record and cover all the important points

to be conveyed to the patient. Evidence shows that written information, presented in an appropriate form, enhances patients' understanding and memory. Written information should be:

- easy to read — use short words and sentences
- expressed in the active rather that the passive voice
- expressed in positive rather than negative sentences
- attractively presented.

It seems likely that in the next decade, electronic means of conveying information will overtake the printed word. Some general practitioners are now using videos in their waiting rooms to provide patients with information. Interactive videos are being used, not only to provide information, but also to involve patients in decision-making. For example, male patients with benign prostatic hypertrophy are being helped to decide whether or not to have an operation by means of a video that they can interact with.

Obtaining informed consent

All patients who are assessed as being competent must give their consent before any procedure is carried out on them. This includes physical examination. Without it, a doctor can be legally charged with assault. Recently, the need to gain consent from patients when they are involved in teaching has been highlighted.[3] In particular, all patients must give their written consent to rectal and vaginal examinations by students when they are sedated or anaesthetized.

One of a house surgeon's jobs is to obtain a patient's 'informed consent' in writing before they undergo any surgical procedure. In Britain the standard consent form includes the sentence: 'I confirm that I have explained to the patient the nature and purpose of this operation'. The doctor signs below, and the patient signs to confirm that: 'the nature and purpose of the operation have been explained to me by Dr ...'.

Concern is often raised as to whether or not the patient's consent is truly 'informed'. The issues that need to be addressed are the nature of the information given to the patient, the manner in which it is given and the way in which consent is obtained. Here are some guidelines for obtaining informed consent from a patient:

1. The patient should be given information about the procedure, its benefits and risks. The nature of the operation should be clearly explained, perhaps with the aid of a drawing, if appropriate. Then the benefits and possible risks should be discussed. One of the dilemmas is how much information should be given about the risks. On the one hand, we do not want to alarm the patient by itemising all the possible risks (some of which may be very remote); but on the other hand, they need to be 'fully informed'. It is difficult to give hard and fast rules. It is clearly important to encourage the patient to ask questions and to give clear, truthful answers.

2. It is essential that the patient understands the information. This means following the rules of information giving:

a. Explain how you are going to structure the information:
First of all, I'm going to explain what the surgeon will do. Then we will discuss how we think it will help you. Lastly, I will talk about the problems which could arise.

b. Use short words and use short sentences.

c. Avoid medical jargon.

d. Check their understanding of what you have said.

e. Do they have any questions?

f. Do they give their consent for the procedure?
Adequate time must be allowed for this process. It might be tempting to think of it as a quick formality at the end of clerking of the patient. Quite apart from the legal aspects, it has been shown that patients who are fully informed are more satisfied and may make a better postoperative recovery.

3. The patient's consent must be given voluntarily and no coercion must be used. Remember that there are subtle ways of putting pressure on someone who has to make a decision.

4. The patient must be considered competent to sign the form. This means that you have judged them capable of understanding the information given them, that they are able to make a choice and able to communicate it to you.

We have discussed informed consent in the context of a patient about to undergo surgery. There are, of course, other circumstances in which it will be necessary to obtain consent (taking part in a drug trial, for example), but the same guidelines can be followed.

Obtaining informed consent is important for the patient and the doctor. It is not a task to be taken lightly, and it is a good test of your ability to convey information effectively and sensitively.

Key points

- The way in which information is given influences patients' satisfaction and compliance with treatment.
- Before giving information, find out what the patient knows about their problem and its possible treatment and take this into account when giving them information.
- Outline the stages of giving the information (diagnosis, treatment, etc.).
- When giving information:
  - give the most important information first
  - use short words and short sentences
  - avoid medical jargon
  - avoid vagueness – give specific information.
- When deciding on a treatment plan with a patient:
  - identify and acknowledge their beliefs and worries about their problem and its management
  - find out their treatment preference
  - negotiate a treatment plan.
- At the end of the interview, ask the patient to summarise what has been agreed.

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Informed consent: Is it always necessary?

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Summary Informed consent plays a pivotal role in human clinical research. It serves as a marker for the subject's comprehension of all the pertinent elements of the study. It is also a pledge by the investigator that during the trial, the rights and safety of the subject will be protected. Informed consent attempts to ensure that ethical behaviour will be upheld throughout the study. However, obtaining informed consent from certain vulnerable populations is a challenge, and thus warrants improvement. While informed consent is mandated for almost all clinical trial involving human subjects, there are situations of emergency research and trials with minimal risk that call for a waiver of the consent.

Introduction

Currently there are over 27,000 clinical studies underway in the United States.[11] While the noble goal of all these investigations is to further scientific knowledge for the betterment of our society, the safety of the human subjects involved in these studies and means of garnering this knowledge can not be overlooked.

When a clinical research project is being developed, it is necessary to assess the ethical aspects surrounding it and its impact on the subjects. However, informed consent is not the only ethical criteria to take into account; it also constitutes the legal and ethical cornerstone for all research involving human subjects. Informed consent serves as a valuable tool in asserting proper regulations in clinical trials, as well as providing assurance of safety for the patient.

While most clinical studies can only be performed under an informed consent, there are exceptions to this rule. In situations such as emergency research or research with minimal risk to the subject, informed consent is not absolutely necessary. Nevertheless, efforts to protect the subject's rights and safety should be a principal concern in every clinical study.

Definition of informed consent

Informed consent is the process of obtaining the permission of a subject to participation in studies and have an opportunity to decide about his or her healthcare. This notion originates from the legal

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and ethical right of the patient/subject to retain autonomy and from the ethical duty of the physician/researcher to involve the patient in healthcare decisions. Informed consent also implies that a dialog has taken place about the nature of the decision, reasonable alternatives, relevant risks, benefits and uncertainties of the decision, and the comprehension and acceptance of the healthcare decision by the patient/subject.[10,4]

Historical context of informed consent

We need not look any further than recent history to highlight the importance of informed consent. There have been some paramount circumstances which have necessitated greater regulation of human subject medical research. The inception of informed consent has its roots in the Nuremberg Code of 1945. This code was formulated in response to the shocking discoveries during the Nuremberg trials. Nazi doctors were found to have committed horrific medical experimentation abuses against the inmates in concentration camps, who were exploited as research subjects. These experiments ranged from inflicting burns and gunshot wounds onto the subjects to test anti-infective agents, to immersing detainees in tubs of ice water for hours to assess the body's reaction to cold temperatures. The code attempted to set a standard for ethical behaviour when conducting human experimentation. It reflected the need for informed consent, condemned physical and mental suffering in experiments, stated that death and disability were not expected outcomes of experiments and affirmed that human subjects were to be protected from the slightest possibility of harm. The Nuremberg Code was a first legal attempt to grapple with ethical issues involved in human research.[4]

Soon thereafter in 1953, the Declaration of Helsinki was drafted by the World Medical Association. It reaffirmed the Nuremberg Code's stance on informed consent as well as allowed legal guardians to grant permission to enrol patients in therapeutic and non-therapeutic research. The Declaration of Helsinki also recommended written consent, a proposal not mentioned in the Nuremberg Code.[4]

While significant strides were occurring in the informed consent field, human subject safety in clinical trails was far from being guaranteed. The efforts to improve the ethical standards in clinical research took a significant step backwards when the details of Tuskegee Study came to light in 1972. Overseen by the Center for Disease Control and Prevention, this study, which began in 1932, exploited the lives of more than 400 African American sharecroppers suffering from syphilis by withholding medical treatment. These findings resulted in a considerable damage to the reputation of the medical research community and helped harbour irreconcilable mistrust from the public.[4]

In 1974, Congress passed the National Research Act in an effort to better protect human subjects. This act mandated that Institutional Review Boards (IRBs) be responsible for peer reviewing any research involving human subjects by requiring informed consents and reviewing the protocols of the experiments. This move was unprecedented since investigators never before had to seek approval of their own experiments.[4]

Responsibilities of the IRB

An IRB may be created by independent firms or run by hospitals or universities. IRB is legally bound to be comprised of a wide variety of members ranging from scientists to lawyers to clergymen. Their responsibility lay in assessing the risks and benefits to ensure that the risks do not outweigh the potential benefits. They must also agree with the ethical standards met by the proposed study and ensure that the rights of vulnerable populations such as children, prisoners, pregnant women and mentally disabled persons are not compromised. The IRB also must be convinced that it is clinically appropriate to conduct the study. However, the IRB's responsibilities do not end there, since it is constantly updated on the study's progress and is notified of any changes in protocol during the course of the investigation.[4]

Informed consent

Reason for informed consent

In many ways, informed consent serves as a patient's bill of rights. It is the patient's right to be completely informed about the study, to be presented with information that is understandable, and to agree to participate willingly without coercion. Therefore, it is imperative that guidelines exist which ensure safety and eliminate false pretences for human subjects. Protection of research participants is based on three principles: *Beneficence,* which implies that the goal of the study is to maximise the benefits to society while minimising the risks to study subjects; *Respect for persons,* which states that individuals must be respected regardless of their race, age, gender and socioeconomic status. This principle also asserts that certain individuals may be incapable of making decisions without the aid of a guardian or caregiver; and *Justice,* which

declares that risks and benefits must be shared equally among different types of people.[4]

Consent procedures

To properly assess informed consent, the investigator or the coordinator of the research conducts the consent process and presents the study with elements pertaining to the consent. These elements of informed consent include: statement explaining the purpose of the research; the procedures involved and the duration of the study; description of foreseeable risks; description of benefits; disclosure of alternative treatments or procedures; explanation of compensation; list of contacts to help with questions; and a statement that participation is voluntary.[4]

Responsibilities of the principal investigator

Although the patient agrees to participate in the study by signing the consent, informed consent does not absolve the physician/researchers from their responsibility to conduct safe and ethically sound practices. Informed consent also retains the patients'/subjects' right to file a lawsuit against the physician/researchers if wrong doing is suspected. The other responsibilities of the principal investigator include conducting the study in accordance to the approved protocol, maintaining adequate and accurate records and informing the IRB in cases of adverse experiences or deviations from the protocol.[4]

Challenges of obtaining informed consent

Vulnerable populations

There are populations of research subjects that are for various reasons not considered to be fully autonomous and are thus designated by the FDA as ''vulnerable population.'' There are many variables that would affect the level of autonomy, such as ethnicity, education level, age (children), mental capacity, pregnant women and incarcerated prisoners.

Ethnicity and cultural beliefs play a critical role in patient recruitment. In many cultural circles, the idea of primary intervention or prevention is a foreign concept. Many ethnicities do not seek medical help until issues have a risen. Furthermore, the concept of research is unfamiliar to them. Therefore, it is a challenge to convince this population to participate in research. Recruitment of subjects is especially difficult in populations who share the cultural belief that women are considered property of their husband. This adds another problematic dimension since consent is not granted by the patient herself, but from her husband. In such a situation, proper communications play a key role in explaining written consent.[3]

A patient's educational level can also pose a significant challenge for subject recruitment. Potential participants who are illiterate would be unfairly excluded from research since written consent information would make it difficult to fully communicate all aspects of the study for these patients. Patients with below average educational levels would find if difficult to decipher the consent forms since they might not be familiar with the scientific terminology. Ultimately, many potential participants with lower literacy levels are excluded in clinical studies.[3]

In 2000, the FDA established Pediatric Rule which demanded that paediatric trials be conducted for all new medications used to treat conditions or diseases in children. This was to ensure that doctors receive appropriate information to safely prescribe new medications to children. With the surge in request for child participants for clinical research, new concerns and issues have risen regarding informed consent. Due to their legal inability to consent, children are thus part of a vulnerable population. Therefore, to protect the rights of children, the FDA has mandated that children must assent to participate in clinical trials, and their parents or guardians should provide fully informed consent.[4]

Patients with mental disabilities have impaired reasoning and judgment, and are thus considered a vulnerable population. This population includes patients with schizophrenia, manic depression, Alzheimer's disease and substance abuse. Since there are no federal regulations for the protection of human subjects with mental status impairment, the IRBs play a greater role in preserving the rights and safety of these subjects. If and when IRB deems a study fair and reasonable with benefits outweighing the possible risks, mentally ill patients are allowed to participate in the clinical trial. However, a legally competent adult must consent on behalf of the patient.[4]

While it is rare to find pregnant women in clinical trials, the Department of Health and Human Services (DHHS) code has limited their involvement in these studies. This vulnerable population is at potential risk for fetal toxicity as well as for maternal health complications. According to DHHS, pregnant women are only allowed to participate in trials if there is minimal risk to the fetus and if the study meets the mother's health needs. If the research is

only to benefit the fetus, then an informed consent from the father is needed as well. Consequently, pregnant women are also dissuaded from participating in all studies in their early stages due to their uncertain risks.[4]

Lastly, prisoners are considered to be a vulnerable population since they have limited choice and greater chances of being coerced into clinical trials. To ensure that proper ethical measures are taken, the IRBs are granted more responsibilities, which include making certain that risks/benefits are appropriate and that the selection of subjects is conducted in a fair manner. Additionally, federal regulation has mandated that at least one member on the IRB be a prisoner.[4,7]

Emergency research

Voluntary informed consent is the cornerstone of federal policies regulating clinical trials. However, there are situations where a written informed consent is difficult to attain. Such is the case in a critically ill or injured patient who is unconscious or incompetent. Consequently, investigational treatment may be required immediately to resuscitate the patient under a life-threatening situation. However, without the informed consent, the potential life saving experimental therapy cannot be instituted. To better deal with this dilemma, the FDA and DHHS enacted the Final rule in 1996. This rule allowed for a slight exception to the requirements of informed consent when admitting critically ill patients in emergency clinical study. It stated that prior to the study, the IRB must determine that: patients have a life-threatening condition; the experimental treatment is unproven; research is necessary to asses the safety and effectiveness of the treatment; obtaining informed consent from the patient is unfeasible; participation may directly benefit the subjects; the waiver of informed consent is absolutely necessary for the clinical study; the investigator as agreed to contact all legal surrogates; and procedures are in place to allow family members to decline the subject's participation in the study. If these criteria are met, the investigators can proceed with the clinical study.[1,2,6]

Furthermore, additional safeguards have also been instituted due to the vulnerable state of these critically ill patients. This protection method, known as "community consultation," expects the investigators to publicly disclose the study plans, expected risks and benefits to the community. By constantly performing ongoing scientific monitoring on a current trial, community consultation can also determine whether the study should continue to proceed. The goal of this safeguard is to achieve better interaction between the community and the investigators in the hope of better education about the proposed research for the public.[1,2,6]

When informed consent is not necessary

While federal regulations have required informed consent on almost all clinical research, there are instances where it is not necessary. Informed consent is not required for research involving no more than minimal risk. Minimal risk is defined as risk that is comparable to those encountered in daily life. Informed consent is also not required in studies where the consent process may adversely impact the findings by disclosing too much information and creating a bias.[8,9]

As in the case of Final rule, if informed consent is waived in favour of initiating emergency treatment, consent can be deferred until later in the course of the study. This consent can be granted by the patient or his or her representative.[1,2,6,5]

Conclusion

The recent history of human medical research necessitated proper protection of subjects' rights and safety. Through it all, informed consent emerged as a means to uphold ethical behaviour towards patients and to protect them in clinical studies. While it has served its purpose well, it is not without its shortcomings. There are still many challenges encountered in acquiring informed consent. Difficulties faced with vulnerable populations, especially with cultural biases and discrepancies in educational levels, warrant a simplification of the consent forms. Additionally, these challenges also highlight the need for greater emphasis on effective communications and on the consenting process. Therefore, alternative consenting procedures need to be explored as well.

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Improvement of informed consent and the quality of consent documents

Michael Jefford, Rosemary Moore

Guidelines on informed consent intend to protect patients and promote ethical research conduct. To give informed consent, individuals should understand the purpose, process, risks, benefits, and alternatives to research (or a proposed clinical intervention) and make a free, voluntary decision about whether to participate. Many participants have incomplete understanding of various features of clinical trials. Issues associated with the length, format, and language of documents for written informed consent are common. Here, we analyse the written consent form, particularly in the context of clinical research, and the discussions that take place between clinician or investigator and patient. We review strategies to improve consent forms, particularly the use of plain language. Recommendations are made on discussions between investigator and patient to improve participant comprehension and satisfaction with the informed-consent process.

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Introduction

Guidelines on informed consent intend to protect patients and promote ethical research conduct through full explanation of a proposed treatment, including any possible harms, and through the requirement that people freely consent (figure).

In the research setting, the idea of written informed consent dates from at least 1900, when Walter Reed obtained written consent from patients in his research on yellow fever in Cuba.[1] The practice of obtaining informed consent in clinical settings has been done for centuries, founded partly on perceived obligations derived from the Hippocratic oath. To some extent, the practice of informed consent in clinical care and in the research setting have evolved separately, leading to increased regulation in the research setting.

An important event in the codification of informed consent occurred in the USA in 1914 when Justice Cardozo laid down the basic principle that has shaped US law on informed consent and affected developments elsewhere. The principle is that: "every human being of adult years and sound mind has a right to determine what should be done with his own body".[2]

The Nuremberg Code was developed in 1947 after human experimentation by Nazi doctors and the trial of those responsible. This Code established a set of principles and guidelines for the ethical conduct of clinical research and was a foundation for future guidelines.

In the clinical setting, the term "informed consent" arose in the USA in 1957. It shifted emphasis from medical paternalism towards that of a duty to respect patient autonomy. Californian law created an "informed-consent standard", stating that the nature, consequences, harms, benefits, risks, and alternatives of a treatment was the information needed by an ordinary person to make a "reasonable" decision about its acceptance or rejection.[3]

The World Medical Association Declaration of Helsinki in 1964[4] established worldwide ethical principles for medical research that involved human participants:

> "...each potential subject must be adequately informed of the aims, methods...anticipated benefits and potential risks of the study and the discomfort it may entail. The subject should be informed of the right to abstain from participation in the study or to withdraw consent to participate at any time without reprisal. After ensuring that the subject has understood the information, the physician should then obtain the subject's freely given informed consent, preferably in writing".

Ethics guidelines for scientific research that involves human beings have been founded on these important principles.[5] An "informed-consent doctrine" gradually evolved that was consistent with these guidelines and legal precedents.[6] A US court case of Cobbs *vs* Grant[7] noted that the doctrine of informed consent is "anchored" in four postulates: first, patients are generally ignorant of medicine; second, patients have a right to control their body and decide about medical treatment; third, consent to treatment must be informed to be effective; and fourth,

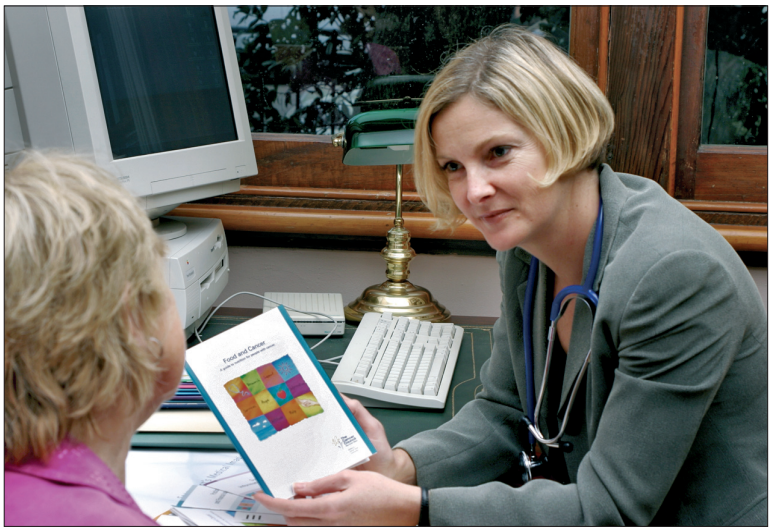

Figure: **Consent discussions between patients and investigators or clinicians are crucial for patient understanding**
Reprinted with permission of The Cancer Council, New South Wales, Australia.

patients depend on their physicians for truthful information and must trust them. These postulates refer to clinical treatment, but also apply in the research setting.

Main principles of informed consent

Informed consent has two main aims: first, to respect and promote participants' autonomy; and second, to protect them from potential harm. Provision of information in an understandable way lends support to both these aims. Furthermore, guidelines promote ethical conduct of research by establishing a standard and by reflecting community expectations. Patients need to understand the diagnosis, prognosis, nature and purpose of the intervention, alternatives, risks, and benefits—these are minimum requirements for genuine informed consent. Participant satisfaction with the consent process is also a desirable outcome.

International guidelines for research that involves human beings include the International Conference on Harmonisation (ICH) Guideline for Good Clinical Practice.[8] Country-specific guidelines also inform clinical research (eg, the Australian National Statement on Ethical Conduct in Human Research[9] and the US National Institutes of Health Guidelines for the Conduct of Research Involving Human Subjects[10]).

Ethics committees or institutional review boards are required to review and approve the process of obtaining informed consent and the written information for prospective participants to ensure that these guidelines are followed.

Clinical care and clinical research: similarities and differences

Respect for patient autonomy and protection from harm are paramount in clinical care and research settings. Patients need information to make informed decisions. Reasons for a potential intervention and the potential negative effects should be explained to the patient in an understandable way.

However, clinical care and clinical research differ. The main aim of clinical care is to benefit a patient. By contrast, the main aim of research is to gain new knowledge; benefits from such research are reaped mainly by future patients.[11] Many clinical trials are reasonable therapeutic options. However, clinical research might have a risk of additional side-effects. New treatments might be associated with unknown or theoretical risks. In this circumstance, there might be a greater need to tell participants about these potential side-effects.

Thus, the standard for informed consent in clinical care or research might differ depending on the context or level of risk. In practice, clinical research is more tightly controlled by regulatory codes and has greater oversight by ethics committees or institutional review boards compared with informed consent in clinical care.

Issues with the consent process

Emphasis on disclosure

Current practice in obtaining informed consent seems to have been shaped by emphasis on the legal duty of disclosure, particularly in the research setting. Consent is seen as an action, concluded by signing a form. However, informed consent needs not only disclosure and a signature, but also promotion of participants' understanding of the research project and the voluntary nature of their decision to participate.[12]

The written informed-consent document (ie, consent form) is an important part of the requirement to disclose and advise participants of the details of a proposed trial. Although the form has been said to give "legal and symbolic documentation of an agreement to participate",[13] the length and complexity of informed-consent documents hinder participant understanding.[14] Viewing the consent form mainly as a legal document tends to hinder attempts to create reader-friendly documents: "many sponsors and institutions appear to view them primarily as a legal instrument to protect them against litigation".[15]

Poor participant understanding

For participants, signing of the consent form is meant to indicate their agreement to participate in the trial and confirm that they understand the aim and risks of the trial and their participation in it. However, this agreement and confirmation might only be symbolic: signing does not always represent understanding. Patients might have incomplete or incorrect understanding of matters relevant to an informed decision to join a clinical trial.[14,16–33]

In a cross-sectional survey[34] of participants in clinical trials of cancer treatments, Joffe and colleagues used a validated measure of "quality of informed consent". They found that 186 (90%) of 207 respondents were satisfied with the informed-consent process and considered themselves well informed. However, many were unaware of particular features of trials, including the unproven nature of the treatment, the uncertainty of benefits to themselves, or the main aim of trials to benefit future patients.[29] In Australia, we found high levels of satisfaction with the decision to participate in clinical trials, but again, substantial problems in understanding.[14]

Inadequate explanation

Sometimes, features of trials are not discussed adequately and patients might not have the opportunity to ask questions. For example, in audiotaped discussions in which consent was sought for participation in a randomised study, the word "randomisation" was used in only 62% of discussions and patient understanding checked in only 17% of discussions.[35] Although the word "randomisation" might not be appropriate, the idea is important and patient understanding should be checked in all situations.

A study[36] of paediatricians' explanations and parents' understanding of randomisation in trials of leukaemia in childhood recorded that physicians explained randomisation in 83% of discussions and a consent form was presented during 95% of discussions. However, only 50% of parents understood randomisation.[36] In audiotaped consultations in which informed consent was sought, patients rarely received complete information to make a decision and physicians rarely checked patients' preferences for the type and amount of information.[37] Although all patients should understand the fundamental idea of a proposed intervention, some might desire further information that might be excessive for others.

Physicians might be both the patient's treating doctor and trial investigator, which might create a situation in which doctors inappropriately direct patients towards trial involvement or limit full disclosure. Potential conflict of interest is a serious concern, although full discussion is beyond the scope of our review. Nevertheless, this dual relation might contribute to inadequate disclosure. In a survey[30] of 412 members of the Swedish Society of Oncology, 45% of doctors thought that patients might not participate if they were adequately informed. In a randomised study,[38] Simes and colleagues showed that total disclosure of all relevant information, rather than an individual approach at the discretion of the doctor, was associated with less willingness to agree to randomised treatment; however, the strategy led to better patient understanding.

Emanuel and colleagues[5] suggest "to enrol individuals in clinical research without their authorization is to treat them merely as a means to purposes and ends they may not endorse and deny them the opportunity to choose what projects they will pursue." Consent forms need to advise of all reasonable alternatives to joining a trial, including, for example, the possibility of not pursuing further anticancer treatment, but receiving best supportive care that includes optimum palliative care.

The written consent form: readability and comprehension

Written consent is needed for almost all studies. For more than 25 years, researchers have noted that consent forms might be written inappropriately.[15,39,40]

In the US Department of Health and Human Services, consent forms are required to be "in language understandable to the subject or representative".[40] The ICH guideline recommends use of oral and written language that is "as non-technical as practical and... understandable to the subject". The US National Institutes of Health recommend writing that is understandable at the reading level of eighth grade or lower at school.[10]

Although material for patient information might call for a reading-comprehension ability that is between 10th and 14th grade in US schools,[41,42] patients in public hospitals might have an average reading comprehension of around 6th grade.[42] Informed-consent forms fare little better: reading levels might be as high as grade 11.[40] Grossman and colleagues noted that only 6% of 137 consent forms had readability at or below 8th grade using the Flesch Kincaid formula. In an analysis of 107 consent forms from cancer clinical trials, none was written at or below 8th grade reading level and only 11% were below 10th grade.[15]

Almost half of US adults read at or below 8th grade level.[43,44] Australians are likely to have similar literacy levels: a national literacy and numeracy survey noted that half the population were likely to have substantial difficulty with written materials used in everyday life.[45]

A person's reading-comprehension level might be several grades lower than the last grade level they completed at school. Self-reported education levels do not accurately measure health literacy.[44,46] Consent forms and other material for health education should be written at least three grade levels lower than the average educational level of the target population.[46]

Plain language

Plain language (commonly called plain English) is straightforward and easy to understand. Advocates have called for its use in government, legal, and medical documents since the 1970s, when plain-English movements arose in the UK and the USA, and then worldwide (panel 1).

In non-clinical-trial settings, information written in plain language assists in decision making about medical treatments,[47] strengthens intentions to implement clinical guidelines, increases positive feelings towards the guidelines, and leads to perceived greater control using the guidelines.[48]

In clinical trials, simplified information appeals to patients.[49] It is associated with decreased anxiety about consent and increased satisfaction with the informed-consent document.[31]

Modification of consent forms

Various studies have looked at improving the readability of the consent form. Some have concluded that understanding might be improved if the consent form is easy to read.[50–54] Others suggest that understanding and recall might be improved if care is taken in reading the consent form[16,23] and if sufficient time is allowed to read them.[21,55] Short consent forms might also be useful.[13,15,51]

***Panel 1:* Websites about plain language**

These websites (accessed Feb 15, 2008) can give advice and examples on many principles of plain language:
www.askoxford.com/betterwriting/plainenglish/
www.plainlanguage.gov
www.plainlanguagenetwork.org
www.health.gov/communication/literacy/plainlanguage/
www.plainenglish.co.uk

Enhanced and simplified print versions might benefit people with poor reading skills.[56]

Simplification of consent forms to improve readability might be part of the answer, but not the whole solution. Several studies[31,49] have noted positive findings from simplifying consent forms, but these do not always include improved comprehension.

Coyne and colleagues[31] did a randomised comparison (n=207) of an easy-to-read consent form with that of a standard consent form. They postulated that the modified form would lead to higher patient comprehension and satisfaction, lower anxiety, and higher patient accrual compared with the standard form. Patients who were assigned the easy-to-read consent form showed significantly lower anxiety to giving consent and higher satisfaction than did those assigned the standard form. However, comprehension and state anxiety (anxiety that is triggered by events or situations, as opposed to trait anxiety, which is the tendancy of a person to show anxious behaviour) did not differ between groups.

Davis and colleagues[49] postulated that a simplified consent form would be less intimidating and more-easily understood by individuals with poor to marginal reading skills than a standard consent form. Participants were mostly healthy and were asked to consider a hypothetical clinical trial. They were asked to read either a standard consent form (written at 16th grade level) or a simplified form (written at 7th grade level). Participants were interviewed to assess their attitudes towards, and comprehension of, the standard form and then were given the alternate consent form and asked which they preferred and why. Overall, participants preferred the modified, simpler form. Most considered this simplified form easier to read than the standard form. However, the level of understanding generated by both forms was similar. Importantly, this study did not assess patient preference and understanding in the context of a real trial—the participants did not have cancer and did not need to make a decision about trial participation.[49]

Flory and Emanuel[57] did a systematic review of studies that were designed to improve trial participants' understanding of information disclosed in the informed-consent process. They reviewed 30 eligible studies of 42 trials. Interventions to improve understanding were categorised into five groups: multimedia; enhanced consent form; extended discussion; test or feedback; and miscellaneous. 12 trials of multimedia interventions (two in a cancer setting) showed that they commonly did not improve understanding. Of the 15 trials with enhanced consent forms, six showed significantly improved understanding, whereas nine did not; one of the trials enrolled patients with cancer.[31] Extended discussion between study staff and participants significantly increased understanding in three of five trials (one of which enrolled patients with cancer[58]). All five trials that assessed test or feedback strategies showed improved understanding; however, these studies have important drawbacks in their methods. Flory and Emanuel[57] suggest that improved person-to-person interactions (ie, extended discussions and, possibly, test or feedback) are the most effective strategy to improve participant understanding. However, they also conclude that further research is needed.

In summary, research suggests that modification of the content, writing style, format, or length of the consent form is no more successful than other approaches that aim to improve comprehension.[57] Do we therefore abandon efforts to improve the consent form? For several reasons, we think that attention must continue to be paid to the language of the consent form. In clinical trials, simplified language appeals to patients and is associated with decreased anxiety and increased satisfaction. Knowledge of the usefulness and comprehension of the consent form from the perspective of others who might use it would be useful. For example, parts of the consent process might be administered by health-care professionals other than the investigator, or the patient might discuss the consent form with their general practitioner. These professionals might welcome simple explanations of the trial that are easy to convey.

Knowledge of whether family members influence the decision to participate; whether they rely on the consent form to exert influence; and whether plain language is more acceptable and comprehensible to them compared with language used in standard forms would be useful. To decide on the basis of the review by Flory and Emanuel[57] that plain language should be abandoned and consent forms allowed to develop into even longer and more complex documents would be a mistake. There seems to be no reasonable argument for retaining the highly technical language that is commonly found in consent documents. The act of explaining has positive effects apart from comprehensibility and, importantly, "represents a tangible commitment to the informed-consent process".[40]

The discussion

Alongside written information comes the discussion between a prospective trial participant and the investigator, trial coordinator, research nurse, or research assistant.

Although the patient's signature might represent agreement, it does not imply understanding. It might be evidence of consent, but not proof. Given the duty of disclosure and the patient's individual circumstances, researchers should record details of risks explained, queries and concerns raised by patients, and responses to these queries. An attempt to assess understanding should be made and documentation recorded.

Various recommendations have been made on making the information given brief, simple, and clear; on

***Panel 2:* Checklist for clear communication**

- Use familiar words and ideas
- Use short words and sentences where possible
- Avoid misleading descriptions
- Use readability checkers or formulae to estimate reading grade level (see panel 3)
- Discuss standard treatments and trial treatments
- Encourage support from others
- Give information to take away
- Check understanding

presenting risk information that might raise anxiety in a non-threatening way; and on involving potential study participants by asking them to answer multiple-choice questions or writing about the information.[59]

Decision aids and prompts

A decision aid might improve satisfaction and understanding, at least for some studies and some patients. A decision aid for women who were considering participation in prevention studies for breast cancer seems to have been received favourably.[60] After reading the decision aid, women seemed to have good subjective understanding of the clinical trial.

Currently under investigation in a randomised controlled trial is the use of a question prompt sheet about clinical trials. These sheets increase question-asking, and, when endorsed by the doctor, decrease anxiety, shorten consultations, and improve recall of information.[61]

Training of investigators

In 1997, Skene and Millwood,[62] showed poor understanding by doctors of the law's requirements for disclosure, which might be improved with increased education.[62] The researchers suggest that medical journals are an important way that doctors gain new knowledge. Gore[63] highlighted a hospital-based postgraduate education programme on ethical issues including informed consent. As discussed earlier, a validated measure exists to assess the quality of informed consent,[34] which enables comparisons between different approaches.

Brown and co-workers[64] have established a set of ethical communication strategies based on ethical, linguistic and psychological theory to assist doctors when discussing possible trial participation. Moreover, they assessed the effect of a 1-day communication skills training workshop,[65] which seemed to have some modest effect.

Improvement of the consent process

Plain language aims to simplify explanations such that the meaning is clear to a readership with varying reading experience and abilities. A clear and simple message is likely to be understood by more people than a message with complex wording.

Plain language is important during the consent discussion. The discussion allows for checking of understanding—an important advantage over a form, however simply it is written. Panel 2 is a checklist for clear communication.

Suggestions for writing a consent form

Use of familiar words and ideas

Most trial sponsors and investigators tend to use technical language. However, research participants might have poor or incomplete understanding of medical or research terms. Furthermore, some trial-related terms such as "protocol", "open-label", and "subsequent" might be understood poorly.[66]

If possible, terms that are likely to be familiar to people without specialised health knowledge should be used. Writing that includes familiar vocabulary and ideas is easy to read and comprehend.[67]

Some ideas, even when worded simply, might be inaccessible to some people, which might explain the failure of strategies intended to improve readability and therefore comprehension. For example, Bjorn and colleagues[50] highlight that older people had difficulty understanding "randomisation", even when explained simply. Consistent evidence of such difficulties should alert investigators to focus on these challenging areas during discussions of informed consent.

Use of short words and sentences

Words of three or fewer syllables should be used when possible; words of more than three syllables begin to affect readability.[40] However, health-care professionals are unlikely to be able to (or want to) produce a consent document written entirely in very short words and sentences. Rather, consideration should be given to improving readability through use of short, but equally acceptable, words, and through breaking longer sentences that contain several ideas into shorter sentences that contain only one.

The paragraph below has several words of more than three syllables and is assessed by the Flesch-Kincaid readability checker as around grade level 15 (panel 3). The first sentence also contains several different ideas:

> "As with any experimental treatment, additional unexpected and sometimes serious side effects, apart from those listed here, are a possibility. If you have any unusual symptoms, you should report them to your medical practitioner immediately".

A rewritten version below has shorter words (and is a little longer because it includes an explanation of "experimental"). It is assessed as grade level 5·2. We have rewritten the sentences to decrease the ideas in every one. We thought it important to stress to patients to see their doctor about any health change, rather than leaving it up to them to determine whether a symptom is "unusual":

***Panel 3:* Establishment of document readability**

Readability can be calculated through various formulae. Microsoft Word (Microsoft Corporation, Washington, DC, USA) can calculate readability according to two formulae: Flesch reading ease and the Flesch–Kincaid grade level. In versions of Word older than 2007, select "Tools", followed by "Options", and "Spelling and Grammar". Tick the box: "Show readability statistics". After running a check of spelling and grammar, a box will indicate Flesch reading ease (score ranges from 0 to 100, low numbers indicating harder-to-read text) and the Flesch–Kincaid grade level. The grade level indicates that the text might be understood by a typical student in that US grade of schooling.

> "This treatment is experimental. This means it has not been tested very much on people. We know about side effects that can sometimes happen with this experimental treatment. The known side effects are listed on this page. But there could be side effects that we don't yet know about. Tell your doctor right away about any change in your health".

However, the meaning should not be compromised by needless simplification of long words to improve readability score.[68] In an example about chemotherapy below, there is no need to replace "chemotherapy" in a plain-language statement for an adult. It is a term that people who can read adequately will come to recognise during treatment:

> "The aim of chemotherapy is to kill cancer cells that may have escaped treatment and still be in the body. These cancer cells could cause the cancer to return".

Note that some short words are difficult and unfamiliar, such as "protocol"; arguably, so too is "research". It is important to try to use familiar words and check understanding with the person during the consent discussion.

Plain language is not the same as children's writing

Most people appreciate that plain language and simple materials do not offend people who are highly educated.[31] The example below is from a book that explains breast cancer to children.[69] Children's writing is characterised by intensifiers and repetition, and commonly has a story form:

> "'Then why do you have to keep having the medicine?', Harriet asked. 'Good question', said Mum. 'It's to try to make sure that every little bit of the cancer is gone. Cancer can grow again from a very small bit. So small that it's hard to see. And we want to make sure that every little bit has gone'".[69]

The same information in plain language for an adult would read like the chemotherapy example above. Unlike children's writing, plain-language writing for adults permits some difficult words and the option to include a glossary or explanation of difficult terms. It also assumes some level of knowledge—eg, some understanding or ability to grasp the idea of "cells".

Use of bullet points to break-up long explanations

Even experienced readers can find a long and dense paragraph daunting. Note the following example:

> "The effects of this treatment on the unborn child are not known. If childbearing is a possibility, you will be required to undergo a pregnancy test prior to commencing the study. If you are male, you should not father a child while participating in this study. Male participants are strongly advised to use effective contraception during the course of the study and for a period of 12 months after the completion of the study. Women of childbearing potential must agree to use a reliable method of birth control for the duration of the study and for a period of 12 months after the completion of the study".

This text can be summarised into bullet points:

> "The effects of this treatment on the unborn child are not known.
>
> - You must not become pregnant or father a child while in the study.
> - Women who may become pregnant will be asked to have a pregnancy test before joining the study.
> - Men and women must use reliable contraception while in the research study and for 12 months afterwards".

Avoidance of misleading descriptions

Potentially misleading descriptions need to be anticipated and avoided. For example, use of "treatment" rather than "experimental treatment" in phase I clinical trials might reinforce misapprehension that the study is aiming to treat rather than test toxic effects or establish a maximum tolerable or a biologically effective dose. In traditional dose-finding phase I studies, investigators need to state clearly that the trial is experimental, and should be clear that benefit from the trial is unlikely.[32] The table shows examples of other language to avoid.

Use of readability checkers or formulae to estimate reading level

Advice on which reading level to aim for in patient information ranges from about 4th grade to that of 9th grade.[15,43,66] Achievement of a low reading grade alone is inadequate to ensure good understanding and comprehension.[44] Moreover, a readability checker does not assess sense (panel 3).

Suggestions for the consent discussion

Extended discussions between study staff and research participants might improve patient understanding. Further research is needed on the content of, and other matters around, consent discussions.[57] Aaronson and colleagues[58] assessed patients with cancer who were considering

	Original language	Improved language
People are not tumours	"You have progressed on..."	"The cancer has grown..."
	"You have failed chemotherapy"	"The chemotherapy is no longer helping you"
Avoid language that might be inappropriately persuasive or exploits vulnerability	"You have been invited..."	"This trial might be suitable for you"
	"If you are eligible..."	"If the trial is suitable for you..."
	"Because there are no other options..."	"Instead of being in this study, you might decide to have..."
Address the reader as "you" and consider their perspective	"Study participants will..."	"If you choose..."
	"Giving study medication intravenously and collecting blood samples might involve temporary discomfort or bruising"	"If you choose to join this trial, you will have the drugs through a needle in your arm. The doctor will also use a needle to take blood for testing. You might have a bit of pain or bruising from the needle"

Table: **Examples of language found in consent forms that could be improved**

participation in phase II or III studies. Patients received standard consent discussions, with or without a subsequent nurse telephone contact. Those who had the additional telephone discussion were more informed about several features of trial participation compared with those who did not have the telephone discussion.

We recommend being mindful of most of the plain-language features discussed above for written consent documents. In addition, the discussion should also take into account the following.

Discussion of standard treatments and trial treatments

Information about the trial should be presented clearly and simply.[59] The conversation should first include a discussion of standard treatments, followed by discussion of potential treatment as part of a clinical trial.[37,70]

All matters relevant to a particular person must be discussed, including procedures, risks, costs, time implications, and their own understanding of personal benefit from the trial. People must understand that they can withdraw from the trial at any time without explanation and without compromising their medical care. Verbal presentation of items normally included in an informed-consent document and responses that are reflective, patient-centred, and supportive might be associated with increased accrual to clinical trials.[71]

Encouragement of support from others

Involvement of people in the processing of information is important.[59] The patient should be encouraged to have a friend or relative with them, and they might wish to have an extra nurse or other professional attend the interview with them.[29,70,72]

Provision of information to take away; encouragement of time to consider

The patient should, according to their preference, be given written information or a recording of the conversation (or both).[72] Delaying of consent might increase satisfaction with participation and improve understanding.[14,29,70–73]

Checking of understanding

Health-care professionals should check patients' understanding. Patients should be asked whether they have any questions and be offered time to think about the information and discuss with others.[74] So-called teach back can confirm understanding.[44,57] Health-care professionals ask the person to say in their own words what has been described, and ask again if the patient's words show incomplete or inaccurate understanding.[75] The question, "Do you understand?" should not be asked; people will generally answer, "yes". Patients might think that they have understood the information and might report high levels of satisfaction, but have poor understanding.[14,29]

Conclusion

> "Making sure that patients are fully informed before they agree to be included in any randomized clinical trial has been, and continues to be, an immense challenge for all who are concerned with the ethical advancement of science".[76]

Many studies have assessed the language of consent. Recently, they have focused on the content and particularly the language of the written-consent form. However, conclusions such as those reached by Flory and Emanuel[57] reinforce the importance of discussion between the investigator or clinical-research professional and the patient.

There are reasons for putting effort into the production of plain-language participant information and consent forms. However, evidence suggests that these forms should not be relied on solely to ensure that a person understands details about a trial. Plain-language forms should be seen as part of the process that aims to achieve meaningful informed consent.

Consent is a process, rather than an event, and professionals and research participants should continue to engage in conversation to ensure good understanding, satisfaction, and continuing consent to participate.

Search strategy and selection criteria

Data for this review were identified by searches of Medline, PsychInfo, and CINAHL and from references of relevant articles using combinations of the search terms: "clinical trials"; "informed consent"; "consent forms"; "comprehension"; "communication"; "reading"; "health education"; "physician–patient relations"; and "neoplasms". Abstracts and reports from meetings were included only when they related directly to previously published work. Only papers published in English between 1980 and September 2007 were included.

Conflicts of interest
The authors declared no conflicts of interest.

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หัวข้อ : Breaking bad news

การแจ้งข่าวร้าย

Breaking Bad News

รองศาสตราจารย์นายแพทย์ สุพจน์ พงศ์ประสบชัย

ภาควิชาอายุรศาสตร์ คณะแพทยศาสตร์ศิริราชพยาบาล

ความสำคัญ

การแจ้งข่าวร้าย (breaking bad news) เป็นทักษะการสื่อสารอันหนึ่งที่มีความสำคัญอย่างยิ่งของแพทย์ในเวชปฏิบัติ เนื่องจากแพทย์ต้องเกี่ยวข้องกับการแจ้งข่าวร้ายแก่ผู้ป่วยและญาติเสมอ ๆ ไม่ว่าจะเป็นการแจ้งผลการวินิจฉัยโรค การสืบค้นที่ผู้ป่วยต้องได้รับ การรักษา ผลการรักษา และพยากรณ์โรค ข่าวร้ายเป็นสิ่งที่ไม่มีผู้ป่วยคนใดปรารถนา แพทย์เองก็ไม่พึงปรารถนาและบางท่านอาจรู้สึกว่าการแจ้งข่าวร้ายเป็นเสมือนการทำร้ายผู้ป่วยและพยายามหลีกเลี่ยงไม่อยากทำ แต่ข่าวร้ายคือความจริงและจะเป็นประโยชน์อย่างยิ่งยวดต่อผู้ป่วยในอนาคต การหลีกเลี่ยงการแจ้งข่าวร้ายจึงอาจเป็นการทำร้ายผู้ป่วยทางอ้อมและมักก่อผลเสียต่อผู้ป่วยในที่สุด

การแจ้งข่าวร้ายเป็นการสื่อสารแบบหนึ่ง แต่มีเรื่องของอารมณ์และความรู้สึกของผู้รับสารร่วมด้วยอย่างมาก แพทย์ที่ต้องแจ้งข่าวร้ายจึงต้องประณีตในการทำ ไวต่อความรู้สึก มีความรู้ ทักษะ และต้องใส่หัวใจเข้าไปในการทำด้วยเสมอ การแจ้งข่าวร้ายไม่มีเทคนิคมาตรฐาน แต่มีหลักการที่ขอเพียงแค่แพทย์เข้าใจ นำไปฝึกฝน และใส่หัวใจเข้าไปในการทำก็มักจะทำได้ดี ทักษะการแจ้งข่าวร้ายเป็นทักษะสำคัญที่แพทย์ขาดไม่ได้แต่น่าแปลกที่กลับมีการสอนทักษะการแจ้งข่าวร้ายในโรงเรียนแพทย์ค่อนข้างน้อย ทำให้แพทย์จำนวนมากไม่มั่นใจและพยายามหลีกเลี่ยงเพราะเกรงว่าถ้าทำได้ไม่ดีจะเกิดผลร้ายต่อผู้ป่วยตามมามากกว่าผลดีและกลัวว่าญาติผู้ป่วยอาจไม่เข้าใจหรือไม่พอใจ เป็นต้น ความกลัวเหล่านี้เป็นมิจฉาทิฐิ เพราะทำให้ผู้ป่วยที่เราต้องการรักษาประโยชน์กลับกลายเป็นเสียประโยชน์ในที่สุด

ควรแจ้งข่าวร้ายแก่ใคร ผู้ป่วยหรือญาติ หรือทั้งคู่?

หลักการ

ในสังคมโลกตะวันตกนั้นการแจ้งข่าวร้ายเป็นสิ่งที่ต้องแจ้งกับผู้ป่วยโดยตรงตามหลักของสิทธิผู้ป่วย (patient autonomy) แต่ในสังคมโลกตะวันออกรวมทั้งประเทศไทยนั้น กลับกลายเป็นว่าแพทย์จำนวนมากเลือกที่จะแจ้งข่าวร้ายแก่ญาติมากกว่า (ยกเว้นโรคเอดส์เพียงโรคเดียวที่แพทย์จะแจ้งแก่ผู้ป่วยเท่านั้น) โดยเฉพาะถ้าเป็นข่าวที่ร้ายมาก ๆ เช่น โรคร้ายแรงถึงชีวิต หรือโรคมะเร็ง เป็นต้น ด้วยเหตุผลต่าง ๆ นานา เช่น กลัวผู้ป่วยจะรับไม่ได้ (แต่กลับคิดว่าญาติจะรับได้) กลัวผู้ป่วยทรุด (ซึ่งส่วนใหญ่ไม่เป็นความจริง ถ้าแจ้งข่าวร้ายอย่างถูกต้อง ผู้ป่วยอาจซึมเศร้าไปช่วงหนึ่ง แต่ในระยะยาวผู้ป่วยมักค่อย ๆ ดีขึ้น) แต่เหตุผลลึก ๆ ที่แพทย์มักกังวล คือ แพทย์กลัวว่าถ้าบอกข่าวร้ายไปแล้วผู้ป่วยแย่ลง ญาติจะไม่เข้าใจและจะมาเอาเรื่องแพทย์ในภายหลัง

ดังนั้นเมื่อคำนึงถึงสิทธิผู้ป่วยและประโยชน์ต่อผู้ป่วยในระยะยาวแล้ว การแจ้งข่าวร้ายควรให้แก่ผู้ป่วยเป็นหลัก ยกเว้นผู้ป่วยไม่ต้องการรู้ ไม่มีสติสัมปะชัญญะ หรือแพทย์คิดว่าข่าวร้ายนั้นอาจไม่มีประโยชน์ใด ๆ ต่อผู้ป่วยอีกแล้ว เช่น ผู้ป่วยอายุมากๆ และโรคร้ายเป็นมากจนน่าจะอยู่ได้อีกไม่นาน ผู้ป่วยอยู่บนเตียงไม่สามารถทำอะไรได้นัก เป็นต้น ข้อมูลในผู้ป่วยไทยที่เป็นโรคมะเร็งที่โรงพยาบาลศิริราช พบว่าประมาณร้อยละ 90 อยากให้แพทย์บอกการวินิจฉัยตามจริง ในขณะที่ประมาณร้อยละ 10 อยากให้แพทย์บอกกับญาติมากกว่า (ข้อมูลจากอาจารย์นายแพทย์ไพโรจน์ สินลารัตน์ สาขาวิชาเคมีบำบัด โรงพยาบาลศิริราช) ข้อมูลนี้ทำให้แพทย์ต้องทำความเข้าใจใหม่ว่าแท้จริงแล้วผู้ป่วยไทยส่วนใหญ่ก็ยังต้องการให้แพทย์แจ้งข่าวร้ายแก่ตนตามจริงมากกว่า

ประโยชน์จากการที่ผู้ป่วยได้ทราบความจริง

ข้อดีของการที่ผู้ป่วยทราบความจริงมีมากมาย ได้แก่

1. ผู้ป่วยจะได้วางแผนชีวิตของตนเอง เมื่อข่าวร้ายนั้นมีผลอย่างมากต่ออนาคต แพทย์หรือญาติที่ไม่ใช่ผู้ป่วย ย่อมไม่มีทางรู้ว่าผู้ป่วยต้องการอะไรและกำลังวางแผนชีวิตอะไรอยู่

2. ผู้ป่วยจะสามารถเป็นผู้ตัดสินใจเลือกการสืบค้นหรือการรักษาได้ด้วยตนเอง ในกรณีที่เป็นการตรวจหรือรักษาที่มีความเสี่ยง (เช่น การผ่าตัด การให้เคมีบำบัด เป็นต้น) หรืออาจตัดสินใจได้ยาก (เช่น การเลือกที่จะใส่ท่อหายใจหรือการปฏิบัติการกู้ชีวิต เป็นต้น) ผู้ป่วยย่อมเป็นผู้ตัดสินใจได้ดีที่สุด

3. ไม่มีความลับระหว่างแพทย์กับผู้ป่วยหรือญาติกับผู้ป่วย ทำให้การพูดคุยเป็นไปได้อย่างเปิดเผย ไม่ต้องงุบงิบลับ ๆ ล่อ ๆ ไม่ต้องคอยระวังว่าความลับจะแตก *ไม่เคยมีแพทย์หรือญาติสามารถปิดบังความลับต่อผู้ป่วยได้* เพราะผู้ป่วยจะรู้ตัวเองเสมอ ทั้งจากอาการของตนเองที่ทรุดลงเรื่อย ๆ จากท่าทีของแพทย์ ท่าทีของญาติ และจากการหลุดปากของคนรอบตัว การที่ผู้ป่วยมักรู้ความจริงเองแต่ไม่ครบถ้วนอาจทำให้ผู้ป่วยเข้าใจผิด ๆ และมักกังวลไปในทางที่ร้ายกว่าความเป็นจริง ผลคือ *ผู้ป่วยต้องเผชิญกับความทุกข์อย่างโดดเดี่ยว เพราะไม่สามารถคุยกับใคร ไม่สามารถปรับทุกข์กับใคร และไม่สามารถร้องไห้กับใคร* เพราะคนรอบข้างพยายามปิดบังไม่พูดถึงเรื่องนี้ ทำให้บรรยากาศในครอบครัวเต็มไปด้วยความเงียบเหงาและความอึดอัด (conspiracy of silence) ทั้ง ๆ ที่เวลานี้เป็นเวลาที่ผู้ป่วยต้องการคนที่รักมาช่วยรับฟังและให้การประคับประคองอย่างที่สุด

ผู้ป่วยน่าจะเป็นผู้เลือกว่าอยากให้แพทย์แจ้งข่าวแก่ตนเองหรือแก่ใคร

ผู้ป่วยแต่ละคนมีพื้นฐานและบริบทของตนเอง ผู้ป่วยจึงเป็นผู้ที่เหมาะสมที่สุดที่จะเลือกว่าอยากให้แพทย์แจ้งข่าวแก่ตนเองโดยไม่ต้องบอกญาติ หรือให้แจ้งญาติโดยไม่ต้องบอกตน หรืออยากให้แจ้งแก่ทั้งตนและญาติพร้อม ๆ กัน ซึ่งแพทย์สามารถส่งเสริมความต้องการนี้ได้โดยการคุยกับผู้ป่วยและญาติตั้งแต่การมาตรวจครั้งแรก ๆ หรือก่อนจะรู้ผลตรวจ เช่น การพูดว่า

"คุณสมชาย (ผู้ป่วย) ครับ ผมขอปรึกษาหน่อยครับ อยากทราบว่าครั้งหน้าถ้าได้ผลตรวจแล้ว อยากให้หมอแจ้งกับคุณสมชายโดยตรง หรืออยากให้แจ้งกับญาติ ๆ หรืออยากมาฟังด้วยกันทั้งหมดครับ" เป็นต้น

หากญาติกังวลไม่อยากให้แพทย์แจ้งข่าวร้ายแก่ผู้ป่วยจะทำอย่างไร

บ่อยครั้งญาติจะแอบมาบอกแพทย์ก่อนว่า ถ้าเป็นโรคร้าย (เช่น มะเร็ง) ไม่ให้บอกผู้ป่วยเป็นอันขาดเพราะกลัวผู้ป่วยจะทรุด ความห่วงใยของญาติแบบนี้ก็เป็นที่เข้าใจได้ แต่ส่วนใหญ่เกิดจากความเข้าใจผิด แพทย์ไม่จำเป็นต้องทำตามใจญาติ แต่ควรพูดคุยกับญาติอย่างเข้าใจ ชื่นชมในความห่วงใยของญาติ ถามเหตุผลที่คิดเช่นนั้น แก้ไขความเข้าใจผิด เช่น กลัวผู้ป่วยจะทรุด เป็นต้น บอกประโยชน์ที่ผู้ป่วยจะได้หลังจากทราบความจริงตามเหตุผลต่าง ๆ ที่กล่าวแล้วข้างต้น และบอกญาติให้คลายกังวลว่าแพทย์มีกระบวนการแจ้งอย่างข่าวร้ายอย่างระมัดระวัง ไม่ต้องวิตก จากประสบการณ์ของผู้เขียนพบว่าญาติมักเข้าใจและยินดีให้บอกความจริงแก่ผู้ป่วยเกือบทุกราย แต่หากญาติยังไม่เข้าใจและยืนกรานไม่ให้บอกผู้ป่วย ผู้เขียนแนะนำว่าอาจทำตามความต้องการของญาติไปก่อน ไม่ควรหักหาญน้ำใจ แล้วค่อย ๆ พยายามอธิบายใหม่ในครั้งต่อ ๆ ไป หรืออาจบอกญาติว่าแพทย์จะลองเลียบเคียงถามจากผู้ป่วยดูว่าพอจะทราบอะไรมาแล้วบ้าง ซึ่งถ้าพบว่าผู้ป่วยพอทราบมาก่อนแล้ว ก็สามารถอธิบายญาติให้ยอมรับว่าผู้ป่วยพอรู้แล้ว ไม่น่าต้องปิดบังอะไรอีก หรือเมื่อถึงจุดที่ต้องมีการตัดสินใจที่ยาก เช่น เลือกจะให้เคมีบำบัดหรือผ่าตัดหรือไม่ เป็นต้น ซึ่งแพทย์น่าจะถือโอกาสนี้ชี้ให้ญาติเห็นว่าถ้าผู้ป่วยทราบความจริงผู้ป่วยน่าจะเลือกเองได้ดีที่สุด ดังนั้นน่าจะแจ้งผู้ป่วย เป็นต้น

เทคนิคการแจ้งข่าวร้าย

การแจ้งข่าวร้ายมีหลายเทคนิค แต่เทคนิคที่มีผู้แนะนำค่อนข้างมาก[1] และผู้เขียนเองนิยมใช้คือเทคนิค "SPIKES" ซึ่งเสนอโดย Buckman และคณะ[2] ซึ่งมีรายละเอียดดัง **ตารางที่ 1**

ตารางที่ 1 ขั้นตอนการแจ้งข่าวร้ายโดยวิธี SPIKES

S	Setting up
P	Patient perception
I	Invitation of bad news
K	Knowledge
E	Emotion
S	Strategy

S (Setting up)

หมายถึง การเตรียมการ แพทย์ควรต้องมีเวลาเพียงพอ ไม่เร่งรัด สถานที่พูดคุยควรมีความเป็นส่วนตัว เงียบสงบพอสมควร ควรมีที่นั่งสำหรับผู้ป่วยและญาติทุกคน (ไม่ควรยืนคุย) พยายามตัดสิ่งรบกวน เช่น แจ้งบอกพยาบาลล่วงหน้าไม่ให้ใครมารบกวนขณะกำลังคุยกับผู้ป่วย แพทย์ควรปิด

โทรศัพท์มือถือระหว่างคุย ควรมีกระดาษทิชชูเสมอในกรณีที่ผู้ป่วยอาจร้องไห้ แพทย์เองก็ต้องทำจิตใจตนเองให้สงบเช่นกัน ควรทบทวนประวัติและผลตรวจต่าง ๆ ของผู้ป่วยให้เข้าใจถ่องแท้

P (Patient perception)

หมายถึง การประเมินว่าผู้ป่วยพอทราบอะไรมาบ้างแล้ว แพทย์ควรเริ่มการสนทนาด้วยการทักทาย แนะนำชื่อตนเอง ทวนชื่อผู้ป่วย และถามชื่อญาติ (ควรถามชื่อญาติทุกคนได้จะดีที่สุด ไม่ควรเรียกญาติว่า *"ญาติ"*) ควรมี small talk เล็กน้อยเพื่อสร้างความคุ้นเคย แล้วค่อยประเมินว่าผู้ป่วยพอทราบอะไรมาบ้างแล้ว เช่น

"คุณสมชายครับ ครั้งที่แล้วที่คุณสมชายมาตรวจเพราะเรื่อง..... จำได้มั้ยครับว่าผมได้อธิบายอะไรให้คุยสมชายฟังบ้างครับ..... หมอว่าหมอสงสัยว่าเป็นอะไร?.....ลองเล่าให้หมอฟังหน่อยครับ"

หากพบว่าผู้ป่วยพอทราบบ้างแล้ว แต่ดูกังวลหรือกลัว ก็ควรถามลงลึกลงไปว่าเหตุผลที่กังวลและอาจให้ความหวังเสริมไปได้เลยในขั้นตอนนี้ เช่น

"คุณสมชายกลัวเป็นมะเร็ง เพราะอะไรครับ?"

"ใช่ครับ เรากำลังสงสัยวัณโรคหรืออาจเป็นเนื้องอกมะเร็ง แต่ไม่ว่าจะเป็นอะไรก็รักษาได้ครับ"

ถ้าผู้ป่วยบอกว่ายังไม่ทราบ หรือบอกว่าแพทย์ไม่ได้บอกอะไร อาจเกิดจากแพทย์คนที่แล้วไม่ได้อธิบายเลยจริง ๆ ก็ต้องคุยอธิบายผู้ป่วยใหม่ แต่ถ้าคิดว่าแพทย์น่าจะอธิบายมาเพียงพอแล้ว ก็อาจเกิดจากผู้ป่วยทราบแต่พยายามปฏิเสธ (denial) ต่อสิ่งที่แพทย์พูดในครั้งที่แล้ว แพทย์ก็ควรเข้าใจ อย่าโกรธผู้ป่วยว่าทำไมเข้าใจยาก ควรถามคำถามเจาะลงไป (explore) เพื่อหาสาเหตุ ทำให้แพทย์สามารถอธิบายผู้ป่วยได้ เช่น

"คุณสมชายกำลังกังวลอะไรหรือเปล่าครับ ช่วยเล่าให้หมอฟังหน่อยครับ"

I (Invitation of bad news)

หมายถึง การเชื้อเชิญและเตรียมให้ผู้ป่วยทราบว่าแพทย์กำลังจะบอกข่าวร้าย เช่น

"คุณสมชายครับ วันนี้เราจะมาฟังผลตรวจกันนะครับ"

"คุณสมชายครับ คุณสมชายอยากให้หมอบอกผลการตรวจมากน้อยแค่ไหนครับ"

"ตอนหมอบอกผลตรวจ คุณสมชายอยากให้..(ญาติ)..อยู่ด้วยมั้ยครับ"

ถ้าข่าวร้ายนั้นค่อนข้างร้าย ก่อนจะบอกข่าวร้าย แพทย์ควรมี "warning shot" ก่อนเสมอ เช่น

"ผลชิ้นเนื้อออกมาไม่ค่อยดีครับ...."

"ผลออกมาไม่เป็นดังที่เราหวังครับ....."

หลังจากนั้นจึงบอกข่าวร้าย

K (Knowledge)

หมายถึง การให้ข่าวร้าย (ไม่ใช่การให้ความรู้ทางการแพทย์) ได้แก่ ตัวข่าวร้ายที่แพทย์ต้องการแจ้งนั่นเอง ควรบอกอย่างชัดเจน ตรงไปตรงมา ไม่กำกวม หลังจากบอกข่าวร้ายแล้วผู้เชี่ยวชาญบางท่าน (รวมทั้งผู้เขียน) มักให้ความหวังแก่ผู้ป่วยตามมาเสมอ เช่น

"ผลเป็นมะเร็งครับ..... แต่มีทางรักษา (ช่วย) ได้ครับ" เป็นต้น

ข้อผิดพลาดที่พบบ่อย ๆ คือ หลังจากแจ้งข่าวร้ายและแพทย์พยายามให้ความหวังแล้ว ถ้าโรคนั้นรักษาไม่หาย แพทย์มักกังวลใจแล้วพูดต่อมากเกินไปจนกลายเป็นทำลายความหวังนั้นเสียเอง ซึ่งจะทำให้ผู้ป่วยรู้สึกแย่ลงเพราะสิ่งที่จะเป็นความหวังนั้นถูกทำลายไป เช่น

"ผลเป็นมะเร็งครับ แต่มีทางรักษาได้...ถึงแม้การรักษานั้นจะได้ผลไม่ 100% และไม่หายขาด"

"ผลเป็นมะเร็งครับ พอมีทางรักษาได้... แม้การรักษานั้นจะควบคุมโรคให้ดีขึ้นได้ระดับหนึ่ง"

"ผลเป็นเลือดบวก (เอดส์) ครับ แต่มียารักษาได้ ถึงแม้จะไม่หาย ได้แค่ชะลอก็ตาม" เป็นต้น

สาเหตุคือ แพทย์มักรู้สึกว่าไม่ควรพูดให้ความหวังมากจนเลิศเลอเกินไป มิเช่นนั้นจะเหมือนการโกหก และภายหลังผู้ป่วยจะมาเอาเรื่อง ซึ่งที่แท้จริงแล้วเราไม่ได้โกหก การที่เราบอกว่ามีทางช่วย มีทางรักษานั้นเป็นความจริงแท้แน่นอน แพทย์ควรบอกความจริงเท่าที่มีประโยชน์ต่อผู้ป่วย ไม่จำเป็นต้องพูดทุกอย่างจนหมดเปลือก ผู้เขียนพบว่าผู้ป่วยส่วนใหญ่หลังจากได้ฟังข่าวร้ายแล้วได้ความหวัง มักไม่ซักไซ้แพทย์ต่อว่ารักษาได้หายขาดได้หรือไม่ คาดว่าเพราะผู้ป่วยเองก็อยากถนอมความหวังเอาไว้ ไม่อยากซักถามต่อที่อาจจะเป็นการทำลายความหวังนั้นเสียเอง แต่บางครั้งญาติเองต่างหากที่ไม่เข้าใจและพยายามถามแพทย์ว่า *"จะหายขาดหรือไม่?"* ซึ่งบางครั้งเหมือนซักใบให้เรือเสีย ผู้เขียนเองมักไม่ตอบคำถามนี้แต่จะใช้การพูดยืนยันเหมือนเดิมว่า *"รักษาได้ครับ"*

การพูดในขั้นตอนนี้ แพทย์ควรพูดให้ช้า ให้ชัด อาจหยุดเพื่อถามความเข้าใจผู้ป่วยเป็นระยะๆ (tell-ask-tell) ต้องคอยสังเกตปฏิกิริยาของผู้ป่วยตลอดเวลา ยังไม่ควรพูดข้อมูลทางการแพทย์มากมาย เช่น รายละเอียดของโรคหรือการรักษาในขั้นตอนนี้

E (Emotion)

หมายถึง การรับมือกับอารมณ์ของผู้ป่วย เนื่องจากผู้ป่วยหลังจากได้รับข่าวร้ายจะมีการตอบสนองแตกต่างกันไป เช่น ผู้ป่วยอาจร้องไห้ โกรธ ปฏิเสธ ต่อรอง ช็อก เงียบไป หรืออาจยอมรับได้เป็นอย่างดี แพทย์มักรู้สึกว่าถ้าผู้ป่วยที่มีปฏิกิริยา ร้องไห้ โกรธ ปฏิเสธ ต่อรอง ช็อก เงียบไป แปลว่าผู้ป่วย *"รับไม่ได้"* แสดงว่าการแจ้งข่าวร้ายนี้ไม่ประสบความสำเร็จ ซึ่งเป็นความเข้าใจที่ผิด เพราะปฏิกิริยาทั้งหมดนี้ล้วนเป็นสิ่งปกติ เป็นกลไกป้องกันทางจิตใจของผู้ป่วยเอง ดังนั้นหน้าที่ของแพทย์คือต้องเข้าใจและช่วยส่งเสริมกลไกเหล่านี้ให้ไปสู่การทำให้ผู้ป่วยยอมรับในที่สุด ได้แก่

ผู้ป่วยที่ร้องไห้ (crying) แพทย์มักกลัวและทำอะไรไม่ถูก จึงมักรีบยับยั้งหรือปลอบผู้ป่วยเร็วเกินไป เช่น พูดว่า *"อย่าร้องไห้.....ใจเย็น ๆ.....ไม่ต้องคิดมาก"* เป็นต้น ซึ่งเป็นการทำร้ายผู้ป่วยทางอ้อม เพราะการร้องไห้ทำให้ความทุกข์ที่ท่วมท้นในใจของผู้ป่วยหลั่งไหลออกมา ผู้ป่วยจะดีขึ้นและสงบลงเอง

จนพร้อมจะรับฟังแพทย์ต่อได้เอง ที่จริงผู้ป่วยที่ร้องไห้กลับเป็นผู้ป่วยที่รับมือง่ายกว่าอย่างอื่น สิ่งที่แพทย์ควรทำคือ ควรเงียบให้ผู้ป่วยร้องไห้สักพัก ยื่นกระดาษทิชชูให้ (ไม่ควรใช้ผ้าเช็ดหน้าของแพทย์) หรือการสัมผัสโดยแตะมือผู้ป่วยเบาๆ (ไม่ควรแตะสูงเกินไหล่ หรือต่ำกว่าเอว) โดยอาจไม่ต้องพูดอะไรเลย

ผู้ป่วยที่โกรธ (anger) แพทย์มักกลัวที่สุด ผู้ป่วยอาจกล่าวโทษแพทย์ กล่าวโทษโรงพยาบาลอื่น หรือโทษโชคชะตา เป็นต้น แพทย์ควรเข้าใจ ไม่ควรรีบยับยั้งผู้ป่วย เช่น *"ใจเย็นๆ", "ค่อย ๆ พูดค่อย ๆ จา" "หมอเข้าใจความรู้สึกของคุณ"* หรือรีบแก้ตัว เป็นต้น เพราะผู้ป่วยจะยิ่งรู้สึกว่าแพทย์ไม่เข้าใจ แพทย์ควรให้ผู้ป่วยระบาย (release) สิ่งที่อัดอั้นออกมาผู้ป่วยจะดีขึ้น เช่น พูดว่า *"พูดออกมาเลยครับ หมอกำลังฟังครับ"* เมื่อผู้ป่วยระบายความโกรธออกมาแล้วจนเริ่มสงบแล้วแพทย์อาจพูดว่า *"หมอขอบคุณที่คุณสมชายบอกให้หมอทราบ"* หรือ *"หมอเสียใจกับเรื่องที่เกิดขึ้น"* เป็นต้น ไม่ควรไปแก้ตัวต่าง ๆ นานา หรือแก้ตัวแทนผู้อื่นก่อนจะให้ผู้ป่วยระบายความโกรธออกเสียก่อนเพราะจะทำให้ผู้ป่วยโกรธยิ่งขึ้น

ผู้ป่วยที่ปฏิเสธ (denial) เช่น *"ไม่น่าใช่มั้งครับ.....ผลผิดพลาดหรือเปล่าครับ.....หมอตรวจอีกทีมั้ยครับ"* เป็นต้น ผู้ป่วยมักไม่ได้ต้องการคำตอบจริง ๆ แพทย์ไม่ควรไปตอบหรือย้ำผู้ป่วยว่า *"ใช่แน่นอนครับ .....ผลไม่ผิดแน่ครับ.....ไม่ต้องตรวจใหม่ครับ....."* เป็นต้น เพราะจะเป็นการย้ำแผลที่ผู้ป่วยปฏิเสธให้เจ็บยิ่งขึ้น แพทย์ควรรับฟัง แสดงความเห็นใจ เช่น การสัมผัส แสดงความเห็นใจ (empathy) บอกผู้ป่วยว่า เช่น *"หมอเข้าใจ" "คุณสมชายคงไม่อยากเชื่อ"* เป็นต้น

ผู้ป่วยที่ต่อรอง (bargaining) ยังลังเลหรือสองจิตสองใจ แพทย์ควรรับฟังและแสดงต่อผู้ป่วยว่าท่านเข้าใจ ให้เวลาผู้ป่วย บางครั้งก็ต้องนัดแนะมาใหม่ภายหลัง

ผู้ป่วยที่ช็อก (shock) หรือเงียบไป (silence) กลับเป็นผู้ป่วยที่รับมือยากกว่าแบบอื่น เพราะดูยากว่าผู้ป่วยคิดอะไรอยู่ ควรให้ผู้ป่วยเงียบอยู่กับตนเองสักครู่ แล้วจึงกระตุ้นผู้ป่วยโดยการสัมผัส แล้วถามหยั่ง (probing) ดู เช่นพูดว่า *"ดูคุณสมชายเงียบไป รู้สึกอย่างไรครับ บอกหมอหน่อยครับ"* เป็นต้น ผู้ป่วยก็จะแสดงออกมาว่าที่จริงมีปฏิกิริยาอย่างไร แพทย์ก็จะรับมือได้ง่ายขึ้น

S (Strategy)

หมายถึง การวางแผนต่อไป หลังจากรับมือกับอารมณ์ของผู้ป่วยและผู้ป่วยสงบแล้ว แพทย์สามารถถามผู้ป่วยได้ว่าพร้อมที่จะให้แพทย์พูดคุยต่อเรื่องแนวทางต่อไปเลยหรือไม่ เช่น

"คุณสมชายครับ พร้อมที่จะคุยกับหมอต่อแล้วยังครับ"

ถ้าผู้ป่วยพร้อมก็สามารถพูดคุยแนวทางในระยะอันใกล้นี้ได้เลย ยังไม่ควรพูดเรื่องระยะยาว หรือพยากรณ์โรคในครั้งนี้ ควรพูดช้า ๆ พูดให้น้อย ๆ เฉพาะสิ่งที่จำเป็นใกล้ ๆ นี้เท่านั้น โดยสลับกับการสอบถามความเข้าใจเป็นระยะๆ (tell-ask-tell)

แพทย์ควรใช้ภาษาที่คนทั่วไปเข้าใจ (layman language) และควรฝึกใช้คำเรียกชื่อโรคต่าง ๆ ที่ไม่ชวนตระหนก เช่น หัวใจทำงานไม่ค่อยดี (แทนคำว่า หัวใจล้มเหลวหรือหัวใจวาย), ไตทำงานลดลง

(แทนคำว่า ไตวาย), น้ำคั่งค้างในปอด (แทนคำว่า น้ำท่วมปอด) เป็นต้น และแพทย์ควรหลีกเลี่ยงคำพูดเชิงลบให้มาก เช่น คำว่า แย่, แย่ลง, ทรุด, เจ็บปวด, ทรมาน, ร้ายแรง, ลุกลาม, กระจาย, ระยะ 4 เป็นต้น

ก่อนจบการสนทนา ควรเปิดโอกาสให้ผู้ป่วยได้ซักถาม หลังจากนั้นแพทย์ควรพูดสรุป (summarize) สิ่งที่ได้พูดกันมาในวันนี้และนัดแนะการพบกันครั้งต่อไป เช่น

"คุณสมชายครับ หมอขอสรุปนะครับว่า วันนี้หมอได้แจ้งผลตรวจผลชิ้นเนื้อคุณสมชาย สรุปว่าเป็นมะเร็งครับ แต่มีทางรักษาได้.....โดยเราจะตรวจเอกซเรย์เพิ่มเติม และจะนัดมาให้ยาเคมีบำบัดในสัปดาห์หน้านะครับ" เป็นต้น

หลักการแจ้งข่าวร้ายในบางสถานการณ์จำเพาะ

หลักการแจ้งข่าวร้ายโดยเทคนิค "SPIKES" สามารถนำมาใช้ในการแจ้งข่าวร้ายเกือบทุกสถานการณ์ แต่ในบางสถานการณ์จำเพาะอาจมีหลักการบางอย่างเพิ่มเติม ได้แก่

ผู้ป่วยแย่ลงฉับพลันหรือเสียชีวิตโดยไม่ได้คาดหมาย

เนื่องจากเป็นข่าวร้ายที่ไม่ได้คาดหมายมาก่อน ทำให้ญาติ (หรือผู้ป่วย) ไม่ได้เตรียมใจมาก่อน บางครั้งจึงอดมีความระแวงไม่ได้ ดังนั้นหลักการคือ

1. แพทย์อาจต้องมีการแจ้งเป็นช่วง ๆ เป็นระยะ ๆ ว่าเกิดอะไรขึ้น ซึ่งแพทย์กำลังพยายามช่วยอยู่อย่างเต็มที่ แล้วจึงมาแจ้งอาการต่อมาเป็นระยะ ๆ จนท้ายที่สุดแจ้งว่าผู้ป่วยเป็นอย่างไร (แย่ลง เสียชีวิต เป็นต้น)

2. ควรอธิบายสิ่งที่เกิดขึ้นช้า ๆ อย่างละเอียด (อาจต้องบอกเวลาอย่างชัดเจนเป็นนาที ๆ ณ จุดต่าง ๆ) เพราะจะเป็นการทำให้ญาติเชื่อมั่นว่าแพทย์โปร่งใส ไม่ได้ปิดบังอะไรต่อญาติ อธิบายจนถึงตอนท้ายสุด แล้วจึงบอกข่าวร้าย

3. ควรอธิบายให้เห็นความพยายามของแพทย์ (และทีมแพทย์) ว่าไม่ได้นิ่งนอนใจ ได้พยายามแก้ไขสิ่งที่เกิดขึ้นอย่างเต็มความสามารถ แต่อย่าพูดปกป้องตนเองจนเกินไป

4. อย่าลังเลใจที่จะบอกญาติหรือผู้ป่วยว่า ท่านเสียใจกับสิ่งที่เกิดขึ้น

5. กรณีที่ท่านไม่ทราบสาเหตุที่เกิดขึ้น ไม่ควรด่วนแจ้งสมมติฐานของท่านหรือความเห็นของท่าน เพราะญาติมักจะถือว่าเป็นคำตอบที่แน่นอน ควรบอกว่ายังไม่ทราบแน่ชัด แต่จะรีบทบทวนอย่างละเอียดถี่ถ้วนที่สุดเพื่อหาสาเหตุจะดีกว่า

ผู้ป่วยเกิดภาวะแทรกซ้อน (ที่อาจพบได้ตามปกติ) จากการทำหัตถการหรือการผ่าตัด

มีหลักการคล้ายคลึงกันคือ

1. ควรอธิบายสิ่งที่เกิดขึ้นช้า ๆ อย่างละเอียดว่าขณะทำตอนนั้นเป็นอย่างไร เห็นอะไรที่สงสัยว่ามีภาวะแทรกซ้อนเกิดขึ้น จวบจนเราวินิจฉัยได้ว่าเกิดภาวะแทรกซ้อน

2. ควรแสดงให้เห็นความพยายามของแพทย์และทีม ว่าได้พยายามแก้ไขสิ่งที่เกิดขึ้นอย่างรวดเร็ว สุดความสามารถ และดีที่สุด

3. อย่าลังเลใจที่จะบอกญาติหรือผู้ป่วยว่า แม้สิ่งนี้จะเกิดขึ้นได้ (ดังที่ได้แจ้งตั้งแต่ก่อนทำหัตถการ) แต่ท่าน *"เสียใจ"* กับสิ่งที่เกิดขึ้น

ผู้ป่วยเกิดภาวะแทรกซ้อนจากความผิดพลาดของแพทย์

มีหลักการเหมือนกับผู้ป่วยที่เกิดภาวะแทรกซ้อนจากหัตถการ แต่ในกรณีนี้ไม่ต้องลังเลใจเลยว่าน่าจะบอกญาติหรือผู้ป่วยว่า *"หมอขอโทษ"* เพราะเกิดจากความผิดพลาดของเราจริง ๆ การขอโทษจากใจจริงมักทำให้ญาติหรือผู้ป่วยให้อภัยและไม่ติดใจในที่สุด และมักช่วยลดการฟ้องร้องได้อย่างมาก

สรุป

การแจ้งข่าวร้ายเป็นกระบวนการที่สำคัญและมีประโยชน์ต่อผู้ป่วยเป็นอย่างยิ่ง การแจ้งข่าวร้ายเป็นทั้งศาสตร์และศิลป์ โดย "ศาสตร์" ได้แก่ การใช้เทคนิค "SPIKES" ส่วน "ศิลป์" ได้แก่ การไวต่อความรู้สึก ความเห็นอกเห็นใจ และการฝึกฝนจนชำนาญในที่สุด

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เอกสารประกอบการอบรม

18 Oct 2018

18 Oct 2018

หัวข้อ : Disclosure of medical errors negligence, and complications

Disclosure of
Medical Error

Objectives

1) What is the key of teaching disclosure?

2) How to structure teaching session

3) How to facilitate teaching session

Some **FACTs** about disclosure

Almost all patients want to be disclosed

แม้ความผิดพลาดจะ**เพียงเล็กน้อย**ก็ตาม

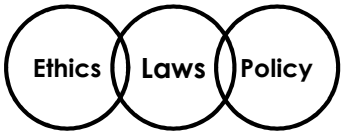
Trust & Relationship

อย่าทำลายสิ่งสำคัญ

Disclosure is the right thing to do

ไม่ใช่แค่ควรทำ แต่**ต้องทำ**

Disclosure needs balance



Patient autonomy

จริงใจ หรือ หลอกลวง

เพื่อผู้ป่วย หรือ ตนเอง

Justice or fairness

สิทธิที่จะได้รับการ**ชดเชย**

Ethics Non-disclosure

เกิดอันตรายในภายหลัง

ขาดการมีส่วนร่วม

ทำลายความสัมพันธ์

เพิ่มความกังวลหรือสงสัย

องค์กรไม่พัฒนา

Law Non-disclosure = dishonesty

Unprofessional behavior

Policy **No** blames **No** shame culture

สนับสนุน ช่วยเหลือ แก้ไขระบบ

Disclosure is **NOT** an instinct

ต้องเรียนรู้ ฝึกฝน และมีแนวทาง

How to facilitate

Disclosure of medical errors?

"**3P**" to design a simulation event

Purpose
- ✓Objective

Participant
- ✓Level of learners' experience

Process
- ✓ Simulator chosen
- ✓ Scenario development
- ✓ Simulation class

Adapted from: Swanwick T, Understanding Medical Education, 2011

Facilitation

The act of helping other people to deal with a process or reach an agreement or solution without getting directly involved in the process, discussion, etc. Cambridge dictionary

What should be facilitated?

How to facilitate?

Essential skill of being a "facilitator"

- ✓Questioning
- ✓Listening
- ✓Constructive feedback
- ✓Management

How to disclose Medical Errors

Before disclosure

1. Data gathering and prepare

เตรียมข้อมูลให้พร้อม อย่างครบถ้วน

2. Preserve trust and relationship

อย่าทำลายความเชื่อใจและความสัมพันธ์

3. Authority and leadership

อย่าฉายเดี่ยว ต้องทำงานเป็นทีม พร้อมผู้เกี่ยวข้อง

4. Prompt disclosure

ทำเร็วที่สุด เมื่อทุกอย่างพร้อม

5. Family involvement

ให้ทุกคนมีส่วนร่วมในการรับรู้ข้อมูล

When?

1. Focus on facts

อย่าเดา อย่ามั่ว อย่าแก้ตัวหรือคาดเดา

2. Focus on patient's need

หาความต้องการให้เจอ อย่าทำให้สงสัยหรือมีคำถาม

3. Reduce uncertainty

วางแผนการดูแลให้ชัดเจน ไม่มีใครชอบความไม่แน่นอน

4. Sharpen your saw

ฝึกทักษะที่สำคัญ ฝึกฟัง ฝึกพูด ฝึกจับความรู้สึก ฝึกควบคุมอารมณ์

5. Do responsibility

แสดงความเห็นใจ เสียใจ และรับผิดชอบ

6. Show what you have learned

แสดงให้เห็นว่ามีการพัฒนาความปลอดภัยในการดูแลผู้ป่วย

7. Careful documentation

ให้ความสำคัญกับเวชระเบียน

After disclosure

1. Offer follow up meeting

อย่าพยายามดำเนินการให้เสร็จสิ้นในครั้งเดียว แนะนำให้เจอกันบ่อย ๆ

2. Offer/Refer to 2nd opinion

เปิดโอกาสให้มีทางเลือกที่ดีกว่าอย่าย้อไว้หากหมดซึ่งศรัทธาหรือความไว้ใจ

3. Accept outcomes

ทำให้ดีที่สุด สุดท้ายต้องยอมรับผลลัพธ์ที่เกิดขึ้น

4. Organization leadership

องค์กรต้องอย่าปล่อยให้บุคลากรเดียวดายหรือเผชิญหน้าโดยลำพัง

BMJ

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CLINICAL REVIEW

An introduction to advance care planning in practice

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Advance care planning has been defined as a process of formal decision making that aims to help patients establish decisions about future care that take effect when they lose capacity.[1] It recently gained increased importance in the United Kingdom, after being recommended by the end of life care strategy.[2] The first national guidance for health and social care staff in the UK was produced in 2007 and revised in 2011.[3] Before this, terms and concepts used in the UK had included "living wills" and "advance directives," which have been replaced by terminology outlined in the national guidance and the Mental Capacity Act 2005.[4]

Advance care planning differs from general care planning in that it is usually used in the context of progressive illness and anticipated deterioration. This has implications for its acceptability to patients. It is a voluntary process and may result in a written record of a patient's wishes, which can be referred to by carers and health professionals in the future. If a patient loses capacity, health and social care professionals should make use of information gleaned from the advance care planning process to guide them in decision making when needed.

The Royal College of Physicians and other national organisations stress the need to avoid a document driven or "tick box" approach to this process,[5] and many authors advise focusing on communication rather than on specific interventions or outcomes.[6-8] The success of advance care planning should therefore not be defined on the basis of completed paperwork alone.[9]

This review aims to provide an overview of the potential benefits and risks of advance care planning, to summarise barriers to taking part in it, and to give practical guidance to health professionals on how to approach the process, with reference to the Mental Capacity Act 2005. Although this article is based on UK law and practice, we believe that the concepts and approaches discussed could be applied more widely. For example, both the Australian and American Medical Associations endorse similar concepts to those used in the UK.[10 11]

What are the benefits of advance care planning?

Theoretically, the process can facilitate patient autonomy so that patients' future wishes can be carried out once they can no longer decide for themselves,[1] but evidence regarding real benefit is mixed. A controlled trial of the impact of combining improved communication about resuscitation preferences with information on prognosis found no improvement in the quality of end of life care.[12] Other authors have suggested that the wider advance care planning process may also be ineffective in achieving positive outcomes.[13-16]

Conversely, some evidence, including that from a recent small systematic review in patients with dementia and cognitive impairment,[17] points to several possible benefits. These include less aggressive medical care and better quality of life near death, decreased rates of hospital admission, especially of care home residents, and increased rates of hospice admission,[18-20] with those having completed an advance care plan being more likely to receive care that is aligned with their wishes.[21 22] A UK retrospective study of 969 deceased hospice patients found that those who had completed such a plan (57%) spent less time in hospital in their last year of life. It also found that those who died outside of hospital had a lower mean hospital treatment cost than those who died in hospital.[23]

Advance care planning is also thought to help families prepare for the death of a loved one, to resolve family conflict, and to help with bereavement.[24 25] For example, a randomised controlled trial of facilitated advance care planning versus usual care in elderly patients in Australia showed that 86% of patients in the intervention arm had their end of life wishes known and respected compared with 30% in the control arm. The same study highlighted a greater level of satisfaction among patients and relatives in the intervention group. Family members of patients in the intervention group who died had lower levels of psychological morbidity.[25]

A systematic review published in 2008 examined evidence for improving palliative care at the end of life. It included 41 articles relating to advance care planning and found moderate evidence supporting multicomponent interventions to increase patient

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Summary points

- Advance care planning aims to help patients establish decisions about future care that take effect when they lose capacity
- Evidence for the benefit of advance care planning is mixed; more recent evidence suggests that it can facilitate the delivery of care more in keeping with patient wishes and increase patient and family satisfaction with care
- Advance care planning discussions should be centred around the beliefs, goals, and values of patients, rather than on specific outcomes or interventions
- A sound working knowledge of the Mental Capacity Act 2005 is important when facilitating advance care plan discussions

Sources and selection criteria

We searched Medline, Embase, and the *Cochrane Database of Systematic Reviews* using the search terms "advance care planning" and "advance directives", focusing on publications in the past five years, but including older papers that seemed relevant. Where possible we prioritised systematic reviews and controlled trials. We did not carry out a systematic review of the literature and studies are of variable quality, with many being small.

uptake of advance directives; however, these studies seldom measured clinically important outcomes. The paper also concluded that recent research supports an approach to care planning that engages values, involves skilled facilitators, and focuses on key decision makers (for example, patients, care givers, and providers).[26]

Patients can find the process itself helpful, particularly when discussion focuses on their goals, values, and beliefs, rather than on particular treatments or interventions.[25-28]

Patients report several reasons for wishing to make advance decisions, including not wanting to be a burden on others and concern for self,[27 29] with underlying specific issues relating to their personal experiences and fears.[29 30]

What are the risks and barriers to advance care planning?

Some patients will not wish to engage in discussions about future care because this involves thinking about a deterioration in their condition.[6-32] There may also be cultural sensitivities to such conversations. Self identified barriers to the process in one qualitative study of older medical patients included perceiving advance care planning as irrelevant, having insufficient information to engage in the discussions, and the time constraints of health professionals.[33] A further challenge is that the process asks patients to predict their future experience of illness, which some may find difficult.[34 35] However, a person's willingness to engage in the conversation may change over time, so it may be appropriate to re-offer discussions at a later stage.

Equally, barriers may exist for professionals[31-37]; in particular, doctors may be unwilling to initiate such discussions, because this may "bring death into full view."[6] Some may fear that honesty about prognosis will cause patients undue distress or destroy their hope.[6 38] However, although caution in discussion is obviously needed, a longitudinal qualitative study found that patients have a variety of responses to, on the one hand, wanting support for hope and, on the other, wanting honest prognostic information; responses included being able to hope for things other than cure.[38] This accords with our experience—some degree of emotional upset may occur, but it is usually appropriate to the situation, and most patients who accept the offer of a discussion for advance care planning find such conversations empowering.

Some patients think that professionals should raise the matter,[39] so if we do not do this their needs may remain unmet. Being in a trusting relationship with patients,[24] or being able to develop such a relationship,[40] is helpful in this context.

How can we initiate discussions?

Advance care planning can apply to patients with a wide range of diagnoses, but particularly those with long term conditions or receiving end of life care.[5] It should be offered when the patient is still well enough to participate in the discussions and before any relevant loss of mental capacity.[5 41] This can mean that for certain conditions, such as dementia, discussions may have to be offered early in the course of disease. One UK systematic review found that a maximum of 36% of patients with cognitive impairment and dementia being admitted to a nursing home had capacity to participate in advance care planning.[17] However, data on the best timing of advance care planning discussions in patients with dementia are conflicting. One recent qualitative study suggested that patients with mild dementia find such discussions acceptable,[42] but another found that people with dementia had difficulty considering their future selves.[35]

More generally, some studies have identified particular triggers for initiating these conversations, such as recurrence of cancer.[6] The timing of conversations with patients with non-cancer conditions, such as chronic obstructive pulmonary disease, may also prove challenging. This disease is often not perceived to be terminal and therefore not relevant to the principles of advance care planning.[36] This reflects the nature of chronic conditions in which disease can be stable and well managed for many years, before moving on to the terminal phase. However, because sudden changes in condition can occur, the opportunity to take part in advance care planning could be missed if the subject is not broached early on.

Another crucial factor is the communication skills of health professionals. A number of authors recognise the potentially challenging, sensitive, and complex nature of conversations about advance care planning,[13 43] with others recommending that practitioners need specific training.[5-44] One component of such highly skilled communication is knowing when not to proceed with discussions—for example, when doing so might cause disproportionate levels of distress[5]—and how to "titrate" information over time.

Box 1 includes a list of suggested triggers for initiating or reviewing such discussions.

Practical approaches to communication

When preparing to offer discussions it may be useful to consider the following:

- Patients may need time to think and reflect, so the initial advance care planning process may extend over several conversations.[5 6] One study found that the process took a median of 60 minutes over one to three conversations[25]

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Box 1 Triggers for initiating or reviewing advance care planning discussions

There is no agreed standard frequency with which to review these discussions, so the interval should be based on patients' wishes, taking into account their clinical condition.

Triggers include:

- Patient initiates the conversation
- Diagnosis of a progressive life limiting illness
- The diagnosis of a condition with a predictable trajectory, which is likely to result in a loss of capacity, such as dementia or motor neurone disease
- A change or deterioration in condition
- Change in a patient's personal circumstances, such as moving into a care home or loss of a family member
- Routine clinical review of the patient, such as clinic appointments or home visits
- When the previously agreed review interval elapses

- Ensure that any outcomes of these discussions are appropriately shared among relevant teams and organisations,[26 45] and updated if decisions change
- Avoid giving the impression that it is possible to anticipate and plan for every eventuality[13]
- Do not assume that other health or social care professionals have offered opportunities for such discussions[36 37]
- Discussions that take place in the patient's wider family or social network may give rise to conflict, which is best dealt with early, to avoid conflict coming to light when the patient has lost capacity or died.[24]

Mahon suggests two questions that may be useful for initiating an advance care planning discussion that focuses on the patient's goals:

1) If you cannot, or choose not to, participate in healthcare decisions with whom should we speak?

2) If you cannot, or choose not to, participate in decision making what should we consider when making decisions about your care?[8]

For some patients answering question 1 may be as far as they wish to take such a discussion, and hopefully this question can be asked without causing patients undue anxiety. Box 2 outlines our communication suggestions.

How does advance care planning fit with the Mental Capacity Act 2005?

As well as knowing about a patient's disease and its likely consequences,[5] an adequate understanding of the law (including capacity assessment), the advance care planning process, and the related documentation is necessary.[9 48] However, two UK studies have shown that some professionals have a limited understanding of advance care planning,[44 49] with the authors of one suggesting that those with specialist skills in particular diseases may be better placed to undertake more complex aspects of the process.[44] This section serves as a brief introduction to some of the key legal problems.

The Mental Capacity Act 2005 legislates for England and Wales on the way in which decisions are made by, and on behalf of, people with impaired mental capacity.[4] It sets out five principles and a legal framework designed to protect patients with impaired capacity and their carers, who have to make decisions about their care and treatment. It is accompanied by the Mental Capacity Act 2005 code of practice, and practitioners have a legal duty to have regard to this.[50] Abiding by a person's wishes about a health related advance decision comes into effect only once the person has lost capacity to make that particular decision.

Mental capacity

People are assumed to have capacity unless it is established that they lack capacity despite all practicable steps taken to help them make the decision in question (see box 3 for the mental capacity assessment).

Best interests

Section 4 of the act deals with making decisions in accordance with the best interests of the person lacking capacity and specifies an initial checklist of common factors that must always be considered. It states that whoever determines what is in someone's best interests must consider, so far as is reasonably ascertainable, the person's past and present wishes and feelings, particularly any relevant written statement made when he or she had capacity,[4] thus giving "weight" to the advance care planning process.

What are the potential outcomes of an advance care planning discussion?

In addition to documents recording a person's preferred place of care or death, advance care planning has three main tools—advance statements, advance decisions to refuse treatment, and lasting powers of attorney.

Advance statements

These are statements about what the patient would or would not want to happen in the future, their goals of care, or their personal values; they are sometimes known as a statement of preferences and wishes. They can be about medical treatment ("I would wish to be ventilated if I stop breathing") or about social aspects of care ("I prefer coffee in the morning"). They are not legally binding but must be taken into account when best interest decisions are made about the person after capacity has been lost. They can be written by the patient or be verbal statements. It is useful to record verbal statements in the patient record, and it is important that they are accessible for those making decisions in the future.

Advance decision to refuse treatment

Valid and applicable advance decisions to refuse treatment (box 4) are legally binding statements (usually written documents) that allow patients to refuse specific medical treatments if they lose capacity in the future. Patients can refuse only medical and nursing treatments in advance and not basic care (such as the offer of food and drink by mouth and repositioning in bed).

It is best, but not a requirement, if the specific circumstances in which patients wish to refuse treatments are made clear, because this information will be used by clinicians in the future

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Box 2 Communication tips

Initiating the conversation

Start with general open questions, then be guided by the patient's cues and responses to know whether to explore further

Examples:

- How have you been coping with your illness recently?
- Do you like to think about or plan for the future?
- When you think of the future, what do you hope for?[46]
- When you think about the future, what worries you the most?[46]
- Have you given any thought to what kinds of treatment you would want (and not want) if you became unable to speak for yourself?[47]
- What do you consider your quality of life to be like now?[47]

During the conversation

Use language that patients can understand and any other communication aids you might need

Give patients enough information to make informed choices without overloading them

Clarify any ambiguous statements that patients make—for example:

- Patient: "I don't want heroics"
- Professional: "What do you mean by heroics?"

Ending the conversation

Summarise what has been discussed to check mutual understanding, or ask the patient to do so

Screen for any other problems—for example: "Is there anything else you would like to discuss?"

Arrange another time to continue, complete, or review the discussion if necessary—for example, if the patient would like help completing an advance decision to refuse treatment

Document the contents of the discussion in the patient record

Share the contents (with the patient's permission) with anyone else who needs to know, such as family, carers, the community team, and the general practitioner or specialists

Box 3 Assessing mental capacity

Mental capacity is decision specific and time specific—it is specific to the decision in question and may be of time limited relevance.

The test for mental capacity has two parts:

- The diagnostic test. This is positive if the person has "an impairment of, or disturbance in the functioning of, the mind or brain" (Mental Capacity Act 2005 section 2). Otherwise, by definition, the person has capacity
- The functional test (Mental Capacity Act 2005 section 3) applies only if the diagnostic test is positive. People who can understand, retain, and use or weigh information relating to a decision, as well as be able to communicate their decision, have not lost capacity, even if the diagnostic test is positive. Loss of one or more of these four elements confirms loss of capacity for the specific decision

Mental capacity for a particular decision may fluctuate over time and may need to be reviewed frequently. For example, a patient may be temporarily incapacitated by an episode of sepsis, or through the use of alcohol.

Box 4 Determining whether an advance decision to refuse treatment is valid and applicable

Such decisions come into effect only if the person has lost mental capacity to make the decision in question. The person must have had relevant capacity at the time the advance decision was made and it must be about the decision in question.

Validity

For such a decision to be valid, it should not have been withdrawn by the person, and the person should not have later behaved in a way that is inconsistent with it. In addition, if the person has subsequently made a lasting power of attorney regarding the same decision the advance decision is rendered invalid.

Applicability

For the refusal to be applicable it must be about the treatment currently in question and relate to the circumstances in which the patient now finds himself or herself, if these have also been specified. For example, a person specifically refusing antibiotics for treatment of a chest infection might receive antibiotics for a urinary tract infection if clinically appropriate. However, if the advance decision covers all antibiotics under the specified circumstances then health professionals would be bound not to administer them.

An advance decision may not be applicable if circumstances have changed (for example, an unanticipated advance in medical treatment) and there are reasonable grounds to believe that these changes would have affected the advance decision if the person had known about them when making the decision.

Life sustaining treatment

When the treatment to be refused is potentially life sustaining, such as cardiopulmonary resuscitation, as well as being valid and applicable, the decision must be written, signed by the patient in the presence of a signed witness, and must state that it applies even if life is at risk.

to determine if the refusal is applicable. The wording of these statements can be difficult, because potential future situations must be anticipated and described unambiguously. If more than one circumstance is specified for a given refusal of treatment, all have to be present at the same time for the advance decision to apply. Verbal wishes to refuse treatments that do not sustain life can be recorded in the patient's notes.

If you are satisfied that the advance decision to refuse treatment is valid and applicable then you will have to abide by it (best interests do not apply). The only circumstance in which an advance decision is not binding is when the person is detained under the Mental Health Act 1983.[51] Such patients can be treated for their mental disorder without their consent, even if they have a valid and applicable advance decision to refuse the treatment

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in question (electroconvulsive therapy is an exception to this rule).

Lasting power of attorney

These are legal documents that replace the previous enduring power of attorney. They allow patients (donors) to nominate someone (attorney) to whom they want to give decision making powers (if they lose capacity in the future). There are two types of lasting power of attorney: "property and financial affairs" and "health and welfare." Once made, these documents must be registered with the Office of the Public Guardian (for a fee) before coming into effect. It is possible to nominate more than one person as an attorney, or nominate different people for different decisions.

A health and welfare lasting power of attorney comes into effect only when the donor loses the capacity to make the decisions that are covered by the document. If there are worries that an attorney is not making decisions in the best interests of the donor, the decision should be challenged. It can then be adjudicated on by the Court of Protection (which might appoint a court appointed deputy, usually someone close to the patient, who would be able to take best interests decisions for the patient).

What are electronic palliative care coordination systems?

Appropriate dissemination of advance care planning decisions is a challenge; other than for lasting powers of attorney, the UK has no central register of advance care plans. Electronic palliative care coordination systems are designed to improve communication and facilitate health professionals' access to this information. Electronic registers, or urgent care records, such as Coordinate my Care in London (www.coordinatemycare.co.uk/index.html), hold immediately accessible information about patients' advance care plans and other information, such as treatment escalation plans, and are available to a wide range of relevant professionals. In some areas, this has led to an increase in patients dying in their preferred place of care.[52]

When should advance care planning decisions be reviewed? (see box 1)

Although no specific evidence or recommendations are available on when to review these decisions, on the basis of personal experience, several factors may be relevant and should prompt review. For example, if the personal circumstances of patients change, such as place of residence or perception of quality of life, they may wish to reconsider their decisions. New therapeutic options may become available or, as the condition progresses, the patient's values and goals may change, and this may affect earlier decisions. Advance care planning must be reconsidered regularly, either to confirm or amend the content, while the person has mental capacity to do so. This will allow the document to reflect the patient's current wishes and increase the likelihood that it will be judged as valid and applicable at the relevant time.

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Additional educational resources

Resources for patients

National End of Life Care Programme (www.endoflifecare.nhs.uk/search-resources/resources-search/publications/planning-for-your-future-care.aspx)—Outlines the different options available to people when planning for their end of life care and comes in a range of languages

Aging with Dignity (www.agingwithdignity.org/forms/5wishes.pdf)—US based website that aims to help people take control of how they are treated if they are seriously ill

Regents of the University of California (www.prepareforyourcare.org)—Aims to help patients make medical decisions for themselves and get the right medical care

Resources for professionals

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SPECIAL ARTICLE

Advance Care Planning

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Advance care planning is the process of planning for future medical care, particularly for the event when the patient is unable to make his or her own decisions. It should be a routine part of standard medical care and, when possible, conducted with the proxy decision maker present. It is helpful to think of the process as a stepwise approach. The steps include the appropriate introduction of the topic, structured discussions covering potential scenarios, documentation of preferences, periodic review and update of the directives, and application of the wishes when needed. The steps can be integrated flexibly into routine clinical encounters by the physician and other members of the health care team. The process fosters personal resolution for the patient, preparedness for the proxy, and effective teamwork for the professionals. The process also has pitfalls of which to be aware. *Arch Fam Med. 2000;9:1181-1187*

WHAT IS ADVANCE CARE PLANNING?

Advance care planning is a process, not an event. It is the process of planning for future medical care in the event that the patient is unable to make his or her own decisions. During this process, patients explore, discuss, articulate, and document their preferences.[1]

The process helps patients identify and clarify their personal values and goals about health and medical treatment. They identify the care they would like, or not like, to receive in various situations. Patients also determine whom they would like to make health care decisions on their behalf in the event they cannot do so themselves.[2]

Ideally, advance care planning is a process of structured discussion and documentation woven into the regular process of health care that is reviewed and updated on a regular basis.[3] It is designed to ensure that a patient's wishes will be respected in the event that the patient is unable to participate in decision making.[4,5] In the case of a child, it is designed to ensure that the patient's parents are provided with an understandable discussion of the child's prognosis and of the treatment options, should the child's condition deteriorate to a terminal state.[6] The sense of control and peace of mind that this process fosters in the patient and the reduction of anxiety in proxy decision makers are important benefits.

Advance care planning is important for physicians for many reasons. Patients have a right to participate in the planning of their health care. Physicians have a legal and professional responsibility to ensure this, even if the patient loses the capacity to make decisions. The process of determining those preferences for treatment builds trust and a sense of teamwork among the patient, proxy, and physician in several ways. The invitation to

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discuss future care permits the patient (or the parents if the patient is a child) to understand his or her own values, goals, and preferences that govern his or her life. The physician and proxy learn about those preferences and needs. The process helps to relieve anxieties and fears on both sides because a spirit of frankness and openness is fostered. Advance care planning is preventive medicine because it avoids future confusion and conflict.

The model for advance care planning can be applied to other decision-making processes as patients plan for the end of their lives (eg, planning for bequests, autopsy, burial or cremation, funeral or memorial services, and guardianship and choices of caregivers and settings for care).

INVOLVEMENT OF OTHERS

The physician plays an important role in initiating and guiding advance care planning. The physician needs to be involved in some, but not all, stages of advance care planning to understand the patient and establish a trustworthy shared decision-making process. Recent studies suggest that patients prefer discussing these issues with their family members. However, as the physician will be responsible for the actual medical orders, sufficient involvement is necessary for the physician to feel comfortable and able to pursue the goals and priorities for care that the patient wants.

Many physicians are concerned that advance care planning is too idealistic or time intensive to include it in their busy practice.

This article provides a framework for the routine and practical inclusion of the process into practice. The patient, proxy, and family can perform most of the work without the physician if they are given a worksheet and background materials. For purposes of reimbursement, the time that the physician takes to counsel and provide information about advance care planning can be incorporated into the coding of complexity of the encounter.

Some physicians choose to have other members of the health care team assist them with advance care planning (eg, a nurse, physician assistant, or social worker). Once the patient's ideas have been gathered, the physician can focus on the core discussions in direct meetings with the patient, proxy, and family. Preparatory work will permit these discussions to be to the point and effective. Once the core discussion has taken place, the patient should be invited to reflect on things and to return at a subsequent visit with decisions to review.

There are legitimate cultural, ethnic, and age-related differences in approaches to medical decision making and advance care planning. However, generalizations should not be used to rationalize the omission of this topic for an individual patient. Pediatric patients and their parents can benefit from the advance care planning process, too. Determine how a patient and family want medical information to be shared and medical decision making to be handled early in the therapeutic relationship.

Terms used in advance care planning can be confusing. *Advance directives* are previous directives by the patient for his or her own health care. Advance directives fall into 2 categories, those concerning instructions for medical care and those concerning designation of a proxy for the patient. *Instructional directives* for care can be recorded in a number of types of documents. A *living will* is usually a simple statement asking for no heroic care in case of poor prognosis. A personal letter may also be used. A *values history* is a statement of values regarding health care in life-threatening illness situations. A *medical directive* is a set of instructions based on likely scenarios of illness, goals for care, and specific treatments, combined with a general values statement. It is also combined with a proxy designation section. A person who is empowered to make decisions in the place of the patient is sometimes termed a *health care proxy* or a durable power of attorney for health care.

FIVE STEPS FOR SUCCESSFUL ADVANCE CARE PLANNING

Step 1: Introduce the Topic

Research shows that most patients believe that it is the physician's responsibility to start advance care planning and will wait for the physician's initiative. Advance care planning is most easily accomplished during stable health, since changes often require a period for adjustment before the patient will have stable goals again.

In the face of life-threatening illness or other significant change in health status, advance care planning becomes even more necessary. Try to find a time when there is as much stability and adjustment to the new illness circumstances as possible.

Sometimes the most difficult part of the advance care planning process is the introduction of the topic. Physicians often have a number of concerns that make them reluctant to do so. Some may be concerned that the subject of advance care planning will frighten the patient or send the wrong message. Others may be uncertain about the most effective approach to use. In fact, most patients welcome the opportunity to discuss their preferences with their physician, and physicians who routinely engage in the process find it helpful and not too time-consuming.

Although some patients will be more likely to need advance care planning than others, healthy people who experience an unexpected illness, such as major trauma, can suddenly be the patients most in need

of advance directives. Whenever possible, physicians routinely should initiate the advance care planning process with every adult patient in their practice, regardless of age or current state of health. An outpatient office visit or other nonthreatening setting is ideal.

For children with a chronic illness, the optimal timing of advance care planning will vary. At a minimum, the discussion should take place after a relapse of disease, or at the time of significant complications, but before the child is in a state of crisis.

When introducing the topic, inquire how familiar the patient is with advance care planning. Some patients may already have advance directives in the form of a living will or durable power of attorney for health care. If this is the case, review the documents and amend them if appropriate. An advisory medical directive can be used to amend existing statutory documents.

Before beginning the process, be prepared to explain the purpose and nature of the process that you recommend using. You may have literature that you would like the patient to read. If you are using a validated worksheet, give it to the patient to look over before the next discussion. Explain the roles of other family members or a proxy. If appropriate, introduce other members of the health care team who will be involved in the process.

Although most patients will welcome the opportunity to discuss these matters, be aware of the patient's comfort level during the introduction of the topic. If a patient (or parent if the patient is a child) does not seem comfortable talking with you, be supportive and provide information, but do not force the conversation. It may happen later when the patient is ready.

As patients frequently wish to minimize the decision-making burden for family, suggest that the patient involve family members, friends, and even members of the community to explore how best to manage potential burdens. Ask the patient to identify a possible proxy decision maker, who might act on his or her behalf, to be involved in subsequent conversations. The best proxy decision maker is not always a family member. Sometimes the decisions are too difficult for people close to the patient, who may be overly influenced by their attachment or by burdens of care. Whether close or not so close, the proxy should be someone whom the patient trusts and who would be willing and able to represent the patient's wishes. Encourage the patient to bring that person, or persons, to the next meeting and book a time to follow up.

Step 2: Engage in Structured Discussions

A critical success factor for advance care planning is the ability to structure discussions with the patient that convey the information patients need and to elicit relevant preferences to determine their advance directives. To prevent any misunderstanding, remind the patient that it is the goal of advance care planning to plan for the potential loss of his or her capacity to make decisions, temporarily or permanently. Convey commitment to follow the patient's wishes and to protect the patient from unwanted treatment or undertreatment, and convey intent to help plan for any caretaking needs of the patient's family.

Role of the Proxy. Involve the potential proxy decision maker in the discussions and planning so that he or she can have a thorough and explicit understanding of the patient's wishes. Usually, the appropriate role for the proxy during the initial discussions is to listen, perhaps to take notes, and to ask questions for clarification. A joint meeting involving the patient, physician, and proxy to ensure common understanding can be invaluable if the proxy and physician are later called on to collaborate in decision making.

As part of the advance care planning process, the patient should specify the role he or she would like the proxy to assume if the patient is incapacitated. Proxies may try to implement specific treatment choices, they may try to decide according to the patient's best interests, or they may decide by taking into consideration the interests of all parties that the patient cares about in a form of substituted judgment. Although these possibilities often coincide, they may not, and it can be very helpful for the patient to decide which standard is most important.

In all cases, the proxy will need to work with the physician and, in general, should have the same participation in decisions that the patient would have had. Most commonly, the proxy uses a blend of standards—his or her own judgment based on the situation and what he or she knows about the patient's wishes. This allows for unexpected factors that could not be anticipated during the advance care planning process.

Patient and Proxy Education. At the core of advance care planning is the empowerment and preparedness of the patient and proxy. Both usually require some education, time for reflection, and discussion. To make informed choices, the patient must understand the meaning of the various clinical scenarios under discussion, as well as the benefits and drawbacks of the various treatment options. The discussion should provide insight into the types of clinical scenarios that might arise and the types of decisions that proxies most commonly face.

Define key medical terms using words the patient and proxy can understand. Explain the benefits and burdens of various treatment op-

tions (eg, life support on a ventilator may be needed for a short time only if the underlying problem is reversible). Remind them that any intervention can be refused or stopped if it is not meeting overall treatment goals. Because recovery cannot always be predicted, help patients to consider situations involving uncertainty, incomplete recovery, or even death.

Elicit the Patient's Values and Goals. Develop an understanding of the patient's values and goals related to health and illness. For pediatric patients, involve them to the level at which they are comfortable and work with the parents or guardians. There are a number of ways to facilitate this part of the discussion. Ask about past experiences—the patient's own or those of other people the patient knows. Describe possible scenarios and ask the patient what he or she would want in such a situation.

As a range of clinical situations is reviewed with the patient, it will be possible to get a sense of where thresholds exist for withdrawal or withholding of care. Help the patient to articulate his or her own general principles, values, and goals for care in given situations and specific treatment wishes. Consider asking the patient if he or she wants to write down in a letter to the physician how such things should be handled.

Use a Validated Advisory Document. To guide the discussion and capture patient preferences, consider using a worksheet or other carefully developed and studied tool. Many people find that, by using a worksheet, the discussion with the patient readily identifies the patient's values and attitudes regarding health and medical care across a range of medical situations, possible goals, and treatment choices. By going through various scenarios and options, the patient's personal threshold for use or nonuse of interventions can become clearer. Proxy decision makers can be identified and their roles defined.

Ensure that the worksheet includes a range of potential scenarios that patients should consider. It should elicit the patient's values and goals related to health and medical care in general terms and should include the most common lifesaving interventions. If a patient already has a life-threatening condition, the conversation may be more focused on specific scenarios and treatment issues. For example, a patient with end-stage cardiomyopathy needs to consider the issues of cardiopulmonary resuscitation and the role of intensive care units. The patient with end-stage renal disease must consider dialysis. The patient with advanced acquired immunodeficiency syndrome needs to consider dementia and respiratory failure.

A number of validated worksheets are available from which to choose.[7-9] They provide a consistent approach, are easy to use, and reduce the chance that important information will be left out or framed in a biased way; the preferences they elicit tend to be reliable and durable reflections of the patient's wishes. Once they are complete, worksheets can serve as a resource that the patient, proxy, and family members take home. They may also be able to serve as a formal advisory document.

Step 3: Document Patient Preferences

Formalize the Directives. Once the patient has made some decisions, to avoid the possibility of a directive that cannot be implemented, it is crucial for the physician to review the advance directives with the patient and proxy. Check for, and help to correct, any inconsistencies and misunderstandings. Make sure that the directives provide the type of information needed to make clinical decisions.

After a final review is complete, ask the patient to confirm his or her wishes by signing the directives. Although any statement of a patient's wishes—written or verbal—can be considered an advance directive and should be respected by physicians, a formal written document signed by the patient can avoid ambiguity.

Enter Directives Into the Medical Record. Once the directives have been reviewed and accepted, the physician must document them formally in the patient's medical record. When a validated worksheet has been used to structure the planning discussion, the completed, finalized, and signed worksheet can itself be used as the entry in the medical record.

In the absence of a validated worksheet, the physician should describe the patient's wishes in a written document and ask the patient to review and amend it as appropriate. Once everyone is satisfied, have the patient sign the document and enter it into the medical record. It is also useful for the physician and proxy to sign the advance directive and provide their location information. This offers reassurance to the patient and helps to ensure the physician's and proxy's involvement in eventual decision making.

Recommended Statutory Documents. For added protection, patients should be encouraged to complete one or more statutory documents (eg, living will or durable power of attorney for health care) that comply with state statutes. Physicians should familiarize themselves with the specific advance directive statutory requirements of their state. They can do this by checking with their hospital's legal counsel, their state attorney general's office, or their local medical society.

Distribute the Directives. It is important to have these records wherever the patient may receive care. Place them into a central repository, such as a hospital or a regional or national center. Provide copies to the patient, proxy decision maker, family members, and all health care providers as appropriate. Use wallet cards to help ensure that information is available when it is needed.

Include Advance Directives in the Plan of Care. Once preferences have been established, the physician may need to change the plan of care and put certain things in place to ensure that the patient's wishes can be followed. For patients who may wish to remain at home and never be taken to an emergency department or hospitalized again, appropriate alternative arrangements, including referral to a home hospice agency, provision of appropriate medications, and instructions detailing how to handle symptoms and crises, may be needed. Practical suggestions may be helpful. Consider posting telephone numbers by the home telephone to call in an emergency (eg, the hospice nurse on call) or numbers not to call (eg, 911).

Step 4: Review and Update the Directive

It is important to revisit the subject of advance care planning on a periodic basis to review the patient's preferences and to update the documents. Major life events, such as illness, marriage, the birth of a child, or the death of a loved one, may affect a person's attitude toward his or her health care and/or end-of-life care.

Any changes in preferences warrant discussion to allow the patient to reassess and to ensure that the physician and proxy decision maker fully understand the new wishes. Changes in preferences should be documented, and existing documents should be updated and shared appropriately.

Step 5: Apply Directives to Actual Circumstances

When patients become incapacitated, the application of previous wishes to real circumstances can be challenging. The following guidelines may be helpful to ensure that a patient's advance directives are followed as closely as possible.

Most advance directives go into effect when the patient is no longer able to direct his or her own medical care. Learn to recognize when a patient becomes incapable of making decisions. Although situations where the patient is unresponsive are obvious, if the patient has some ability to respond, the physician first must determine the patient's capacity to make decisions.

Never assume an advance directive's content without actually reading the document. Do not take for granted that patients who have living wills want treatment withheld. Some people indicate within their living will that they want all measures taken to prolong their life.

Advance directives should be interpreted in view of the clinical facts of the case. Validated documents are likely to be more useful than short statements or statutory documents. No matter how thorough they are, advance directives cannot anticipate all possible circumstances. The proxy and the physician may need to extrapolate from the scenarios described in the advance directive to the current situation, and to make an educated guess as to what the patient would want if he or she were able to speak for himself or herself.

Whenever significant interpretation is necessary, the physician should consult the patient's proxy. Sometimes the physician and/or proxy may believe that a patient would have indeed wanted something other than what is reflected by a strict reading of the advance directive. In this case, they should work together to reach consensus.

Certain patterns of decisions have high predictability and follow logic. For instance, a decline of less invasive interventions has been shown to predict decline of more invasive interventions. Acceptance of more invasive interventions predicts acceptance of less invasive interventions. If a patient has indicated that he or she would like intervention in a poor-prognosis scenario, there is a high probability that the patient would also accept intervention in a better-prognosis situation. Likewise, if the patient has indicated that he or she would decline intervention in a better-prognosis scenario, there is a high probability that he or she would also decline if the prognosis were poor.

If disagreements cannot be resolved, assistance should be sought from an ethics consultant or committee.

COMMON PITFALLS OF ADVANCE CARE PLANNING

Anticipating and avoiding the common pitfalls is essential to a successful advance care planning process. There are several.

Failure to Plan

Do not avoid advance care planning. Too often, situations occur and decisions are made without the benefit of advance care planning. Be proactive. It is easy to forget the central role of the patient, and easy to forget the importance of the proxy. Involve both early and often.

Proxy Not Present for Discussions

Do not leave the proxy decision maker(s) out of the initial discussions with the patient.

Unclear Patient Preferences

Vague statements can be dangerously misleading. Clarify patient

preferences if they do not seem clear to you or to the proxy. For instance, patients who make statements such as "I never want to be kept alive on a machine" should be asked to clarify whether their wishes would change if their condition were readily reversible, or if their prognosis were unclear.

Discussion Focused Too Narrowly

Avoid isolated do-not-resuscitate discussions; they often create chaotic emotions and thoughts in patients who have to imagine imminent death to make the decision. A do-not-resuscitate discussion is usually an indication that other palliative goals and measures should be considered in the context of a range of scenarios.

Communicative Patients Ignored

Sometimes people assume that what a patient wants in the present is what he or she indicated for future possible scenarios. As long as the patient is competent, talk to him or her. An impaired patient may still be able to express wishes at some level. In such cases, the advance directive and tangible evidence of the patient's current wishes should be taken into account.

Advance Directives Not Read

Sometimes physicians assume that they know what is stated in an advance directive. This is a mistake. Advance directives can be for aggressive intervention, comfort care, or a wide range of specific views and must be read and understood.

COMPLEMENTARY APPLICATION OF THE MODEL FOR ADVANCE CARE PLANNING TO PREPARE FOR LAST HOURS OF LIFE

Planning other issues that face patients at the end of their lives is critical if their needs and expectations are to be respected by health care professionals and family members who will survive them. Although it would be ideal if all patients and families prepared for death well in advance of the final hours of their lives, most patients with advanced illnesses and their families have not discussed or prepared for their death.

As patients approach the last hours of their lives, they have a last chance to finish their business, create final memories, give final gifts, and say their good-byes. If appropriately assisted, considerable planning can be accomplished around many of these issues.

The 5-step model for eliciting, documenting, and following advance directives can be used to guide these decision-making processes and to document patient choices. As these important tasks are generally more than individual physicians can handle, other members of the interdisciplinary team can help patients and families complete their business and get their affairs in order.

In preparing for death, it is important to understand the perspective and wishes of all who are present, ie, the patient, the family, and the caregivers. Personal expectations, agendas, fears and phobias and acceptable setting(s) for care need to be clear, since any one person may alter the course of care unexpectedly and may interfere with the patient's wishes if such are not clearly known. Personal, cultural, and religious values, beliefs, and practices need to be anticipated and respected, as missed rites or rituals or errors made by unknowing caregivers may have grievous consequences in the eyes of the patient or family members. Identification and acknowledgment that some family members have a need to give care and others do not will help to allow each to participate as closely as makes him or her comfortable.

Advance Practical Planning

Many patients will choose to get their financial and legal affairs in order, give gifts, and plan for bequests, organ donation, autopsy, burial or cremation, their funeral or memorial services, and guardianship of their children as they finish their business. Some patients will even want to give family members permission to build new lives after they die.

Choice of Caregivers

The choice of caregivers for each patient is crucial as vulnerability increases. Patients may or may not want family members to care for them. Family members may or may not be able to assume responsibilities for caring and ideally should have the opportunity to be family first, and caregivers only if they and the patient agree to the role. All caregivers need to have the opportunity to change their role if they feel the stress is too much, or if they are not getting enough of a chance to finish their personal business with the patient.

Choice of Setting

The choice of care setting for the last hours of the patient's life should be as acceptable as possible to the patient, the family, and all caregivers. Each setting will carry benefits and burdens. Whatever the choice, the setting should permit family members to remain with the patient as much as they want, and should provide them with opportunities for privacy and intimacy. Although dying at home may be the wish of many patients, such a choice may expose family members to undue burden or compromise their careers, personal economic resources, or health. If the number of able caregivers and personal resources is limited, or if family members are afraid of ghosts and would not be able to live on in their home afterward, care and death in the home may not be the best choice. An alternate inpatient setting may be a hospice or palliative care facility,

a skilled nursing facility, or even an acute care facility. Depending on the resources that are locally available and whether the staff is skilled in this kind of care, these alternative settings may lead to a far better outcome.

SUMMARY

Advance care planning should be a routine part of standard medical care that is integrated into clinical encounters by the physician and other members of the health care team. Formally, it can be thought of as a stepwise approach, to include the appropriate introduction of the topic, structured discussions covering potential scenarios, documentation of preferences, periodic review and update of the directives, and application of the patient's wishes when needed. Less formally, the process fosters personal resolution for the patient, preparedness for the proxy, and effective teamwork for the professionals.

A number of critical factors contribute to a successful process and outcome: physician guidance and participation, family or proxy participation, and use of a worksheet or structured materials to foster discussion and documentation.

The process also has pitfalls of which to be aware. Vague or misleading statements of wishes can be hazardous; failure to involve the proxy risks discord around decisions; premature activation of the directive when the patient is still competent fails to honor the patient's real-time autonomy; and assumption about wishes in advance directives being for nonintervention may not be accurate.

The following are the key points:

- Every person has the right to participate in the planning of his or her health care.
- Consider using a validated worksheet to guide discussions. Patients, families, and proxies can complete them at home after they have been introduced.
- Revisit the subject of advance care planning on a periodic basis, particularly with major life or health changes.
- Do not presume that patients who are very ill lack the ability to make decisions.

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หัวข้อ : communication with relatives with bereavement

การให้คำปรึกษาแก่ญาติที่มีภาวะเศร้าโศกเสียใจจากการที่ผู้ป่วยเสียชีวิต

ปเนต ผู้กฤตยาคามี

ภาวะเศร้าโศกเสียใจจากการที่บุคคลอันเป็นที่รักเสียชีวิต (grief and bereavement) เป็นภาวะที่อาจเกิดขึ้นได้กับญาติของผู้ป่วยภายหลังจากผู้ป่วยเสียชีวิต ซึ่งในบางครั้งญาติจำเป็นต้องได้รับคำปรึกษาและการดูแลทางด้านจิตใจจากแพทย์เพื่อไม่ให้ภาวะเศร้าโศกเสียใจคงอยู่ต่อเนื่องเป็นเวลานานและส่งผลกระทบต่อการดำเนินชีวิตประจำวัน โดยหลักการให้คำปรึกษาแก่ญาติมีดังต่อไปนี้

1. **การประเมินว่าญาติคนใดมีความเสี่ยงต่อการเกิดภาวะเศร้าโศกเสียใจจากการที่บุคคลอันเป็นที่รักเสียชีวิต**

การประเมินความเสี่ยงสามารถทำได้ตั้งแต่ตอนที่ผู้ป่วยยังไม่เสียชีวิต ซึ่งหากแพทย์สามารถคาดการณ์ได้ว่าญาติของผู้ป่วยรายใดมีความเสี่ยงสูงและรีบให้คำปรึกษาและให้การดูแลทางด้านจิตใจตั้งแต่เนิ่นๆ จะช่วยลดความเศร้าโศกเสียใจให้ญาติได้ภายหลังที่ผู้ป่วยเสียชีวิตแล้ว โดยปัจจัยเสี่ยงต่อการเกิดภาวะเศร้าโศกเสียใจจากการที่บุคคลอันเป็นที่รักเสียชีวิตมีดังตารางที่ 1

ตารางที่ 1 ปัจจัยเสี่ยงต่อการเกิดภาวะเศร้าโศกเสียใจจากการที่บุคคลอันเป็นที่รักเสียชีวิต[1]

ประเภทของปัจจัยเสี่ยง	รายละเอียด
ลักษณะของการเสียชีวิตของผู้ป่วย	- ผู้ป่วยเสียชีวิตตั้งแต่อายุยังน้อย เช่น การเสียชีวิตของบุตร - ผู้ป่วยเสียชีวิตอย่างกะทันหัน - ผู้ป่วยทุกข์ทรมานมากก่อนเสียชีวิต - ผู้ป่วยเสียชีวิตจากโรคที่เป็นตราบาป เช่น โรคเอดส์
ลักษณะของญาติ	- ญาติป่วยเป็นโรคทางจิตเวช เช่น โรคซึมเศร้า - ญาติวิตกกังวลง่าย - ญาติไม่มั่นใจตนเอง - ญาติเคยผ่านประสบการณ์การสูญเสียบุคคลอันเป็นที่รักมาบ่อยๆ
ลักษณะความสัมพันธ์ของญาติกับผู้ป่วย	- ญาติต้องพึ่งพิงผู้ป่วยมาก
ลักษณะของครอบครัว	- มีปัญหาครอบครัว - ญาติอยู่ตัวคนเดียวภายหลังผู้ป่วยเสียชีวิต - ไม่มีญาติคนอื่นๆให้การช่วยเหลือ

หากพบว่าญาติคนใดมีปัจจัยเสี่ยงเหล่านี้หลายๆปัจจัย แพทย์ควรประเมินสภาพจิตใจของญาติและให้คำปรึกษาตั้งแต่เนิ่นๆ

2. **การให้คำปรึกษาแก่ญาติเมื่อผู้ป่วยใกล้เสียชีวิต**

เทคนิคหนึ่งที่อาจช่วยลดความเศร้าเสียใจให้ญาติได้คือการชวนญาติรำลึกถึงความสัมพันธ์ระหว่างญาติกับผู้ป่วยในช่วงชีวิตที่ผ่านมา โดยหากพบว่าญาติยังมีสิ่งใดที่อยากบอกหรืออยากทำให้ผู้ป่วยแต่ยังไม่มีโอกาสได้ทำแพทย์อาจช่วยส่งเสริมให้ญาติได้ทำตามความตั้งใจเพื่อไม่ให้มีสิ่งใดค้างคาใจญาติภายหลังจากผู้ป่วยเสียชีวิตแล้ว นอกจากนี้หากพบว่ามีสิ่งใดที่ดีที่ญาติได้เคยทำให้กับผู้ป่วยแพทย์สามารถชี้ให้ญาติเห็นหรือให้การชื่นชมได้ เทคนิคนี้อาจช่วยลดความรู้สึกผิดของญาติในกรณีที่ญาติรู้สึกว่าตนเองดูแลผู้ป่วยได้ไม่ดีพอ[2]

เมื่ออาการของผู้ป่วยเข้าสู่ระยะสุดท้าย แพทย์ควรส่งเสริมให้ญาติและผู้ป่วยใช้เวลาช่วงสุดท้ายอยู่ด้วยกันอย่างเต็มที่เพื่อให้ญาติและผู้ป่วยได้มีโอกาสบอกความรู้สึกที่มีต่อกันรวมถึงการบอกลาก่อนที่ผู้ป่วยจะเสียชีวิต[2]

3. **การให้คำปรึกษาแก่ญาติภายหลังจากผู้ป่วยเสียชีวิตแล้ว**

หากญาติยังมีความรู้สึกเศร้าเสียใจภายหลังจากผู้ป่วยเสียชีวิตแล้ว แพทย์อาจให้คำปรึกษาโดยเริ่มจากเปิดโอกาสให้ญาติได้ระบายความรู้สึกเศร้าเสียใจพร้อมกับรับฟังอย่างตั้งใจ แพทย์อาจใช้เทคนิคสะท้อนความรู้สึก เช่น เมื่อสังเกตเห็นผู้ป่วยมีน้ำตาคลอแพทย์อาจพูดว่า “ผมเข้าใจครับว่าคุณรู้สึกเสียใจเพราะคุณพ่อมีความสำคัญกับคุณมาก” การที่ญาติได้ระบายความรู้สึกและมีผู้ที่รับฟังอย่างเข้าใจจะช่วยบรรเทาความรู้สึกเศร้าเสียใจของญาติได้ เมื่อญาติได้ระบายความรู้สึกในระดับหนึ่งแล้วแพทย์อาจเปลี่ยนไปถามถึงความทรงจำดีๆที่ญาติมีต่อผู้ป่วยร่วมด้วยเพื่อไม่ให้ญาติหมกมุ่นอยู่กับความเศร้าเสียใจมากจนเกินไป นอกจากนี้การส่งเสริมให้ญาติได้พบปะกับญาติคนอื่นๆ และการชวนคุยเรื่องการวางแผนจัดงานศพตามประเพณีอาจช่วยบรรเทาความรู้สึกเศร้าเสียใจให้ญาติได้[1]

4. **การให้คำปรึกษาโดยใช้หลักการ** dual process model of coping with loss (DPM)[3]

หลักการนี้มาจากแนวความคิดที่ว่าภายหลังจากผู้ป่วยเสียชีวิต ญาติอาจมีปฏิกิริยาได้สองรูปแบบคือ

1) Loss-orientation ญาติยังคงเศร้าเสียใจเป็นอย่างมากเนื่องจากยังคงหมกมุ่นอยู่กับความคิดถึงผู้ป่วยที่เสียชีวิต

2) Restoration-orientation ญาติพยายามเบี่ยงเบนความสนใจจากความทุกข์โดยการจดจ่อกับการวางแผนจัดการเรื่องต่างๆในชีวิตประจำวัน

หากญาติมีปฏิกิริยาทั้งสองรูปแบบสลับกันไปมาอย่างสมดุล จะช่วยให้ระดับความเศร้าเสียใจมีไม่มากจนเกินไป และญาติยังสามารถวางแผนปรับตัวในการดำเนินชีวิตประจำวันโดยที่ปราศจากผู้ป่วยได้ แต่หากมีปฏิกิริยาในรูปแบบใดรูปแบบหนึ่งที่มากจนเกินไป เช่น ยังเศร้าเสียใจมากจนไม่สามารถดูแลบ้านหรือไปทำงานได้ หรือ พยายามลืมความเศร้าโดยการทำงานหนักจนไม่มีโอกาสได้ระบายความรู้สึกของตนเอง จะทำให้ภาวะเศร้าเสียใจยังคงอยู่อย่างต่อเนื่อง ดังนั้นในการให้คำปรึกษา แพทย์อาจถามถึงความคิดและความรู้สึกของญาติเพื่อเปิดโอกาสให้ญาติได้ระบายความรู้สึกเศร้าเสียใจอย่างพอเหมาะโดยระวังอย่าให้ญาติหมกมุ่นอยู่กับความรู้สึกนี้มากจนเกินไป จากนั้นจึงเปลี่ยนรูปแบบการถามเป็นการถามถึงการวางแผนการจัดการเรื่องต่างๆในชีวิตประจำวันเพื่อกระตุ้นให้ญาติสามารถปรับตัวดำเนินชีวิตต่อได้ภายหลังจากที่ผู้ป่วยเสียชีวิตแล้ว

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เอกสารประกอบการอบรม

19 Oct 2018

19 Oct 2018

หัวข้อ : Basic principles of communication skills teaching

Principles of Communication Skills Teaching

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Goals

- After this session, participants will be able to :-
  - Explain key concepts of how to teach communication skills
  - Give examples of methods for communication skills teaching
  - Choose appropriate methods for communication skills teaching

Outline

- Should we teach?
- What to teach?
- How to teach?

Should We Teach?

- Systematic review of literature about communication skills teaching and learning in medicine
  - 180 articles between 1991 – 1998
  - Select 83 high and medium quality articles
  - Overwhelming evidence for positive effect of communication skills training.
  - Low scorers on pre-training test showed the greatest gain from the training.

Aspegren K. Teaching and learning communication skills in medicine: A review with quality grading of articles: BEME guide no. 2. Medical Teacher 1999, 21(6): 563 – 70.

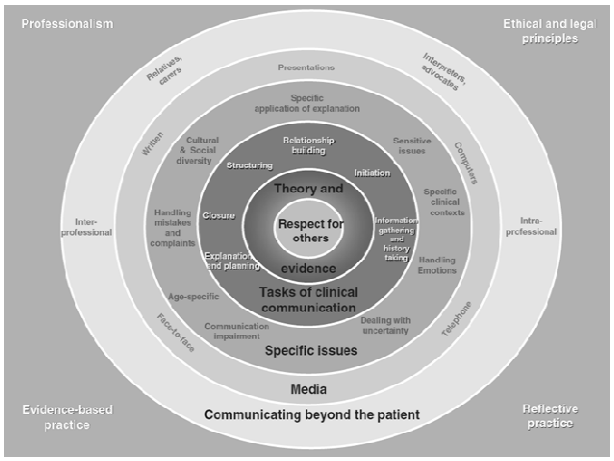
What to Teach?

- จำเป็นหรือไม่ที่อาจารย์ต้องเรียนรู้เนื้อหาของ “ทักษะการสื่อสาร” ก่อนที่จะเข้าสู่วิธีการสอน
  - Experience: little formal training
  - Difficulty in accessing literature
  - Uncomfortable teaching without personal understanding
  - Framework for students’ assessment

What to Teach?

- UK consensus statement on the content of communication curricula in undergraduate medical education
  - Developed by an iterative process of discussion between 33 UK medical schools
  - Product: Communication curriculum wheel

Von Fragstein M, et al. UK consensus statement on the content of communication curricula in undergraduate medical education. Medical Education 2008, 42: 1100 – 1107.



Theory and Evidence

- Awareness of the evidence base for communication skills on
  - Patient satisfaction
  - Wellbeing
  - Adherence and concordance
  - Physical outcomes
  - Psychological outcomes
  - Medico-legal issues
  - Patient safety

Tasks and Skills of Communication

Tasks

- Establish a relationship
- Initiation
- Gather information
- Elicit patient's view
- Explain
- …
- Closing

Skills

- Eye contact
- Facial expression
- Attentive listening
- Balancing open/close questions
- Facilitation
- Summarizing
- Checking patient's understanding

Specific Issues

- Age-specific areas
- Cultural and social diversity
- Handling emotions
- Specific clinical contexts
- Specific application: informed consent, health promotion, behavior change
- Sensitive issues: break bad news, dying and bereavement, child abuse

Media

- Face-to-face communication
- Telephone communication
- Written communication
- Electronic communication
- Making presentation

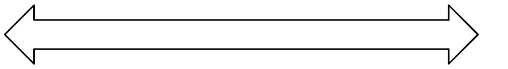
Beyond Patient

- Relatives and caretakers
- Advocates and interpreters
- Intra-professional
- Inter-professional

General Principles for Communication Skills Teaching

- It is taught in clinical context.
- It is objective driven.
- It is based on behaviors and attitudes.
- It is learner-centered.
- It is interactive.
- It is based on objective observation.
- It has constructive feedback.
- It needs a safe learning environment.

Teaching Methods



Facilitator-centered — Learner-centered

Didactic — Experiential

Didactic Methods

- Lecture
- Assigned reading
- Discussion groups
- Demonstrations (live or videotaped)
- Seminars
- E-learning

Experiential Learning

- Audio and video recordings and feedback
- Real patients
  - Pre-recorded videotaped consultations
  - Live interviews of patients
- Simulated patients
- Role play

Patients

- Pre-recorded videotapes of real consult
- Live interviews of real patients
- Simulated patients
- Role play

Summary

- Should we teach?
  - Yes
- What to teach?
  - Communication curriculum wheel
- How to teach?
  - Didactic versus experiential learning

communication curricula

UK consensus statement on the content of communication curricula in undergraduate medical education

Martin von Fragstein,[1] Jonathan Silverman,[2] Annie Cushing,[3] Sally Quilligan,[2] Helen Salisbury[4] & Connie Wiskin[5] on behalf of the UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education

CONTEXT The teaching and assessment of clinical communication have become central components of undergraduate medical education in the UK. This paper recommends the key content for an undergraduate communication curriculum. Designed by UK educationalists with UK schools in mind, the recommendations are equally applicable to communication curricula throughout the world.

OBJECTIVES This paper is intended to assist curriculum planners in the design, implementation and review of medical communication curricula. The document will also be useful in the education of other health care professionals. Designed for undergraduate education, the consensus statement also provides a baseline for further professional development.

METHODS The consensus statement, based on strong theoretical and research evidence, was developed by an iterative process of discussion between communication skills leads from all 33 UK medical schools conducted under the auspices of the UK Council of Clinical Communication Skills Teaching in Undergraduate Medical Education.

DISCUSSION How this framework is used will inevitably be at the discretion of each medical school and its implementation will be determined by different course designs. Although we believe students should be exposed to all the areas described, it would be impractical to set inflexible competency levels as these may be attained at different stages which are highly school-dependent. However, the framework will enable all schools to consider where different elements are addressed, where gaps exist and how to generate novel combinations of domains within the communication curriculum. It is hoped that this consensus statement will support the development and integration of teaching, learning and assessment of clinical communication.

KEYWORDS consensus; *education; medical; undergraduate; *communication; teaching/*methods; Great Britain.

*Medical Education 2008: **42**: 1100–1107*
doi:10.1111/j.1365-2923.2008.03137.x

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INTRODUCTION

The teaching and assessment of clinical communication skills have become central components of undergraduate medical education in the UK.[1–5] This paper recommends the key content for an undergraduate communication curriculum. Although the recommendations have been designed by UK educationalists with UK medical schools in mind, they are equally applicable to communication curricula elsewhere in the world.

This document was developed by an iterative process of discussion between communication skills leads from all 33 UK medical schools conducted under the auspices of the UK Council of Clinical Communication Skills Teaching in Undergraduate Medical

Overview

What is already known on this subject

The teaching and assessment of clinical communication are now central components of undergraduate medical education in the UK.

What this study adds

This consensus statement from all 33 UK medical schools recommends the key content for the undergraduate clinical communication curriculum. By utilising this benchmark, medical schools will be able to develop the range of learning experiences all students should encounter to be sufficiently qualified for a career in medicine. These recommendations are equally applicable throughout the world and in the education of other health care professionals.

Suggestions for further research

The UK Council of Clinical Communication Skills Teaching in Undergraduate Medical Education will next produce written and video-format guidance on the teaching and assessment of the individual domains delineated within this statement.

Education, established in 2005 (details on the current representatives of the UK council are available online as Supporting Information). The document is intended to assist curriculum planners in the design, implementation and review of medical communication skills curricula. We hope that it will also be useful in the education of other health care professionals.

Designed for undergraduate education, the recommendations described here also provide a baseline for further professional development.[6–8] The process of developing and improving competency in the complex area of medical communication skills is something that all health care professionals must engage with throughout their careers.

How this framework is used will inevitably be at the discretion of each medical school. Its implementation will be determined by different course designs. However, the framework will enable all schools to consider where different elements are addressed, where gaps exist and how to generate novel combinations of domains within the communication curriculum. Although we believe that students should be exposed to all the areas described, we consider that it would be impractical to set inflexible competency levels because these may be attained at different stages that are entirely school-dependent. By not defining competencies, we have more readily included areas which are important but which resist easy measurement, such as integrity and respect.

We hope that this consensus statement will support the development and integration of teaching, learning and assessment of clinical communication.

THE CONSENSUS STATEMENT

The consensus statement consists of a diagrammatic representation of the domains of clinical communication followed by a more detailed written description. The statement was generated through a process of iterative discussion between communication leads from all 33 UK medical schools which aimed to produce an empirical model of practical relevance to curriculum design and implementation. It is also based on strong theoretical and research evidence. Comprehensive evidence exists to guide the modern practice of communication skills teaching and learning[9] and over 30 years of accumulated research linked to outcome has guided the choice of communication domains, tasks, skills and issues to include in the statement.[10–14]

COMMUNICATION CURRICULUM WHEEL

A central component of this consensus statement is a diagrammatic representation of the content of clinical communication curricula in undergraduate medical education. In this diagram, the key domains of clinical communication are shown as concentric rings, starting in the centre with ‘respect for others’ and moving outwards through the specific domains of communication learning (Fig. 1). These domains are set within a milieu of four over-riding principles which govern not only communication, but all areas of medicine.

The specific components of each domain are then delineated within each ring. By rotating the rings independently, the communication curriculum planner can in effect ‘dial a curriculum’ by, for instance, dialling up how to teach the specific situation of explanation and planning about an elderly patient, to a relative over the telephone.

This communication curriculum wheel enables curriculum planners to take a helical rather than a

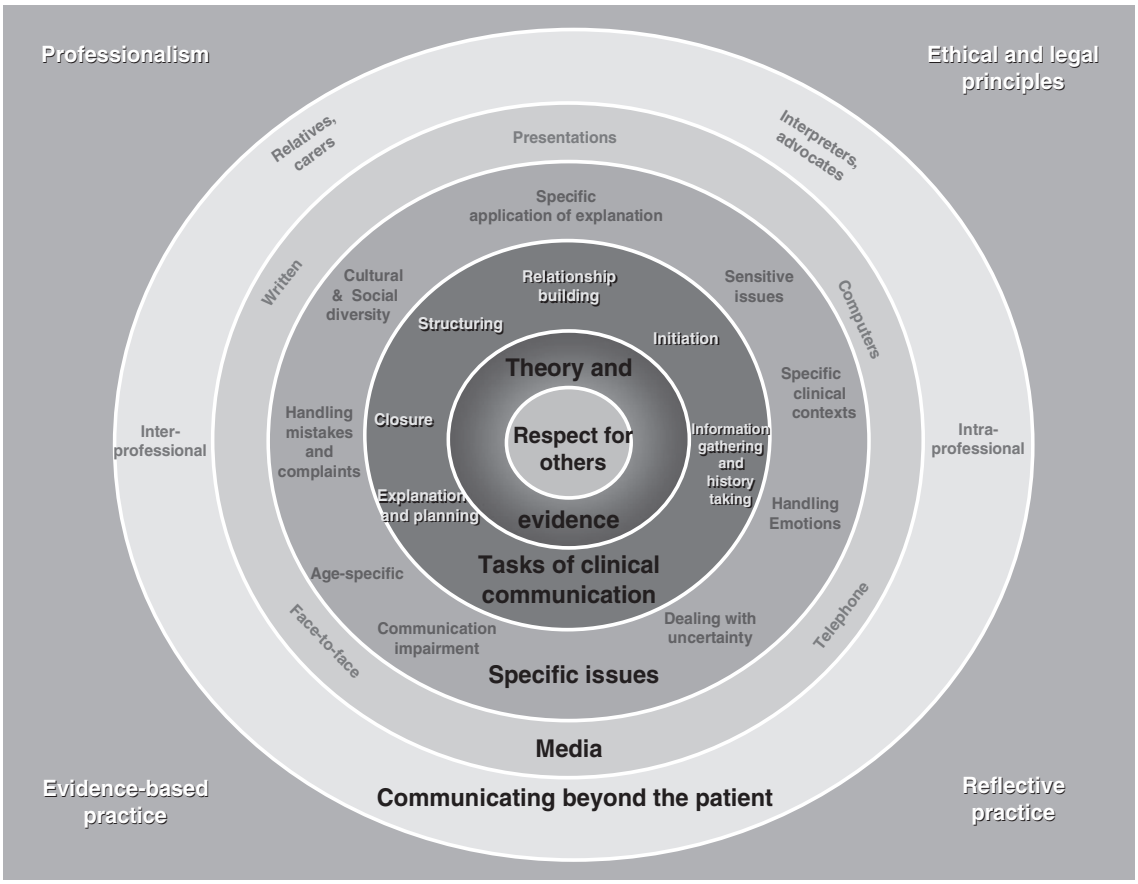

Figure 1 Communication curriculum wheel

linear approach to clinical communication teaching. The dial-a-curriculum model not only enables linkage of the key domains, but also explicitly encourages a reiterative process. A properly planned communication curriculum provides opportunities for learners to review, refine and build on existing skills while simultaneously adding new skills and increasing complexity. If ongoing, helical communication programmes do not run throughout the course, students will fail to master communication.[15]

In the text below, we expand and illustrate the domains and components of the diagram.

DOMAINS OF CLINICAL COMMUNICATION

Respect for others

Underlying all other components of effective clinical communication is respect. Students need to embrace respect for all patients and a commitment to equality in order to be able to communicate effectively and flexibly with individuals, regardless of social, cultural or ethnic backgrounds or disabilities. Our society, like others worldwide, comprises an increasingly diverse mix of cultural groups with unique health beliefs and aspects of individuality that impact on the interaction between doctor and patient. These changes in society emphasise the need for health care professionals to develop respectful partnerships with their patients and colleagues.

Theory and evidence of communication skills

Although this paper largely focuses on the acquisition of skills, these skills are underpinned by a significant body of evidence and theoretical frameworks.[10,11,16] Learners need to be aware of the evidence base for communication and be capable of interpreting and acting upon it appropriately. This includes an awareness of the literature related to:

- patient satisfaction;
- recall;
- adherence and concordance;
- wellbeing;
- physical outcome;

- psychological outcome;
- medico-legal issues, and
- patient safety and reduction of error.

Students need to understand that effective communication is part of an integrated approach to practice in health care and that it stands alongside and is as important to good practice as clinical knowledge and practical skills.

The theoretical approach of patient-centredness[17] has been demonstrated to be a paramount feature of high-quality care and should be a central component of any communication curriculum. Students need to develop a commitment to partnership and the concept of patient autonomy which puts patient choices and self-determined needs at the core of health care interactions.

Tasks and skills of the clinical interview

Tasks

The importance of appreciating the nature and tasks of the consultation should not be underestimated. Students should strive to understand not only the purpose of the consultation, but also how various tasks within the consultation contribute and apply to achieving the overall goal. Effective communication requires a keen understanding of the structure of the medical interview.

As communication is generally purposive, most of the activities of the medical interview can be taught as tasks. A number of well-established consultation models and recommendations list these tasks.[18–24] Experienced doctors operate flexibly and may choose from a mixture of models. The tasks below are typically associated with these models:

- establishing and building a relationship;
- initiating (i.e. opening the consultation and setting the agenda);
- establishing, recognising and meeting patient needs;
- gathering information;
- eliciting and considering the patient's world view;
- conducting a physical examination;
- formulating and explaining relevant diagnoses;
- explaining, planning and negotiating;
- structuring, signposting and prioritising, and
- closing (ending the interview and setting up the next meeting).

These communication *process* tasks are closely linked to the *content* of the medical interview. For instance, the communication task of gathering information, which is achieved via a set of specific process skills, enables the practitioner to obtain the content of the medical history. These two elements of content and process are inextricably linked and require an integrated approach in the medical curriculum.

Skills

There are a number of discrete, observable, specific behavioural skills relevant to the execution of each of the separate tasks above. Examples of these skills include:

- eye contact;
- facial expression;
- attentive listening;
- screening;
- appropriate balance of open and closed questions;
- faciliation;
- empathic reflection;
- responding to cues (both verbal and non-verbal);
- summarising;
- signposting;
- determining the patient's starting point when giving information;
- chunking information, and
- checking the patient's understanding.

These skills form the backbone of effective clinical communication curricula: a full list of these vital skills can be found in the consultation models referenced above. It is important that students understand and can put into practice these key communication skills as delineated in the various models.

The task and skills of 'relationship building' need special emphasis. Learners need to understand and appreciate the particular nature of the doctor's relationship with the patient, including the imbalance of power that is inherent in the consultation. The importance of the therapeutic relationship and the need for professional boundaries require particular attention. Students must recognise the importance of building and maintaining a rapport with the patient and must develop the skills required to put this intention into action.

Specific issues

There are many challenging contexts and situations for doctors when they communicate with patients. The skills necessary to carry out the tasks of the consultation provide a secure platform from which to tackle specific communication issues. The challenge for the

communication curriculum is to deepen learners' understanding of these core skills and to encourage them to use these skills flexibly and responsibly in a variety of specific situations. The following specific areas should be covered within the curriculum.

Age-specific areas

The curriculum should cover communication with children and parents, adolescents, and elderly patients.

Cultural and social diversity

Teaching in the curriculum should include issues related to: ethnicity and nationality; language; religion; sexuality; gender; socioeconomic status; disability; educational status, and spirituality.

Handling emotions and difficult questions

The curriculum should include teaching that enables students to learn how to handle difficult emotions, such as distress; fear; anger; aggression; denial; collusion, and embarrassment.

Skills for specific clinical contexts

The curriculum should include the teaching of skills to be used within specific clinical contexts, such as: in psychiatry (uncovering hidden depression and assessing suicidal risk; working with psychotic patients; working with patients with cognitive impairment; dealing with alcohol and substance abuse); when working in emergency medicine (dealing with aggressive and violent patients; time management and prioritisation).

Specific application of explanation and planning skills

The curriculum should include skills pertaining to seeking informed consent; risk management; health promotion, and behaviour change.

Dealing with uncertainty

Issues of uncertainty require skills that enable the health care professional to deal with: issues concerning uncertain prognosis; changing relationships with patients (the expert patient; the well-informed patient) and medically unexplained symptoms.

Sensitive issues

Medical professionals are also required to assimilate skills that enable them to: break bad news; discuss death, dying and bereavement; talk about sex; explore a patient's gynaecological history, and discuss issues that involve stigmatisation, such as child abuse, HIV infection and mental illness.

Communication impairment

The curriculum must also enable students to acquire the skills required to communicate with patients who have a sensory impairment such as a hearing impairment or a visual impairment; an expressive impairment; or learning disability.

Media

Students need to be able to communicate effectively in spoken, written and electronic formats. Five areas should be addressed within the curriculum.

Face-to-face communication requires students to:

- develop an awareness of environmental factors, both physical and social, and
- be aware of the use of body language.

Telephone communication requires students to:

- understand the specific demands and adaptations required in communication over the telephone.

Written communication requires students to:

- record an accurate initial patient assessment and subsequent daily progress notes in clear and concise written language;
- write discharge and referral letters in a manner that is well structured, comprehensible, comprehensive and clear, and
- write notes, drug charts and death certificates, legibly, clearly and accurately.

Computer-based and electronic communication requires students to:

- have sufficiently competent IT skills to ensure patients' electronic records are well maintained;
- be familiar with computerised patient records, prescribing and referral systems, and
- be aware of issues pertaining to the use of fax and e-mail for communication (e.g. confidentiality).

Making presentations requires students to:

- present patient information in clinical settings in an organised, articulate and coherent manner, and

- present clinical and academic information to large groups.

Communicating beyond the patient

Clinicians need to communicate with relatives, carers and colleagues from a range of health and social care professions and other agencies, while maintaining appropriate patient autonomy and confidentiality.

Individuals who accompany the patient to the consultation, whether relatives, carers, advocates or interpreters, present added challenges to communication. Clinicians also need to collaborate with other doctors and negotiate in the patient's best interests: learners require the opportunity to explore which skills and attitudes are needed to work effectively with medical colleagues. Students will work with the wider health care team, with statutory and voluntary organisations and with management groups. This requires a commitment to communicate effectively and work co-operatively and respectfully with other professionals and organisations. To achieve this, learners will need to be able to identify enabling factors and barriers to effective team-working. Whenever possible, teaching on interprofessional team-working should be planned and taught interprofessionally.

Students need to address the following four areas.

Relatives and carers

Communication with relatives and carers requires students to: explore how to negotiate the inclusion of a third party; enable the patient to present his or her problem freely; consider how to maintain confidentiality, and understand how to manage the dynamics of a triadic interview.

Advocates and interpreters

Students must learn the skills necessary to: work with patient advocates; work with professional and lay interpreters; negotiate and define the parameters of the roles involved, and work effectively within the cultural and practical constraints contained in this type of interview.

Intra-professional

Intra-professional communication requires students to be able to: produce clear, comprehensible oral and written communication; understand the issues relating to handover and ward round presentations; understand techniques for being appropriately assertive when working with a colleague; appreciate how to express concerns to a colleague or peer about his or her performance; be aware of General Medical Council guidelines regarding the responsibility to act if there is any suspicion that a colleague is behaving in a manner that may put patients at risk; deal with complaints and medical errors (understand the mechanisms by which complaints from patients, relatives or staff are dealt with; understand the systems that exist for reporting medical errors and the roles these may have in improving patient safety; consider the impact that being the subject of a complaint or responsible for an error may have on an individual, and the sources of support available).

Inter-professional

Inter-professional communication requires students to be able to: understand other team members' values, roles, expertise and responsibilities and consider how to collaborate effectively; understand the issues that promote effective communication and continuity of care across the primary or secondary care interface, managing and embracing, conflicting sharing information, and maintaining confidentiality.

SUPPORTING PRINCIPLES

The domains described above are set within a milieu of over-riding principles which govern all areas of medical practice. Communication curricula must exist within the following four areas, which will also govern the rest of the undergraduate curriculum.[25–27] This common background underlines the necessity for collaborative and integrative planning across the undergraduate curriculum as a whole.

Reflective practice

Reflective practice includes personal self-awareness and dealing with uncertainty, whether concerning diagnosis, optimal management or prognosis. This requires the student to develop self-awareness and the ability to: recognise areas of personal challenge; understand the extent to which personal views and values can clash with professional responsibility and the potential impact this might have on communication with patients; recognise his or her own limitations; understand when there is a need to refer

to senior colleagues; appreciate the need to respond constructively to feedback; understand professional boundaries; consider personal care and safety. The student also needs to appreciate how to cope with uncertainty by understanding the stress that uncertainty may bring, and reflecting on personal coping strategies.

Professionalism

Students need to develop a professional approach that incorporates integrity, honesty and probity and facilitates the development of an understanding of professional boundaries.

Developing attributes of integrity, honesty and probity will allow students to: accept the moral and ethical responsibilities involved in providing care to individual patients and communities; appreciate the unequal balance of power in the doctor–patient relationship and the need to always act in the patient's best interest; be willing to face difficult situations, including those involving uncertainty, risk and error and communicate in ways that safeguard patient safety; be honest and trustworthy in all communication, including in written reports and documentation, and be responsible for maintaining confidentiality and appropriate sharing of information.

Understanding professional boundaries will enable students to: be aware of the boundaries that exist in the clinical relationship; understand the need for such boundaries, and appreciate the factors that maintain them, such as formality of language and dress, the nature of the clinical environment and the necessary limitations on personal involvement.

Ethics and law

Students also need to be aware of the ethical dimensions of health care and how these are enshrined in law. From this follows understanding of the importance of communicating effectively in difficult ethical areas. Key ethical considerations include familiarity with (and adherence to) the principles of: confidentiality; consent; beneficence; best interest; autonomy; truth telling; non-maleficence, and justice.

Evidence-based practice

The principles of evidence-based practice require that decisions about health care are based on the best available, current, valid and relevant evidence, and that this should be integrated with clinical expertise and the patient's values and preferences.[28] These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources. This applies equally to the following two areas, which are inextricably linked:

- best clinical communication practice, and
- best clinical care practice.

CONCLUSIONS

This document recommends the key content for undergraduate clinical communication curricula. It provides a conceptual model and details the individual components of an effective curriculum. Such a curriculum will facilitate the acquisition of a range of skills and understanding which will enable students to face complex social interactions throughout their medical training and subsequent careers. This document represents the views of UK Council of Clinical Communication Skills Teaching in Undergraduate Medical Education members. We hope that, by setting out a benchmark for clinical communication skills curricula, medical schools will be able to develop the range of learning experiences that all students should encounter in order for them to be sufficiently qualified for a career in medicine.

We also hope that this consensus statement will support the development and integration of teaching, learning and assessment of clinical communication.

Contributors: this paper was developed through an iterative process by the communication skills leads from all 33 UK medical schools conducted under the auspices of the UK Council of Communication Skills Teaching in Undergraduate Medical Education. Following a series of workshops, a small working group, consisting of the authors of this paper, was established to finalise the consensus statement. This was then approved by the UK Council as a whole. All authors contributed to this process.
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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article.

Table S1. The current representatives of the UK Council.

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19 Oct 2018

หัวข้อ : How to teach communication in everyday practice

How to Teach Communication in Everyday Practice

เชิดศักดิ์ ไอรมณีรัตน์

ภาควิชาศัลยศาสตร์ คณะแพทยศาสตร์ศิริราชพยาบาล

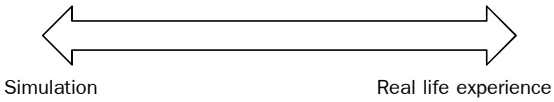
Objectives

- เมื่อสิ้นสุดการสอนในคาบนี้แล้ว อาจารย์ผู้ร่วมกิจกรรมสามารถเพิ่มการสอนทักษะการสื่อสารกับผู้ป่วยให้แก่นักศึกษาและแพทย์ประจำบ้านบ่อยขึ้นกว่าเดิม

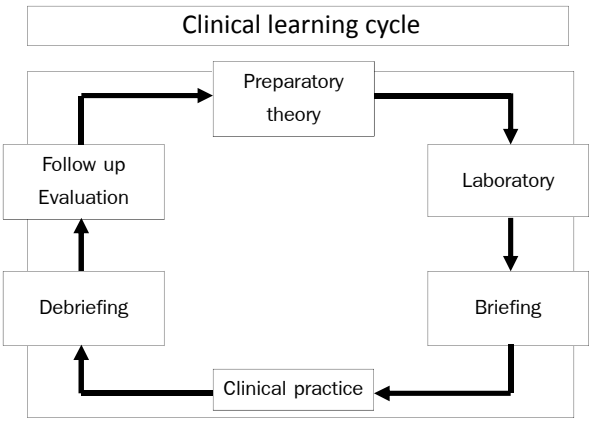
Outline

- Teaching approaches
- Steps in clinical learning cycle

Teaching Communication Skills [Experiential Learning]



Chiniara G., et al. Simulation in healthcare: A taxonomy and a conceptual framework for instructional design and media selection, Medical Teacher 2013, 35: e1380 – 95.



Briefing session

Purposes

- Assess student's readiness for practice
- Identify concerns related to practice
- Set objectives and levels of performance
- Assess student's understanding
- Checking preparation
- Providing encouragement
- Questioning the student's plan of care
- Negotiate the roles to be taken in clinical practice
- Exploring the opportunities for feedback during clinical practice

7

Clinical practice

Purpose

- Acquisition of the skills of clinical competence with a lesser emphasis on the accumulation of theoretical knowledge

8

Debriefing session

Purposes

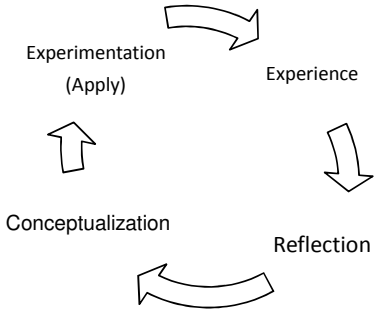
- Reflection on clinical experience
- Identify discoveries, new learning, insight
- Analyze thinking and feeling about the experiences
- Confirm or confront personal bias or beliefs
- Obtain and give feedback on performance

9

"Experience alone is not sufficient for learning to occur. The experience must be interpreted and integrated into existing knowledge structures to become new knowledge. Reflection is crucial for this active process of learning."

John Sandars

Experiential Learning Theory



Kolb DA. Experiential learning. Englewood cliffs, NJ: Prentice-Hall, 1984.
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Reflection

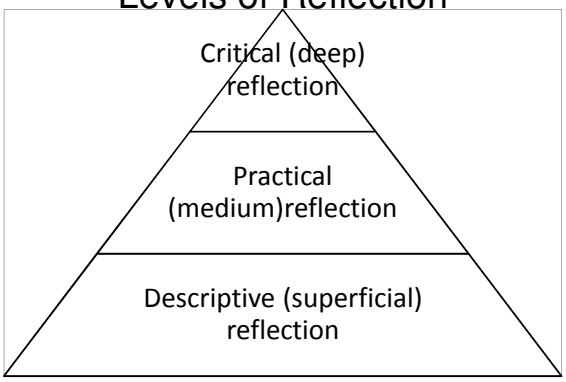
A complex and deliberate process of thinking about and interpreting experience in order to learn from it.

This is a conscious process which does not occur automatically, but is in response to experience and with a definite purpose.

Reflection is a highly personal process, and the outcome is a changed perspective, or learning.

Atkins and Murphy, 1995

Levels of Reflection



Summary

- Teaching communication in everyday practice
  - —Approaches: simulation vs. real-life experience
  - —Clinical learning cycle
    - Briefing
    - Encounter
    - Debriefing
      - —Reflection

“ I don’t want you to be only a doctor, but I also want you to be a man.”

HRH Prince Mahidol Adulyadej

19 Oct 2018

หัวข้อ : How to assess communication skills

How to Assess Communication Skills

เชิดศักดิ์ ไอรมณีรัตน์
ภาควิชาศัลยศาสตร์ คณะแพทยศาสตร์ศิริราชพยาบาล

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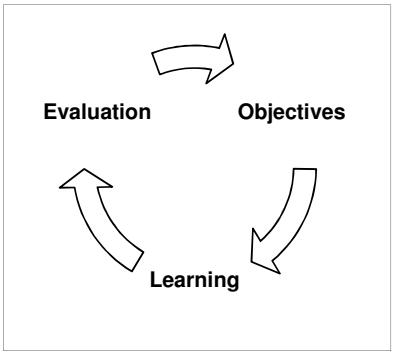


2

Goals

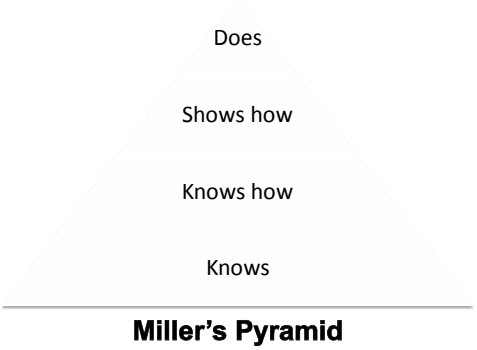
After this session, participants will be able to:

- Explain key factors leading to valid assessment
- Give examples of tools for communication skills assessment
- Choose appropriate tools for communication skills assessment

Outline

- Basic considerations in assessment
- Commonly used assessment tools
- Practice using the instruments

Assessment Approaches



Miller's Pyramid

5 5

Assessment Tools

- A systematic review of instruments assessing patient-centered communication
  - Fourteen instruments
  - Cover wide range of settings and patient populations
  - Number of items: 6 – 20
  - Use in both formative and summative settings
  - Raters: patients, SP, instructors

Brouwers M, et al. Assessing patient-centered communication in teaching: A systematic review of instruments Medical Education 2017, doi 10.11.11/medu.13375.

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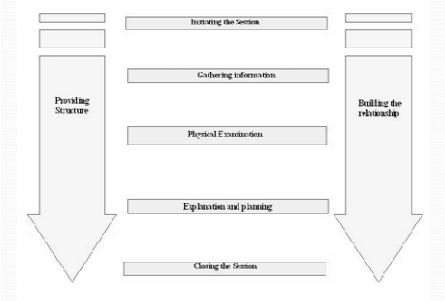
- http://www.skillscascade.com/handouts/CalgaryCambridgeGuide.pdf

Calgary-Cambridge Guides for Effective Physician-Patient Communication



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GKCSAF

- Peterson EB, et al. The reliability of a modified Kalamazoo Consensus Statement Checklist for assessing the communication skills of multidisciplinary clinicians in the simulated environment, Patient Education and Counseling 2014: 96: 411 – 8.

GKCSAF

A. Builds a relationship
B. Opens the discussion
C. Gathers information
D. Understands the patient's and families
E. Shares information
F. Reaches agreement
G. Provides closure
H. Demonstrates empathy
I. Communicates accurate information

RUCIS

- Iramaneerat C, et al. Evaluating the effectiveness of rating instruments for a communication skills assessment of medical residents. Adv Health Sci Educ Theory Pract 2009;14 : 575 -94.

RUCIS

1. Friendly communication
2. Respectful treatment
3. Listening
4. Honest communication
5. Interest in patient as a person
6. Discussion options
7. Encourage questions
8. Clear explanation
9. Physical examination
10. Vocabulary
11. Sensitive subject matters
12. Receptiveness to feedback
13. Overall impression

Summary

- Basic considerations in assessment
  - Formative and summative
  - Knows, knows how, shows how, does
- Commonly used assessment tools
  - Calgary-Cambridge guide
  - Gap-Kalamazoo form
  - RUCIS scale
- Practice using the instruments

"Purposeful assessment drives instruction and affects learning."

Wisconsin's guiding principles for teaching and learning

14

CALGARY - CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW – COMMUNICATION PROCESS

INITIATING THE SESSION

Establishing initial rapport

1. **Greets** patient and obtains patient's name

2. **Introduces** self, role and nature of interview; obtains consent if necessary

3. **Demonstrates respect** and interest, attends to patient's physical comfort

Identifying the reason(s) for the consultation

4. **Identifies** the patient's problems or the issues that the patient wishes to address with appropriate **opening question** (e.g. "What problems brought you to the hospital?" or "What would you like to discuss today?" or "What questions did you hope to get answered today?")

5. **Listens** attentively to the patient's opening statement, without interrupting or directing patient's response

6. **Confirms list and screens** for further problems (e.g. "so that's headaches and tiredness; anything else……?")

7. **Negotiates agenda** taking both patient's and physician's needs into account

GATHERING INFORMATION

Exploration of patient's problems

8. **Encourages patient to tell the story** of the problem(s) from when first started to the present in own words (clarifying reason for presenting now)

9. **Uses open and closed questioning technique**, appropriately moving from open to closed

10. **Listens** attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing

11. **Facilitates** patient's responses verbally and non–verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation

12. **Picks up** verbal and non–verbal **cues** (body language, speech, facial expression, affect); **checks out and acknowledges** as appropriate

13.**Clarifies** patient's statements that are unclear or need amplification (e.g. "Could you explain what you mean by light headed")

14. **Periodically summarises** to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information.

15. **Uses** concise, **easily understood questions and comments**, avoids or adequately explains jargon

16. **Establishes dates and sequence** of events

Additional skills for understanding the patient's perspective

17. Actively **determines and appropriately explores**:
    - patient's **ideas** (i.e. beliefs re cause)
    - patient's **concerns** (i.e. worries) regarding each problem
    - patient's **expectations** (i.e., goals, what help the patient had expected for each problem)
    - effects: how each problem **affects** the patient's life

18. **Encourages patient to express feelings**

PROVIDING STRUCTURE

Making organisation overt

19. **Summarises** at the end of a specific line of inquiry to confirm understanding before moving on to the next section

20. Progresses from one section to another using **signposting, transitional statements**; includes rationale for next section

Attending to flow

21. Structures interview in **logical sequence**

22. Attends to **timing** and keeping interview on task

BUILDING RELATIONSHIP

Using appropriate non-verbal behaviour

23. **Demonstrates appropriate non–verbal behaviour**

- eye contact, facial expression
- posture, position & movement
- vocal cues e.g. rate, volume, tone

24. If reads, writes **notes** or uses computer, does **in a manner that does not interfere with dialogue or rapport**

25. **Demonstrates** appropriate **confidence**

Developing rapport

26. **Accepts** legitimacy of patient's views and feelings; is not judgmental

27. **Uses empathy** to communicate understanding and appreciation of the patient's feelings or predicament; overtly **acknowledges patient's views** and feelings

28. **Provides support**: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership

29. **Deals sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

30. **Shares thinking** with patient to encourage patient's involvement (e.g. "What I'm thinking now is....")

31. **Explains rationale** for questions or parts of physical examination that could appear to be non-sequiturs

32. During **physical examination**, explains process, asks permission

EXPLANATION AND PLANNING

Providing the correct amount and type of information

33. **Chunks and checks:** gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed

34. **Assesses patient's starting point:** asks for patient's prior knowledge early on when giving information, discovers extent of patient's wish for information

35. **Asks patients what other information would be helpful** e.g. aetiology, prognosis

36. **Gives explanation at appropriate times:** avoids giving advice, information or reassurance prematurely

Aiding accurate recall and understanding

37. **Organises explanation:** divides into discrete sections, develops a logical sequence

38. **Uses explicit categorisation or signposting** (e.g. "There are three important things that I would like to discuss. 1st..." "Now, shall we move on to.")

39**. Uses repetition and summarising** to reinforce information

40. **Uses** concise, **easily understood language**, avoids or explains jargon

41. **Uses visual methods of conveying information:** diagrams, models, written information and instructions

42. **Checks patient's understanding** of information given (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary

Achieving a shared understanding: incorporating the patient's perspective

43. **Relates explanations to patient's illness framework:** to previously elicited ideas, concerns and expectations

44. **Provides opportunities and encourages patient to contribute:** to ask questions, seek clarification or express doubts; responds appropriately

45. **Picks up verbal and non-verbal cues** e.g. patient's need to contribute information or ask questions, information overload, distress

46. **Elicits patient's beliefs, reactions and feelings** re information given, terms used; acknowledges and addresses where necessary

Planning: shared decision making

47. **Shares own thinking as appropriate:** ideas, thought processes, dilemmas

48. **Involves patient** by making suggestions rather than directives

49. **Encourages patient to contribute their thoughts:** ideas, suggestions and preferences

50. **Negotiates** a mutually **acceptable plan**

51**. Offers choices:** encourages patient to make choices and decisions to the level that they wish

52. **Checks with patient** if accepts plans, if concerns have been addressed

CLOSING THE SESSION

Forward planning

53. **Contracts** with patient re next steps for patient and physician

54. **Safety nets**, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

Ensuring appropriate point of closure

55. **Summarises session** briefly and clarifies plan of care

56. **Final check** that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss

OPTIONS IN EXPLANATION AND PLANNING (includes content)

IF discussing investigations and procedures

57. Provides clear information on procedures, eg, what patient might experience, how patient will be informed of results

58. Relates procedures to treatment plan: value, purpose

59. Encourages questions about and discussion of potential anxieties or negative outcomes

IF discussing opinion and significance of problem

60. Offers opinion of what is going on and names if possible

61. Reveals rationale for opinion

62. Explains causation, seriousness, expected outcome, short and long term consequences

63. Elicits patient's beliefs, reactions, concerns re opinion

IF negotiating mutual plan of action

64. Discusses options eg, no action, investigation, medication or surgery, non-drug treatments (physiotherapy, walking aides, fluids, counselling, preventive measures)

65. Provides information on action or treatment offered
- name
- steps involved, how it works
- benefits and advantages
- possible side effects

66. Obtains patient's view of need for action, perceived benefits, barriers, motivation

67. Accepts patient's views, advocates alternative viewpoint as necessary

68. Elicits patient's reactions and concerns about plans and treatments including acceptability

69. Takes patient's lifestyle, beliefs, cultural background and abilities into consideration

70. Encourages patient to be involved in implementing plans, to take responsibility and be self-reliant

71. Asks about patient support systems, discusses other support available

References:
Kurtz SM, Silverman JD, Draper J (1998) Teaching and Learning Communication Skills in Medicine. Radcliffe Medical Press (Oxford)
Silverman JD, Kurtz SM, Draper J (1998) Skills for Communicating with Patients. Radcliffe Medical Press (Oxford)

Appendix

Gap-Kalamazoo Communication Skills Assessment Form* – Faculty/Peer Assessment

Date:	Your Name:	Your Title:

Title of Case:	Title of Conversation:

How well did the participant(s) do the following (please select one):

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
A: Builds a relationship (includes the following): • Greets and shows interest in the patient's family • Uses words that show care and concern throughout the interview • Uses tone, pace, eye contact, and posture that show care and concern • Responds explicitly to patient and family statements about ideas and feelings					
B: Opens the discussion (includes the following): • Allows patient and family to complete opening statement without interruption • Asks "is there anything else?" to elicit full set of concerns • Explains and/or negotiates an agenda for the visit					
C: Gathers information (includes the following): • Addresses patient and family statements using open-ended questions • Clarifies details as necessary with more specific or "yes/no" questions • Summarizes and gives family opportunity to correct or add information • Transitions effectively to additional questions					
D: Understands the patient's and families perspective (includes the following): • Asks about life events, circumstances, other people that might affect health • Elicits patient's and family's beliefs, concerns, and expectations about illness and treatment					
E: Shares information (includes the following): • Assesses patient's/family's understanding of problems and desire for more info • Explains using words that family can understand • Asks if family has any more questions					
F: Reaches agreement (includes the following): • Includes family in choices and decisions to the extent they desire • Checks for mutual understanding of diagnostic and/or treatment plans • Asks about acceptability of diagnostic and/or treatment plans • Identifies additional resources as appropriate					
G: Provides closure (includes the following): • Asks if patient and family have questions, concerns or other issues • Summarizes • Clarifies future time when progress will again be discussed • Provides appropriate contact information if interim questions arise • Acknowledges patient and family, and closes interview					
H. Demonstrates Empathy (includes the following): • Clinician's demeanor is appropriate to the nature of the conversations • Shows compassion and concerns • Identifies/labels/validates patient's and family's emotional responses • Responds appropriately to patients and family's emotional cues					
I: Communicates accurate information (includes the following): • Accurately conveys the relative seriousness of the patient's condition • Takes other participating clinician's input into account • Clearly conveys expected disease course • Clearly presents and explains options for future care • Gives enough clear information to empower decision making					

*__Adapted from:__ Essential Elements: The Communication Checklist, © 2001 Kalamazoo Consensus Statement Group, and from: Rider EA. Interpersonal and Communication Skills. In: Rider EA, Nawotniak RH. *A Practical Guide to Teaching and Assessing the ACGME Core Competencies, 2nd edition.* Marblehead, MA: HCPro, Inc., 2010. © 2010 HCPro, Inc. Used with permission. Contacts: Elizabeth Rider, MSW, MD - elizabeth_rider@hms.harvard.edu (member, Kalamazoo Consensus Statement Group) and Aaron Calhoun, MD - aaron.calhoun@louisville.edu (PERCS Program)

What did the participant(s) do best? (Please pick three choices)

- ❑ Builds a Relationship
- ❑ Opens the Discussion
- ❑ Gathers Information
- ❑ Understands the Patient's and Family's Perspective
- ❑ Shares Information
- ❑ Reaches Agreement
- ❑ Provides Closure
- ❑ Demonstrates Empathy
- ❑ Communicates Accurate Information

Why did you choose those particular answers?

In which domains could the participant(s) improve? (Please pick three choices)

- ❑ Builds a Relationship
- ❑ Opens the Discussion
- ❑ Gathers Information
- ❑ Understands the Patient's and Family's Perspective
- ❑ Shares Information
- ❑ Reaches Agreement
- ❑ Provides Closure
- ❑ Demonstrates Empathy
- ❑ Communicates Accurate Information

What could have been done better?

*__Adapted from:__ Essential Elements: The Communication Checklist, © 2001 Kalamazoo Consensus Statement Group, and from: Rider EA. Interpersonal and Communication Skills. In: Rider EA, Nawotniak RH. *A Practical Guide to Teaching and Assessing the ACGME Core Competencies, 2nd edition.* Marblehead, MA: HCPro, Inc., 2010. © 2010 HCPro, Inc. Used with permission. Contacts: Elizabeth Rider, MSW, MD - elizabeth_rider@hms.harvard.edu (member, Kalamazoo Consensus Statement Group) and Aaron Calhoun, MD - aaron.calhoun@louisville.edu (PERCS Program)

Revised UIC Communication and Interpersonal Skills Scale

Please choose the option that best describes how you feel toward the resident's communication skills. Some items also have a 'not applicable' option. Select this option when the context of the case does not allow you to observe that aspect of the resident's performance.	
1. Friendly communication	☐ You did not greet me, or greeted me perfunctorily, or communicated with me rudely during the encounter.
	☐ Your greeting and/or behavior during the encounter was generally polite but impersonal or distant.
	☐ You greeted me warmly and communicated with me in a friendly, personal manner throughout the encounter.
	☐ Your greeting and overall communication were friendly and compassionate. Your tone of voice was appropriate for the situation. Overall, you created an exceptionally warm and friendly environment that made me feel comfortable to tell you all of my problems.
2. Respectful treatment	☐ You showed an obvious sign of disrespect during the encounter. You treated me as an inferior.
	☐ You did not show disrespect to me. However, I observed some signs of condescending behavior. Although I believe it was unintentional, it made me feel that I was not at the same level with you.
	☐ You gave several indications of respecting me. If there was a physical exam, this includes draping me appropriately.
	☐ You were exceptionally respectful throughout the encounter. Your verbal and nonverbal communication showed respect for my privacy, my opinions, my rights, and my socioeconomic status.
3. Listening to my story	☐ You rarely gave me any opportunity to tell my story or frequently interrupted me while I was talking, not allowing me to finish what I said. Sometimes I felt you were not paying attention (for example, you asked for information that I already provided).
	☐ You let me tell my story without interruption, or only interrupted appropriately and respectfully. You seemed to pay attention to my story and responded to what I said appropriately.
	☐ You allowed me to tell my story without interruption, responded appropriately to what I said, and asked thoughtful

	questions to encourage me to tell more of my story.
	☐ You were an exceptional listener. You encouraged me to tell my story and checked your understanding by restating important points.
4. Honest communication	☐ You did not seem truthful and frank. I felt that there might be something that you were trying to hide from me.
	☐ You did not seem to hide any critical information from me.
	☐ You explained the facts of the situation without trivializing negative information or possibilities (e.g., side effects, complications, failure rates).
	☐ You were exceptionally frank and honest. You fully explained the positive and negative aspects of my condition. You openly acknowledged your own lack of knowledge or uncertainty, and things you would have to consult with others. When appropriate, you also suggested I seek a second opinion.
	☐ **Not applicable.** There was no information for the resident to provide.
5. Interest in me as a person.	☐ You never showed interest in me as a person. You only focused on the disease or medical issue.
	☐ In addition to talking about my medical issue, you spent some time getting to know me as a person.
	☐ You spent some time exploring how my medical issue affects my personal or social life.
	☐ You were exceptionally interested in me as a person. You not only explored how my medical problem affects my personal and social life, but also showed your willingness to help me address those challenges.
6. Discussion of options/plans	☐ You did not explain any options or plans, you just told me what you would do without asking for my opinion.
	☐ You explained options to me, but did not involve me in decision making. If you solicited my opinion, you just ignored it. You made all the decisions for me based on your medical opinion.
	☐ You discussed options with me, made recommendations, solicited my opinion regarding the options/plans, and incorporated my opinion into your medical planning.

	☐ You not only solicited my input, but also explored the reasons for my choice and showed your understanding and respect for my decisions by negotiating a mutually agreeable plan.
	☐ **Not applicable**. There were no decisions to be made in this case.
7. Encouraging my questions	☐ You did not solicit questions, or frequently avoided my questions, or did not provide helpful answers.
	☐ You sometimes asked if I had questions, but seldom waited at least 5 seconds to allow me to formulate questions. You addressed my questions briefly without avoiding them.
	☐ You actively encouraged me to ask questions, paused to allow me to formulate them, and provided clear and sufficient answers to all of my questions.
	☐ You actively encouraged me to ask questions several times during the encounter, with sufficient wait time. You spent significant time and effort to answer my questions clearly and confirmed that I understood the answer and that my concerns were addressed.
8. Providing clear explanations	☐ You rarely explained things to me; you did not help me better understand my situation.
	☐ You gave me only brief explanations of my situation; you did not help me understand what would happen next.
	☐ You gave me a full and understandable explanation of my situation, pertinent findings, and important next steps.
	☐ You gave me a full explanation of my situation, your thinking about it and your recommendation, and probed my understanding by letting me summarize pertinent information.
	☐ **Not applicable**. There was nothing to be explained in this case.
9. Physical examination	☐ You never or rarely warned me about what you were going to do with my body. You also never or rarely explained what you found from the physical examination.
	☐ You did not warn me about what you were going to do with my body, OR did not explain to me pertinent findings (both negative and positive) from your physical examination.
	☐ You told me what you were going to do to my body AND described what you found.

	☐ You helped me understand clearly what you were going to do to my body. You also provided clear explanation of what you found from the physical examination and the implications of your findings for my situation.
	☐ **Not applicable**. There was no physical examination in this case.
10. Appropriate vocabulary	☐ You used vocabulary that was too simple or too complex for me, or frequently used medical terms without explaining them to me. Sometimes I could not understand what you told me without asking for explanations of terms you used.
	☐ Your vocabulary was generally appropriate but you sometimes inadvertently used medical terms without explaining them to me.
	☐ Your vocabulary was appropriate and if needed you provided brief explanations of any medical terms you used without need for prompting.
	☐ Your vocabulary was appropriate and you always provided clear and full explanation of relevant medical terms you used. In addition, you helped me better my understanding of my condition with the medical terms you explained to me.
11. Sensitive subject matters (e.g., sexual history, tobacco/alcohol/drug use, religious/cultural issues, giving bad news, or difficult emotional states)	☐ You never warned me before approaching sensitive subject matters. You seemed judgmental and clearly expressed your disapproval of my positions or feelings, making me feel uncomfortable about discussing these subjects or feelings with you.
	☐ You were careful and nonjudgmental in discussing sensitive subject matters. However, you did not express understanding of my feelings and did not provide much emotional support.
	☐ You were sensitive about discussing difficult subjects and were respectful of my feelings. I never sensed that you were judgmental or disapproving of my positions or feelings on these subjects. You showed empathic understanding of my position or feelings and provided appropriate emotional support.
	☐ You were unusually empathic, sensitive and respectful of me and of my feelings and provided exceptional emotional support. In addition, you verbally reflected these back to me (e.g., "You sound sad") to show your understanding.
	☐ **Not applicable**. There were no sensitive subject matters in this case.

12. Receptiveness to feedback	☐ You did not seem open to my feedback about your performance. You responded defensively or dismissively to many of my comments.
	☐ You listened to my feedback agreeably but passively. You did not actively participate during the feedback session.
	☐ You were able to describe some of your own effective and ineffective behaviors, were attentive to my comments, and had an open discussion with me about alternative behaviors.
	☐ You actively solicited additional feedback and showed signs of integrating my feedback into your behavioral repertoire. For example, you tried to role-play the communication techniques I suggested.
	☐ **Not applicable**. I provided no feedback.
13. Do I want to see you again as my personal physician?	☐ I did not feel comfortable in communicating with you at all. I would rather see a different physician.
	☐ I think you were okay in general and might come see you again.
	☐ I was impressed by the way you communicated with me. I would like to see you again.
	☐ I was very impressed with you. I think you are one of the best physicians I have ever seen. I would feel very comfortable discussing any medical problems with you, and would recommend you to my friends.

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Assessing communication quality of consultations in primary care: initial reliability of the Global Consultation Rating Scale, based on the Calgary-Cambridge Guide to the Medical Interview

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ABSTRACT

Objectives: To investigate initial reliability of the Global Consultation Rating Scale (GCRS: an instrument to assess the effectiveness of communication across an entire doctor–patient consultation, based on the Calgary-Cambridge guide to the medical interview), in simulated patient consultations.

Design: Multiple ratings of simulated general practitioner (GP)–patient consultations by trained GP evaluators.

Setting: UK primary care.

Participants: 21 GPs and six trained GP evaluators.

Outcome measures: GCRS score.

Methods: 6 GP raters used GCRS to rate randomly assigned video recordings of GP consultations with simulated patients. Each of the 42 consultations was rated separately by four raters. We considered whether a fixed difference between scores had the same meaning at all levels of performance. We then examined the reliability of GCRS using mixed linear regression models. We augmented our regression model to also examine whether there were systematic biases between the scores given by different raters and to look for possible order effects.

Results: Assessing the communication quality of individual consultations, GCRS achieved a reliability of 0.73 (95% CI 0.44 to 0.79) for two raters, 0.80 (0.54 to 0.85) for three and 0.85 (0.61 to 0.88) for four. We found an average difference of 1.65 (on a 0–10 scale) in the scores given by the least and most generous raters: adjusting for this evaluator bias increased reliability to 0.78 (0.53 to 0.83) for two raters; 0.85 (0.63 to 0.88) for three and 0.88 (0.69 to 0.91) for four. There were considerable order effects, with later consultations (after 15–20 ratings) receiving, on average, scores more than one point higher on a 0–10 scale.

Conclusions: GCRS shows good reliability with three raters assessing each consultation. We are currently developing the scale further by assessing a large sample of real-world consultations.

Strengths and limitations of this study

- The Global Consultation Rating Scale (GCRS) is based on the widely used Calgary-Cambridge guide to the medical interview, and is designed to evaluate a practitioner's communication skills across an entire consultation, linking the identification of potential training needs to an established approach to teaching communication skills.
- We considered evaluator bias and order effects to obtain a more robust assessment of the reliability of GCRS to evaluate communication competence within a particular consultation.
- A particular limitation is that our findings are based on the use of simulated patient consultations. This had an impact on our ability to assess the performance of GCRS to evaluate communication competence of individual doctors, rather than particular consultations. A full evaluation of the performance of GCRS requires the assessment of real-world consultations and we are undertaking this at present.

INTRODUCTION

During the past 30 years, an extensive research literature has defined the skills that enhance communication between doctor and patient. This evidence demonstrates the essential role that communication plays in high-quality healthcare by enabling more accurate, efficient and supportive interviews, by enhancing patient and professional experience and by improving health outcomes for patients. The use of specific communication skills has been shown to lead to improvements in symptom relief, in clinical outcomes and possibly in medicine adherence.[1–6] In light of these findings,

there has been increasing pressure from professional medical bodies to improve the training and evaluation of doctors in communication.[7–13]

In order to evaluate doctors' communication skills effectively, tools with solid theoretical grounding and good psychometric properties are required. Various rating scales exist to assess doctor–patient consultations, which vary widely in their setting, approach and in the published details of their psychometric properties.[14 15] Perhaps for these reasons, none have become standard to use within the National Health Service (NHS), in spite of National Institute for Health and Care Excellence (NICE) standards which require that "Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills."[16] Recently, there has been a move towards domain, or global, marking schemes (awarding overall marks to groupings of items) rather than itemised checklists, the suggestion being that checklists may reward thoroughness rather than competence and work better for novices than for experts.[17] Global marking schemes may be more useful in postgraduate assessments, improving professional authenticity. We have, therefore, developed the Global Consultation Rating Scale (GCRS), based on the Calgary-Cambridge guide to the medical interview, to evaluate the communication effectiveness of an entire doctor–patient consultation, using the domain marking approach.

At present, there is a dearth of assessment tools that robustly measure the overall communication skills of an individual general practitioner (GP) in real-world practice. While a number of existing tools may be used to assess doctor–patient communication, their suitability to assess a doctor's overall communication skills in day-to-day practice irrespective of the content of the consultation is limited and they do not link specifically to educational material commonly used in the UK for subsequent communication skills development. GCRS differs from some alternative instruments, such as the MAAS-Global, in its aim of measuring communication skills only, irrespective of clinical content, to provide an assessment of doctors' generic communication skills and to thereby enable targeted communication teaching. For example, 4 of the 17 items in the MAAS-Global specifically assess medical content related to history, examination, diagnosis and management and other communication items are highly specific to particular content areas.[18] In comparison, the 12 global areas of GCRS include only communication process skills without content. Following the approach of the Calgary-Cambridge guide from which it is derived, GCRS takes the standpoint that, although the context of the interaction changes and the content of the communication varies, the process skills themselves remain the same and can be evaluated independently. This, together with domain rather than individual skill marking, enables the assessment of communication skills across a wide variety of consultations, especially helpful in real-world consultations where communication checklists cannot be specific and tailored for each case.

The Calgary-Cambridge guide to the medical interview[1 19–21] was developed by Silverman, Kurtz and Draper to delineate effective physician–patient communication skills and to provide an evidence-based structure for their analysis and teaching. Within the UK, over half of UK medical schools now use the Calgary-Cambridge approach in their communication skills programmes.[22] It has been widely translated and is used in the USA, Canada and Europe. It has been used to teach communication in general practice and specialist environments, at undergraduate and postgraduate levels.

Specific tools have been developed from the guide for the assessment of medical students, practising paediatricians, dentists, pharmacists and veterinary practitioners, as well as for specific components of the consultation such as explanation and planning in OSCE style examinations.[23–25] Before now however, there has been no validated method of using the Calgary-Cambridge consultation guide to assess complete consultations between qualified doctors and patients. This type of assessment is particularly important in postgraduate and continuing medical education in which the observation of whole consultations from real practice provides increased validity. In addition, for personal development and annual appraisal, a reliable validated assessment tool which also enables a specific link to targeted teaching of communication skills is particularly relevant. Our intention with GCRS is to develop an instrument capable of credibly evaluating a doctor's communication competence, identifying potential areas for improvement which could then be addressed directly with linked, tailored education, using the Calgary-Cambridge guide.

The aim of this study was to investigate the initial reliability of GCRS in simulated patient consultations such as those which might be used in training, as a precursor to its use with real patient consultations where GPs are assessed on their performance. To assess reliability, we asked five specific questions. These are detailed below, together with the reasons for their investigation:

A. Does a fixed difference between scores in GCRS have the same meaning at all levels of performance? If it does not, GCRS scores may not be useful for distinguishing between performance uniformly at all levels of performance, and could require transformation prior to analysis.
B. What is the reliability of GCRS in assessing individual consultations (with different numbers of raters per consultation)? One of two core questions: how consistently does GCRS perform in evaluating communication skills within a particular consultation, and how many raters are required to obtain performance estimates we are confident distinguish better from worse consultations?
C. What is the reliability of GCRS in assessing individual doctors' performance across a number of

consultations (with different numbers of raters and consultations per doctor)? The second core question: how many consultations, and how many raters, do we need to evaluate a particular doctors' consultation skills such that we can differentiate them from their peers?

D. Are some raters more generous than others in their assessments of consultations? Wide variation between the scores assigned by raters can lead to reduced reliability. Understanding whether systematic biases are present helps to inform whether to adjust reliability estimates for these or not.

E. Does the order in which a consultation is rated affect the score? Psychological experiments have shown that the order in which information is presented can influence the way in which that information is processed.[26] Sequential order biases may present themselves either as an overall increase or decrease in scores throughout a judging period; or as observable effects of implicit comparisons being made between the previous and current items being judged.[27 28] Thus, a GCRS rater may use norm-based rather than criterion-based referencing when assigning scores as they proceed through the consultations being evaluated.

METHODS

Trained GP raters watched video recordings of consultations between volunteer GPs and simulated patients and completed GCRS for each. We used videos from a previous study investigating the way in which GPs discussed taking statins to prevent cardiovascular disease with simulated patients trained to play one of two roles. The two roles differed in the extent of the actor's assertiveness in asking questions about proposed management. Both roles displayed sufficient cardiovascular risk to be eligible for statins according to current NICE recommendations. Actors were experienced in playing the role of simulated patients. They were provided with a detailed written role description, including notes on their intended style of response to questions. Actors rehearsed their roles before undertaking videotaped simulations with participant GPs. GPs (n=23) selected for recruitment to the original study varied in age, gender, length of time since qualification and nature of practice (location, size and involvement with dispensing or training). They were recruited from four primary care trusts across the East of England (Cambridge, Luton, Bedford and Peterborough). Each GP conducted two consultations in their practice (one with each simulated patient), furnished with the results of appropriate medical investigations for the simulated patient. The purpose of the consultation was, from the perspective of GP and patient, to discuss the possibility of starting statin medication. This generated a total of 46 recorded consultations. For this study, we excluded videos from two GPs: one had since become a trained GP GCRS evaluator, while the videos for the second were damaged (see online supplementary appendix 1 figure S1). This left 42 videoed consultations for assessment. All GPs gave their written consent for the re-use of their videos.

Global Consultation Rating Scale

The GCRS covers 12 domains from 'initiating the session' to 'closure' (see online supplementary appendix 3 for the full scale). Guidance is given within the text of the scale as to the nature of the skills that are assessed within each individual domain, which is given a score as follows: Not applicable (not scored)

0. Not done/poor
1. Adequate
2. Good

The use of a three-point scale, while narrow, (1) enables a clear focus on identifying the likely need for targeted training in that area and (2) reflects the need for a simple and easy-to-use scale suitable for use while observing a consultation. A total consultation score between 0 and 24 is obtained by summing the scores from the 12 domains. In the case where a domain is considered to be not applicable, scores are renormalised to be out of 24, for example, a score of 12 out of 22 would become a score of 13.1 (=12×24/22) out of 24 (NB: this was not required in this study).

GP raters

We recruited six GP raters experienced in teaching and assessing communication skills using the Calgary-Cambridge consultation guide within the School of Clinical Medicine, University of Cambridge. All attended a 2 h training session on the use of GCRS with JS, which included a specially created training video of consultations for evaluation. In training, particular attention was paid to the differences between 'good', 'adequate' and 'poor' communication behaviours, guided by the criterion referenced norms established by the Calgary-Cambridge guide. The aim was to establish a shared understanding of expected standards of behaviour across each domain.[29] Following training, each evaluator rated 28 videos. These were randomly assigned and provided in a random order for rating. Randomisation was performed with maximum cross over between raters to allow study of possible order effects (see online supplementary appendix for further details).

GP raters were requested to complete evaluations within 1 month of collecting the videos and were paid for their time. On receipt of ratings some missing domain scores were noted (19 of 2184, 0.87%). The five raters who had missed scores watched the corresponding videos again and filled in the missing sections only. Double data entry was conducted (NE, GA) for all ratings. For the four scores (0.20%), in which there was inconsistency, the original score sheets were consulted to obtain the correct score.

Statistical analysis

The overall aim of this work was to estimate the statistical reliability of GCRS as a tool to assess consultations or doctors. Statistical reliability is an index of how well better performance can be distinguished from worse performance, and estimates how much of the variation in scores is due to true variation in performance rather than to noise due to different raters rating the same consultation differently. A reliability of 1 indicates that all the variation in measured scores is due to true variation in performance, that is, that scores are perfectly reliable. A reliability of 0 indicates that all the variation in measured scores is due to statistical noise. Between these two extremes, a reliability of 0.8 is generally considered the minimum required for most applications.[30]

Does a fixed difference between scores in GCRS have the same meaning at all levels of performance?

One of the key assumptions made when calculating reliability is that measurement errors are independent of the true values. When this is not true a single reliability value cannot apply to all scores. Another way of thinking of this is that we require a fixed difference between two scores (eg, a two point difference) to have the same distinguishing quality across the full range of scores. For this to be true, the variability in raters' scores of the same consultation must be the same at all levels of performance. We checked this by plotting the SD of ratings for each consultation against the mean score for that consultation (a variation on the standard Bland-Altman plot, allowing for more than two ratings per consultation). We found that the variance was not the same across all mean scores, implying that, for raw scores, a fixed difference does not have the same meaning at all levels of performance. We, therefore, sought a transformation to stabilise the variance across all mean scores. The transformed data were used for all further analysis.

What is the reliability of GCRS for assessing single consultations?

Our experimental setup allowed us to distinguish between three different sources of variance:

1. differing performance between doctors
2. differing performance of the same doctor between consultations, and
3. differing evaluator scores of the same consultation

In order to calculate the crude reliability, we fitted a three-level linear regression model to reflect this, with no fixed effects and with random intercepts for consultation and doctor (ie, rating nested within consultation further nested within doctor). From such a model we can estimate the reliability that would be achieved for assessing single consultations with different numbers of raters (see online supplementary appendix). The same analysis was performed on the scores for each of the individual domain of GCRS.

What is the reliability of GCRS in assessing individual doctors' performance across a number of consultations?

Using the same approach, we can also estimate the reliability of GCRS for assessing doctor's performance using different numbers of raters to assess each doctor, and using different numbers of consultations per doctor (see online supplementary appendix).

Are some raters more generous than others in their assessments of consultations?

In order to establish whether there were systematic biases between the scores given by different raters, we augmented the model described above with fixed effects for raters. If present, biases between raters will increase the variation in scores, and in turn reduce the reliability of scores. The systematic biases between raters could be accounted for, and we estimated adjusted reliabilities after doing so.

Does the order in which a consultation is rated affect the score?

Finally, to investigate possible order effects we included the order of rating in the above model. To account for non-linear effects we used a restricted cubic spline with three knots. We excluded data from one evaluator in this analysis because they had not rated the consultations in the order requested.

CIs on all estimates were calculated using bias corrected bootstrapping with 1000 repetitions and resampling at the doctor level.

The approach outlined above falls somewhere between classical reliability studies in which only one source of variance is identified (eg, inter-rater reliability) and a generalisability theory approach.[31] However, due to the limited data available we feel the approach taken is the most appropriate, and further it allows a more nuanced investigation of order effects considering non-linear functions.

Statistical analysis was conducted using Stata V.11.2.

RESULTS

The distribution of mean scores for the 42 consultations assessed (untransformed on a 0–24 scale) is shown in figure 1A. The highest mean consultation score was 16.25 of 24 and the lowest 1.5.

Does a fixed difference in GCRS have the same meaning at all levels of performance?

Figure 1C shows the Bland-Altman type plot for the untransformed data. There was a clear trend of increasing SD of scores for each consultation with increasing mean score. This implies that there was a higher degree of agreement between raters at low scores than at the moderate scores (10–14) which form the upper end of our data set. We found that a transformation based on the logit function performed reasonably well at stabilising the variance (see online supplementary appendix

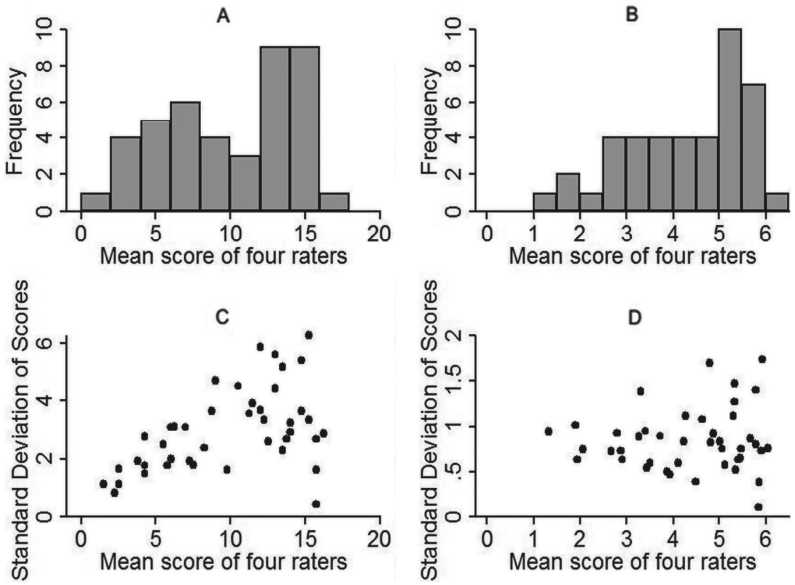

Figure 1 Histograms showing the distribution of mean consultation scores on the native (possible values 0 to 24) scale (A) and transformed (possible values 0 to 10) scale (B). Bland-Altman plot of consultation ratings shown on the native scale (C) and transformed scale (D).

for details and lookup table). The transformation has been constructed such that the transformed scores lie between 0 and 10. The distribution of the transformed scores is shown in figure 1B.

The resulting Bland-Altman plot of transformed data is shown in figure 1D in which there is little indication of a trend (note that the increase in spread of SDs is due to the possible values available and is not considered to be a major issue). All further results relate to the transformed data.

What is the reliability of GCRS in assessing single consultations, and in assessing individual doctors' performance?

The SDs for the three sources of variation estimated from the crude mixed model (with no adjustment for rater bias) are shown in table 1. The largest SD was that for between doctors, implying that this is where the largest variation is seen. The SD of scores of the same consultation by different raters was slightly smaller than that attributed to between doctors' performance. Finally, the estimates suggested that variation at the consultation level within individual doctors was essentially zero ($SD=1.03\times10^{-9}$). This finding is likely to be a function of our dataset. We do not present any reliability estimates for rating doctors here, and outline the reasons for this in the discussion. The reliability estimates for rating consultations for different numbers of raters are shown in table 2. In the crude model, the commonly used reliability thresholds of 0.7 (modest), 0.8 (acceptable) and 0.9 (excellent) were achieved using two, three and seven raters, respectively.[30] With four raters, as used in this study, we achieved a reliability of 0.85 (95% CI 0.61 to 0.88). Details of the distribution of scores and the reliabilities of individual domains are available in online supplementary appendix figure S2 and online supplementary appendix table S2. These indicate that four raters would be sufficient to provide a broad indication of domains where a doctor may have some performance issues.

Are some raters more generous than others in their assessments of consultations?

When we allowed for systematic bias between raters in our model we found that such bias was present (table 3). On an average, a difference of 1.65 (on the 0–10 scale for transformed data) was seen between the least and most generous raters. By adjusting for evaluator bias we increased reliability somewhat (table 2), and the number of raters needed to reach the 0.7, 0.8 and 0.9 thresholds became two, three and five, respectively.

Table 1 SDs estimated for the three sources of variation from a crude model and one adjusting for systematic bias between raters

	SD	
Source of variation	**Crude model**	**Model adjusted for evaluator bias**
Between doctors	1.21 (0.87, 1.38)	1.18 (0.87, 1.33)
Within doctors and between consultations	1.03×10^{-9} (7.25×10^{-13}, 1.95×10^{-9})	0.14 (0.00, 0.15)
Within consultations and between raters	1.03 (0.96, 1.16)	0.88 (0.82, 1.01)

Table 2 Crude and adjusted reliability for evaluating consultations for different numbers of raters using GCRS (transformed 0–10 data)

Number of raters	Crude reliability* (95% CI)	Reliability adjusted for evaluator bias* (95% CI)
1	0.58 (0.28 to 0.66)	0.65 (0.36 to 0.71)
2	0.73 (0.44 to 0.79)	0.78 (0.53 to 0.83)
3	0.80 (0.54 to 0.85)	0.85 (0.63 to 0.88)
4	0.85 (0.61 to 0.88)	0.88 (0.69 to 0.91)
5	0.87 (0.66 to 0.91)	0.90 (0.74 to 0.93)
6	0.89 (0.70 to 0.92)	0.92 (0.77 to 0.94)
7	0.91 (0.73 to 0.93)	0.93 (0.80 to 0.95)
8	0.92 (0.76 to 0.94)	0.94 (0.82 to 0.95)
9	0.93 (0.78 to 0.95)	0.94 (0.84 to 0.96)
10	0.93 (0.80 to 0.95)	0.95 (0.85 to 0.96)

*Calculated from the estimated SDs shown in table 1.
GCRS, Global Consultation Rating Scale.

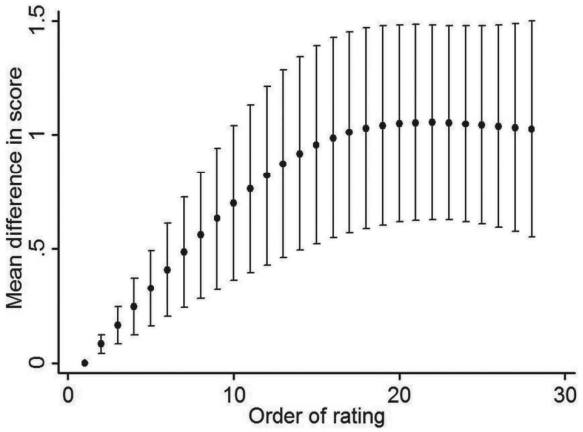

Figure 2 The effect of order of rating on transformed scores compared with the first rating performed. Dots indicate point estimates and bars show 95% CIs.

Does the order in which a consultation is rated affect the score?

Finally, we found evidence of considerable order effects, with raters giving higher scores, on average, as they progressed through the rating of consultations (figure 2). It appears that raters' scoring levelled out after performing around 15–20 ratings. Later consultations received, on average, scores more than one point higher on the 0–10 scale.

DISCUSSION

GCRS shows good reliability (>0.8) with three raters assessing each consultation, and modest reliability (>0.7) with two raters. Overall, consultations received low-to-moderate scores. This reflects previous findings with simulated patients, where it has been seen that participating doctors only attain about 40–60% of the guidelines or standards used for evaluation.[32] GCRS is designed to assess overall communication effectiveness of the entire doctor–patient consultation, encapsulating the quality of the interaction from the opening moments, through the gathering of information, provision of information, achieving shared understanding and shared decision-making, through to closure. It is a performance-based assessment (assessing what doctors actually do in professional practice) rather than a competence-based assessment (assessing what doctors can do in controlled representations of professional practice).[33] It is additionally a criterion-referenced measure; GCRS training course highlights the importance of assessing performance against the 'gold standard' outlined in the Calgary-Cambridge guide.

Table 3 Estimated biases between raters using GCRS (transformed 0–10 data)

Evaluator	Mean difference (95% CI)
1	Reference
2	−0.25 (−0.57 to 0.13)
3	−0.68 (−1.20 to −0.18)
4	0.97 (0.66 to 1.33)
5	−0.25 (−0.76 to 0.31)
6	0.49 (0.04 to 0.96)

GCRS, Global Consultation Rating Scale.

While GCRS was devised as a global assessment, doctors may be interested in knowing their performance in particular domains in order to most efficiently target training. For individual GCRS domains, reliability was broadly acceptable with four raters. Low reliability for two particular domains—non-verbal communication and closure—may be attributable to small between-consultation variance rather than to raters disagreeing with each other on these areas. There are two possible explanations: either that raters find it difficult to distinguish differences in doctors' behaviours on these items (reflecting inadequate training for raters in how to assess these domains, or challenges in capturing, eg, non-verbal behaviour) or that doctors perform comparably across consultations and compared with each other on these two domains, prompting raters to award consistently similar scores.

We found that a fixed difference between scores in GCRS did not have the same meaning at all levels of performance: untransformed scores (on a scale of 0 to 24) showed a higher degree of agreement between raters at low scores than at moderate scores. For this reason, analyses were performed on transformed scores. This has implications for the most suitable score to feedback to participants if, for example, GCRS is to be used in a training situation. Transformed scores may be intuitively more difficult for participants to understand, and we need to undertake further work on the acceptability of using transformed scores in assessments of an individual doctors' performance, and how best to calculate and present transformed scores for doctors and trainers.

While we found good reliability of GCRS in assessing the communication quality of individual consultations, comparison with existing instruments is difficult due to limited published psychometric data on assessing consultation (rather than doctor) quality. Interconsultation doctor reliability has been evaluated using the Four Habits Coding Scheme over 13 consultations (reliability of 0.72 with two raters),[34] and using the Liv-MAAS over nine consultations (reliability of 0.78 with three raters).[35] Evaluating the reliability of GCRS for assessing performance of individual doctors using different numbers of consultations will require more consultations per doctor, probably with greater subject variety, than we had in our dataset. We hope that further work on GCRS will enable us to estimate this in future.

We found consistent differences in scores assigned to consultations by the most and least generous raters. The Hawk/Dove phenomenon is well documented across a wide range of performance assessments, and can be addressed through training, through the use of more than one rater and through the use of post hoc statistical techniques.[36] All of these were employed in this study, and our finding of such variation highlights the importance of using pre-evaluation and postevaluation approaches in monitoring and acting upon differences between raters.[37]

We found evidence of considerable order effects. The use of multiple raters rating consultations in random order will tend to reduce order effects: sometimes a consultation will be rated early by an evaluator, and sometimes late; thus different orders for different raters average out. We have not been able to find other examples of the examination of this in GP consultation evaluation, but as previously stated, the influence of the sequential presentation of information on subsequent assessments of this information is a well-known phenomenon in the psychological literature.[26] Again, this is something which requires further work to assess how GCRS will perform in training situations.

The current study has a number of limitations. We included only a small number of GPs whose consultations had been recorded, derived from an earlier study, and only two similar scenarios per GP. These standardised scenarios do not reflect real-world consultations of variable nature and content, and we believe these are the reasons why we find little variation between consultations of the same doctor. We could not, therefore, assess how raters responded to different contexts: this is the focus of our next stage of work.

There are various sources of possible bias we did not examine due to sample size limitations. For example, contrast effect bias may be important in influencing rater behaviour, where, for example, viewing a good consultation after a series of poor consultations may lead to a substantial leap in scores assigned due to the contrast between them.

Feedback from raters showed that the assessment of consultations required significant concentration. Average consultation length was around 15 min: viewing each consultation and completing the rating scale means each evaluation can take around 20 min.

CONCLUSIONS

GCRS has good reliability (>0.8) for rating consultations if three raters are used. Systematic differences were observed between raters: adjusting for these further improves reliability of the scale. We are currently developing the scale further by assessing a large sample of consultations in a real-world setting. This will enable a more detailed examination of the ability of the scale to assess performance between consultations of the same doctor. Once further psychometric evaluation is completed, we envisage that GCRS has the capacity to provide a robust yet practical assessment tool for the evaluation of communication skills in everyday practice, linked to the Calgary-Cambridge training approach to target identified areas for improvement.

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Contributors JBu designed the study, contributed to the analysis and interpretation of data and drafted the article. GA designed the study, undertook the analysis and contributed to the interpretation of data and drafting of the final version of the article. NE undertook data collection, and contributed to the analysis, the interpretation of data and drafting of the final version of the article. JC and MR designed the study, contributed to the interpretation of data and critically revised the article. JBe designed the study, supervised data collection and contributed to the interpretation of data and drafting of the final version of the article. JS designed the study, contributed to the interpretation of data, critically revised the article and devised the Global Consultation Rating Scale. All authors conceived the study and approved the final version of the article.

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The reliability of a modified Kalamazoo Consensus Statement Checklist for assessing the communication skills of multidisciplinary clinicians in the simulated environment

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ABSTRACT

Objective: With increased recognition of the importance of sound communication skills and communication skills education, reliable assessment tools are essential. This study reports on the psychometric properties of an assessment tool based on the Kalamazoo Consensus Statement Essential Elements Communication Checklist.

Methods: The Gap-Kalamazoo Communication Skills Assessment Form (GKCSAF), a modified version of an existing communication skills assessment tool, the Kalamazoo Essential Elements Communication Checklist-Adapted, was used to assess learners in a multidisciplinary, simulation-based communication skills educational program using multiple raters. 118 simulated conversations were available for analysis. Internal consistency and inter-rater reliability were determined by calculating a Cronbach's alpha score and intra-class correlation coefficients (ICC), respectively.

Results: The GKCSAF demonstrated high internal consistency with a Cronbach's alpha score of 0.844 (faculty raters) and 0.880 (peer observer raters), and high inter-rater reliability with an ICC of 0.830 (faculty raters) and 0.89 (peer observer raters).

Conclusion: The Gap-Kalamazoo Communication Skills Assessment Form is a reliable method of assessing the communication skills of multidisciplinary learners using multi-rater methods within the learning environment.

Practice implications: The Gap-Kalamazoo Communication Skills Assessment Form can be used by educational programs that wish to implement a reliable assessment and feedback system for a variety of learners.

1. Introduction

Sound interpersonal and communication skills are critical to the provision of quality healthcare. Effective communication with patients, families and physicians has been shown to enhance coping, mitigate grief, improve adherence to treatment, alter perceptions of care and reduce medical errors and litigation [1–6]. The National Board of Medical Examiners (NBME), Association of American Medical Colleges (AAMC), Institute of Medicine, and Accreditation Council on Graduate Medical Education (ACGME) have suitably placed a priority on the teaching and assessment of interpersonal and communication skills in undergraduate and graduate medical education [6–10]. Consequently, in the United States, achieving competency in communication has become a factor for promotion, graduation and licensure [7–9]. Teaching and assessing communication skills remains a complex and historically under-represented component of medical education [10,11]. Fortunately, increased awareness of the importance of communication and relationships in healthcare, and more emphasis on the importance of communication skills training in medical education, has led to an ever growing body of literature regarding the teaching and assessing of communication skills available to educators [10,12–17]. This article reports on the psychometric properties of an assessment tool which was derived from The Kalamazoo Consensus Statement [18], an exemplar in the field of medical communication research, education and assessment.

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The Kalamazoo Consensus Statement was developed in 1999 by 21 North American leaders from the fields of medical education and communication [18]. Their intent was to delineate a list of elements essential to physician–patient communication for the purpose of facilitating the development, implementation and evaluation of communication curricula [18]. The result was a list of seven "essential elements," or communication tasks, that define effective physician–patient communication. This consensus statement has since served as a framework for the development of numerous educational programs [10,15,19–23].

In subsequent years the same group met to create the Kalamazoo Essential Elements Communication Checklist (KEECC), an assessment tool for the purpose of rating learners' competency across the seven essential elements of the Kalamazoo Consensus Statement [10]. The essential elements, or competencies (Builds the Relationship, Opens the Discussion, Gathers Information, Understands the Patient's and Family's Perspective, Shares Information, Reaches Agreement, and Provides Closure), are rated using a categorical 4-option scale across 24 sub-competencies. This tool has applicability to all levels of training and various settings [10]. Two additional iterations of the KEECC, the Kalamazoo Essential Elements Communication Checklist-Adapted (KEECC-A) [10] and the Gap-Kalamazoo Communication Skills Assessment Form (GKCSAF) [10] have been published. The GKCSAF has been adapted for multi-rater use, a powerful method for assessing communication skills that enhances self-insight [11,24]. In combination, these three tools have been used in undergraduate and graduate medical education and healthcare education programs nationally and internationally [10,11,24,25].

Simulation, either through the use of role-play or standardized patients, is an increasingly common and effective educational modality for use in communication skills education [3,13,15]. With the growth of simulation-based training comes the need for reliable assessment tools for use in the simulated environment. While psychometric data exists regarding the KEECC [9], KEECC-A [25] and GKCSAF [11], to our knowledge no study has evaluated inter-rater reliability among the communication elements of the Kalamazoo Tools, nor has there been a psychometric analysis for a multidisciplinary field of learners in the simulated environment. The objective of this paper, therefore, is to build on the work of previous studies, by reporting the internal consistency and inter-rater reliability of the GKCSAF when used for multi-rater assessment of multi-disciplinary learners in a simulation-based communication skills education program.

2. Methods

2.1. Tool development

Three assessment tools based on the Kalamazoo Consensus Statement have been published [10]. The original tool, the KEECC, rated learners categorically (i.e., done well, needs improvement, not done, not applicable) on seven competencies and 24 sub-competencies [10,18]. Rider and colleagues at Harvard Medical School adapted the KEECC by adding a 5-point Likert scale (1 = poor to 5 = excellent) [10]. This adapted version, the KEECC-A, allows for evaluation of the seven Kalamazoo Essential Elements on a global ratings scale and the 24 sub-competencies function as a rubric for this checklist [10]. The Likert scale can also be used to rate each competency and sub-competency. Calhoun, Rider and colleagues modified the KEECC-A to include two more communications elements, Demonstrates Empathy and Communications Accurate Information, creating the GKCSAF [10,24]. This latest Kalamazoo Consensus Statement instrument was also modified for use by multiple raters (modeled after 360° assessment tools) and includes a section for gap analysis [24]. Gap analysis is a novel application of multi-rater feedback that consists of comparing rating scores from different groups of raters, for example faculty or peer observers, with self-score of the participant or participant team [11]. This comparison of scores has been shown to enhance learner self-insight [11]. The GKCSAF contains Likert-scale, forced-choice, and free-text fields, enabling it to provide absolute and relative scores for each aspect of communication and specific comments regarding strengths and areas needing improvement. A similar version of the instrument was created for simulated patients/families using language that was assessed by Microsoft Word as suitable for a reader at the United States 6th grade reading level, which roughly translates to a reading level appropriate for a 10–12 year old (Table 1).

Table 1
Description of the Kalamazoo Consensus Statement assessment instruments.[a]

Kalamazoo instrument	Data type	Instrument description	Psychometric studies
Kalamazoo Essential Elements Communication Checklist	Categorical ratings: Done well Needs improvement Not done Not applicable	Includes the Kalamazoo Consensus Statement 7 core communication competencies and 24 sub-competencies	Schirmer JM, Mauksch L, Lang F, Marvel MK, Zoppi K, Epstein RM, Brock D, Pryzbylski M. Assessing communication competence: a review of current tools. Fam Med 2005;37:184–92
Kalamazoo Essential Elements Communication Checklist-Adapted[b]	5-point Likert scale: 1 = poor to 5 = excellent	Global ratings on the 7 core competencies Second version with ratings on 7 core and 24 sub-competencies	Joyce BL, Steenbergh T, Scher E. Use of the Kalamazoo Essential Elements Communication Checklist (Adapted) in an institutional interpersonal and communication skills curriculum. J Grad Med Educ 2010;2:165–9
Gap–Kalamazoo Communication Skills Assessment Form	Likert-scales, forced-choice and free-text fields to provide absolute and relative scores for each competency; and specific comments on strengths and areas needing improvement	Global ratings on the 7 core competencies and 2 additional competencies: Demonstrates Empathy, and Communicates Accurate Information *Versions*: • Clinician/Faculty (also used by Peer Facilitators) • Self-assessment • Patient/Family (6th grade reading level)	Calhoun AW, Rider EA, Meyer EC, Lamiani G, Truog RD. Assessment of communication skills and self-appraisal in the simulated environment: feasibility of multi-rater feedback with gap analysis. Simul Healthc 2009;4:22–9

[a] The instruments are published in: Rider EA, Nawotniak RH. A practical guide to teaching and assessing the ACGME core competencies, 2nd ed. Marblehead, MA: HCPro Inc.; 2010.
[b] To preserve research integrity, we recommend using the authentic versions of the Kalamazoo instruments. The version of the GKCSAF used in this study is included as an Appendix with this article.

2.2. Tool implementation

The GKCSAF has been used for four years to assess communication competencies of participants in the Program for the Approach the Complex Encounters (PACE). PACE is a simulation-based curriculum at the University of Louisville School of Medicine developed to enhance the skills of multidisciplinary healthcare professionals in navigating challenging communication situations [15]. PACE relies on the Kalamazoo Consensus Statement competencies as a framework for communication skills education. During a PACE session, after a brief discussion of communication strategies, resident/nurse (or rarely resident/chaplain) clinician teams embark on a simulated conversation with a patient family portrayed by standardized patients (SP). Clinician teams always consist of one physician and one allied health professional, however, determination of which participants simulate which conversation are left up to the participants themselves. PACE sessions are typically attended by two to three faculty members who help guide post-simulation feedback and discussion. Each simulated conversation is rated by PACE faculty members, standardized patients, peer-observers and the participants themselves in a 360° fashion using the GKCSAF.

2.3. Tool training

Faculty, peer observers, standardized patients and participants were not trained specifically on the use of the GKCSAF prior to this study. This was done intentionally as many assessment tools have been validated by studies in which raters were formally trained on the use of the tool in question. Extensive training, however, is not always possible given the issues of lack of free time that chronically plague busy clinical faculty, residents with duty-hours restrictions and hospital staff carrying full-time work schedules. Thus, we wanted to assess the psychometric properties of the GKCSAF in an environment that most closely reflects how we anticipate this tool will be used.

2.4. Scoring

The GKCSAF is composed of nine essential communication elements rated on a 5-point Likert Scale (1 = Poor, 2 = Fair, 3 = Good, 4 = Very good, 5 = Excellent). In the PACE sessions, four versions of the Gap-Kalamazoo Tool are generated for each simulated conversation, generated by the four groups of raters: a self-assessment, faculty assessment, peer observer assessment and standardized patient (SP) assessment. Competency-specific overall scores are calculated by averaging individual scores for each competency. Learners are provided a written feedback form following their PACE session, detailing cumulative assessment scores from all raters across all communication elements.

2.5. Statistical analysis

For the purpose of statistical analysis, faculty and peer observer ratings were used. The unit of analysis was the clinician team. To assess internal consistency, a Cronbach's alpha score was calculated for simulated conversations to provide an overall alpha for faculty and peer ratings, respectively. These groups were chosen due to the relatively consistent number of raters across all sessions, allowing for more consistent statistical assessment. In addition to this, we calculated a separate Cronbach's alpha for each faculty rater across all sessions and averaged these values to generate an additional Cronbach's alpha. This was done to assure the accuracy of the initial score, given the possibility of intra-session correlations in rating that could artificially elevate the statistic. As the same peer observers did not rate every conversation within a PACE session, we were unable to perform a separate Cronbach's alpha for peer observers in the same manner. Inter-rater reliability was analyzed using intra-class correlation coefficients (two-way random, consistency measures) (ICC). This statistic was calculated for all simulated conversations in which 3 faculty members or peer observers provided ratings. ICC's were calculated for each communication element and for the overall average score of each tool. Cronbach's alpha scores and ICCs are reported for faculty and peer observers separately. Statistics were calculated using SPSS ver 21.

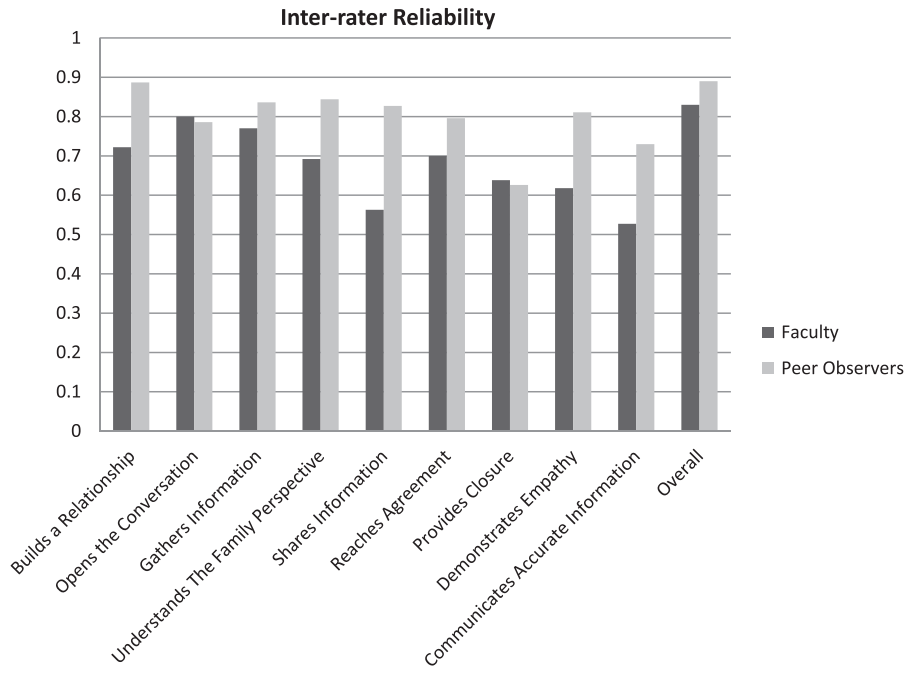

Fig. 1. Intra-class correlation coefficient scores for communication domains of the Gap-Kalamazoo Communication Skills Assessment Form for faculty and peer observers.

3. Results

3.1. Subjects

Since its inception in 2009, PACE has simulated 118 conversations for 173 participants. Participants include medical residents 2–4 years after receiving their M.D. degree (categorical pediatric and combined pediatric/internal medicine residents, $N = 108$), nurses (bedside nurses, nursing administrators and nursing students, $N = 63$) and hospital chaplains ($N = 2$). Of those conversations, 44 had 3 faculty raters and 25 had 3 peer observer raters rendering them eligible for analysis by ICC.

3.2. Tool internal consistency

There were 118 faculty rated conversations and 72 peer observer rated conversations from which to calculate a Cronbach's alpha. The Gap-Kalamazoo tool demonstrated an overall Cronbach's Alpha of 0.844 for faculty and 0.880 for peer observers. Faculty rater-specific Cronbach's alpha scores were 0.837 ($N = 106$ of conversations used for calculation), 0.818 ($N = 104$) and 0.90 ($N = 61$), respectively. The overall average of the faculty rater sub-alpha scores was 0.852.

3.3. Tool reliability

Faculty ICC scores ranged from 0.527 to 0.800 for each domain of communication. Among faculty, the lowest ICC's were noted for the elements of Communicates Accurate Information and Shares Information (0.527 and 0.563, respectively), while the elements with the highest ICC's were Opens the Discussion and Gathers Information (0.800 and 0.770, respectively). The overall ICC was 0.830.

Peer observer ICC scores ranged from 0.626 to 0.887 for each domain of communication. Among peer observers, only one communication domain, Provides Closure, scored <0.7. Five elements had ICCs >0.8. The overall ICC was 0.890 (Fig. 1).

4. Discussion and conclusion

4.1. Discussion

The three published assessment tools developed from the Kalamazoo Consensus Statement (Table 1) are valuable resources for communication skills education [10]. Psychometric analysis of these tools strengthens their applicability across a variety of learning environments. A 2005 analysis of the psychometric properties of the KEECC demonstrated a Cronbach's alpha of 0.88 [9]. Previously published psychometric data analysis of the KEECC-A reported good internal consistency for a cumulative communications rating when used to evaluate medical residents during a simulated clinical encounter [25]. Good internal consistency has been previously published for the Gap-Kalamazoo Tool but was based on a small sample size of only seven learners [11]. To our knowledge no study has evaluated inter-rater reliability among the communication elements of the Kalamazoo Tools, nor has there been a psychometric analysis for a multidisciplinary field of learners. This latter consideration is of special importance, as the GKCSAF was specifically designed for a multidisciplinary, multi-rater assessment.

We designed the PACE curriculum to include multi-rater feedback. Multi-rater feedback is a holistic approach to evaluation particularly suited to communication skills training that places the learner at the center of multiple relationships including peers, patients/families and faculty [11]. By encompassing the feedback of patients/families and multi-disciplinary clinician peers, real-world validity is enhanced and more comprehensive feedback can be generated for learners [11]. Likewise, the GKCSAF is designed for multi-rater use, therefore, we chose to assess the internal consistency and inter-rater reliability for both faculty and peer observer ratings. However, we did not generate a combined ICC value that included both groups. This was done deliberately because we expect that perceptions of skill will differ among the groups of raters. This is due to the nature of multi-rater feedback, which postulates differences in the perspective and hence content of feedback provided between disciplinary groups. If this were not case, multi-rater feedback would be unnecessary as all perceptions of skill will be the same. In support of this view, participants receive written feedback that encompasses the ratings and comments from all groups of raters, and a global general score is not provided.

4.1.1. Internal consistency

The GKCSAF demonstrates good internal consistency with a Cronbach's alpha of 0.844 and 0.880 for faculty ($N = 118$) and peer observer ratings ($N = 75$), respectively. These scores are consistent with previously published data for earlier versions of the tool. Knowing that calculating an overall alpha carried the risk of bias, due to a potential of clustering scores for a given conversation, we calculated a sub-alpha score per randomly assigned faculty rater to ensure the overall alpha was not falsely elevated. Finding an average sub-alpha similar to the overall alpha lends credibility to the internal consistency and lessens the concern about potential bias within a conversation. As mentioned above, we were unable to perform such a sub-analysis for peer observer ratings, as peer observers changed with every given conversation and hence could not be separated in the same manner as faculty. The strength of this study is the number of conversations analyzed, at 118 for faculty, and 72 for peer observer, which is much higher than previously reported psychometric data regarding the Gap-Kalamazoo tool.

4.1.2. Inter-rater reliability

For the purposes of assessing inter-rater reliability, we chose to use conversations that had 3 raters for statistical reasons. This limited our data set to 44 faculty-rated conversations and 25 peer-observer-rated conversations.

The ICC scores for faculty ratings across the nine communication elements assessed in the Gap-Kalamazoo tool ranged from 0.527 to 0.800 but demonstrated high inter-rater reliability with an overall ICC 0.830. Specifically, Communicates Accurate Information and Shares Information had relatively low ICCs of 0.527 and 0.563, respectively, Demonstrates Empathy, Provides Closure and Understands the Patient's and Family's Perspective had acceptable ICCs between 0.6 and 0.7, while the remaining four elements of Builds a Relationship, Opens the Discussion, Gathers Information, Reaches Agreement had good ICCs of ≥ 0.7. It was of interest to us that certain elements of the communication checklist demonstrated higher inter-rater reliability than others. Particularly, the elements of Communicates Accurate Information and Shares Information showed the poorest inter-rater reliability. While we feel that Communicates Accurate Information and Shares Information are two important and distinct communication tasks, the lower ICCs for these two elements could represent a higher subjectivity for these elements or even a perceived redundancy or confusion regarding the essence of these tasks. This could represent a need for clarifying language within the evaluative rubric as to the true conceptual content of these elements. Of note, the overall average scores of the communication encounter demonstrated higher reliability among raters than any individual domain, conceivably indicating that general impressions of overall communication skill are preserved with the Gap-Kalamazoo tool. Hence, even if individual elements lacked agreement, there was consensus regarding the clinician teams' overall performance during the simulated conversation.

The ICC scores for peer observer ratings across the nine communication elements assessed in the Gap-Kalamazoo tool ranged from 0.626 to 0.887 with an overall inter-rater reliability of

0.890. One communication domain, Provides Closure, demonstrated acceptable inter-rater reliability with an ICC of 0.626. Three domains, Opens the Discussion, Reaches Agreement and Communicates Accurate Information had ICCs in the good range of ≥0.7 while the remaining five elements displayed excellent inter-rater reliability with ICCs ≥0.8. Parallel to faculty ratings, the overall rating of the communication encounter demonstrated a higher ICC than any individual domain at 0.890, again suggesting that overall ratings of skill may be preserved among raters even if perceptions of skill for individual communication tasks differ.

In general, higher inter-rater reliability was demonstrated among peer observers than faculty raters. We can think of several reasons why this might exist. First, it is possible that peer observer scores tend to cluster in one direction. We also wondered whether peer observers might cluster scores in a more generally favorable manner. To test the theory that peer observers might perceive overall communication skills as better than faculty raters, we compared the average ratings among peer observer and faculty raters and found they did not differ significantly (3.93 vs. 3.98, *p*-value 0.54 by Mann–Whitney *U*). Second, peer observers were unfamiliar with the GKCSAF prior to completing the assessment tool and this could have led to differences in perception of the communication elements, as opposed to faculty who had prior experience with the tool.

4.1.3. Limitations

While we feel this study shows the Gap-Kalamazoo tool a useful and reliable instrument for assessing learners participating in a communication skills curriculum, there are several limitations that bear discussion.

First, generalizability theory is an alternative method to assess the reliability of assessment tools and is felt to be superior to more traditional means of determining reliability as it can detect multiple sources of error [26]. A generalizability study, had we been able to perform it, would have yielded more information than our current approach. Unfortunately, the structure of our dataset rendered a generalizability study impossible.

Second, this tool is intended for use by multiple raters but we were unable to analyze reliability within all groups of raters. Although ratings are obtained from the four groups, faculty, peer observers, standardized patients and self/participants, we only had sufficient data to analyze faculty and peer observers. To calculate inter-rater reliability we chose to use conversations that were rated by three individuals. Unfortunately, we had no conversations in which more than two standardized patients or participants ("self-scores") rated a conversation so we were unable to assess the psychometric properties within these groups of raters. A study in which reliability was analyzed with all groups of raters would certainly be a stronger study but we did not have the data to perform such an analysis. We still feel the tool demonstrated reasonable reliability within the two groups of raters mentioned above, supporting its' use in a multi-rater fashion. Additionally, due to the variability in peer observer ratings, we were unable to perform a "sub-alpha" to confirm the accuracy of the Cronbach's alpha score for peer observer ratings as we were for faculty ratings. It is possible, then, that the reported Cronbach's alpha score of 0.880 for peer observer ratings is falsely elevated.

Third, other than the theories briefly mentioned above, it is unclear to us why some elements of the tool performed well while others showed generally poor inter-rater reliability, particularly among faculty members. Unfortunately, we have not had the opportunity to discuss the use of the tool among faculty raters, as doing so may elucidate why it was easier to reach agreement among certain elements than others.

Last, and most important, a significant limitation of this study is the fact that post-simulation debriefing occurred prior to completion of the assessment tool. Results regarding inter-rater reliability should be viewed with caution, knowing that post-simulation discussion likely led to some normalization of the data. The order of debriefing in relation to tool completion was a conscious decision from the outset of curriculum development in an effort to create and preserve a learning atmosphere. Simulating complicated, emotionally charged conversations while being viewed by others is a vulnerable position for learners, and we strive to create a safe learning environment that promotes an atmosphere of self-discovery. The GKCSAF takes approximately 10–15 min to complete, time we felt, would create a disruption of the learning environment and place an unwanted emphasis on evaluation and assessment for our learners. We designed the curriculum not for the purposes of validating the assessment tool but with the goal of creating an effective communication skills curriculum. In doing so, we placed a higher priority on the learning environment than the rigors of the study presented here. We realize that this was a judgment call and whether or not completing the assessment prior to debriefing would affect learners as we purport remains to be seen. We do contend that holding the debriefing prior to completing the assessment took led to less normalization of the data than one might think due to the nature of the debriefing session. The debriefing component of this curriculum relies heavily on participant self-directed learning and discovery using recorded simulations for playback and review. Feedback and discussion is directed using frame-by-frame analysis of the conversations, led by the self-insights of the participants and observers. Participants and peer observers are unfamiliar with the GKCSAF. There is no mention of, or reference to, the Kalamazoo Essential Elements framework during the discussion. To summarize, the possibility exists that influence on raters from the debriefing session led to inflation of the inter-rater reliability of the GKCSAF. Given that the environment in which we use the tool is similar to how it will likely be used in practice, we still feel the GKCSAF is a useful tool, viewed within the constraints mentioned above.

4.2. Conclusions

The importance of developing sound communication skills among healthcare professionals and the greater emphasis on communication skills education in undergraduate and graduate medical education makes reliable assessment methodologies essential. The Gap–Kalamazoo Communication Skills Assessment Form is linked to an accepted theoretic framework, builds on studies utilizing earlier versions of the Kalamazoo assessment tools, and has been demonstrated to have good psychometric reliability, and therefore begins to meet this important need. Further research exploring the inter-rater reliability among all groups of raters, completion of the assessment tool prior to debriefing, and use of generalizability theory would further define the usefulness of this tool.

4.3. Practice implications

Despite the limitations mentioned above, the Gap-Kalamazoo Communication Skills Assessment Form can be used by educational programs that wish to implement a reliable assessment and feedback system for a variety of multidisciplinary learners.

Note: A different tool with different contents, but also titled the Kalamazoo Essential Elements Communication Checklist-Adapted, is found on the Internet. To preserve research integrity, we recommend using the authentic, copyrighted, validated version. Questions regarding use of the GKCSAF tool can be directed to aaron.calhoun@louisville.edu or elizabeth_rider@hms.harvard.edu (member, Kalamazoo Consensus Statement group).

Appendix

Gap-Kalamazoo Communication Skills Assessment Form* – Faculty/Peer Assessment

Date:	Your Name:	Your Title:

Title of Case:	Title of Conversation:

How well did the participant(s) do the following (please select one):

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
A: Builds a relationship (includes the following): • Greets and shows interest in the patient's family • Uses words that show care and concern throughout the interview • Uses tone, pace, eye contact, and posture that show care and concern • Responds explicitly to patient and family statements about ideas and feelings					
B: Opens the discussion (includes the following): • Allows patient and family to complete opening statement without interruption • Asks "is there anything else?" to elicit full set of concerns • Explains and/or negotiates an agenda for the visit					
C: Gathers information (includes the following): • Addresses patient and family statements using open-ended questions • Clarifies details as necessary with more specific or "yes/no" questions • Summarizes and gives family opportunity to correct or add information • Transitions effectively to additional questions					
D: Understands the patient's and families perspective (includes the following): • Asks about life events, circumstances, other people that might affect health • Elicits patient's and family's beliefs, concerns, and expectations about illness and treatment					
E: Shares information (includes the following): • Assesses patient's/family's understanding of problems and desire for more info • Explains using words that family can understand • Asks if family has any more questions					
F: Reaches agreement (includes the following): • Includes family in choices and decisions to the extent they desire • Checks for mutual understanding of diagnostic and/or treatment plans • Asks about acceptability of diagnostic and/or treatment plans • Identifies additional resources as appropriate					
G: Provides closure (includes the following): • Asks if patient and family have questions, concerns or other issues • Summarizes • Clarifies future time when progress will again be discussed • Provides appropriate contact information if interim questions arise • Acknowledges patient and family, and closes interview					
H. Demonstrates Empathy (includes the following): • Clinician's demeanor is appropriate to the nature of the conversations • Shows compassion and concerns • Identifies/labels/validates patient's and family's emotional responses • Responds appropriately to patients and family's emotional cues					
I: Communicates accurate information (includes the following): • Accurately conveys the relative seriousness of the patient's condition • Takes other participating clinician's input into account • Clearly conveys expected disease course • Clearly presents and explains options for future care • Gives enough clear information to empower decision making					

*__Adapted from:__ Essential Elements: The Communication Checklist, © 2001 Kalamazoo Consensus Statement Group, and from: Rider EA. Interpersonal and Communication Skills. In: Rider EA, Nawotniak RH. *A Practical Guide to Teaching and Assessing the ACGME Core Competencies, 2nd edition.* Marblehead, MA: HCPro, Inc., 2010. © 2010 HCPro, Inc. Used with permission. Contacts: Elizabeth Rider, MSW, MD - elizabeth_rider@hms.harvard.edu (member, Kalamazoo Consensus Statement Group) and Aaron Calhoun, MD - aaron.calhoun@louisville.edu (PERCS Program)

What did the participant(s) do best? (Please pick three choices)

- ❑ Builds a Relationship
- ❑ Opens the Discussion
- ❑ Gathers Information
- ❑ Understands the Patient's and Family's Perspective
- ❑ Shares Information
- ❑ Reaches Agreement
- ❑ Provides Closure
- ❑ Demonstrates Empathy
- ❑ Communicates Accurate Information

Why did you choose those particular answers?

In which domains could the participant(s) improve? (Please pick three choices)

- ❑ Builds a Relationship
- ❑ Opens the Discussion
- ❑ Gathers Information
- ❑ Understands the Patient's and Family's Perspective
- ❑ Shares Information
- ❑ Reaches Agreement
- ❑ Provides Closure
- ❑ Demonstrates Empathy
- ❑ Communicates Accurate Information

What could have been done better?

*__Adapted from:__ Essential Elements: The Communication Checklist, © 2001 Kalamazoo Consensus Statement Group, and from: Rider EA. Interpersonal and Communication Skills. In: Rider EA, Nawotniak RH. *A Practical Guide to Teaching and Assessing the ACGME Core Competencies, 2nd edition.* Marblehead, MA: HCPro, Inc., 2010. © 2010 HCPro, Inc. Used with permission. Contacts: Elizabeth Rider, MSW, MD - elizabeth_rider@hms.harvard.edu (member, Kalamazoo Consensus Statement Group) and Aaron Calhoun, MD - aaron.calhoun@louisville.edu (PERCS Program)

Conflict of interest

None.

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ORIGINAL PAPER

Evaluating the effectiveness of rating instruments for a communication skills assessment of medical residents

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Abstract The investigators used evidence based on response processes to evaluate and improve the validity of scores on the Patient-Centered Communication and Interpersonal Skills (CIS) Scale for the assessment of residents' communication competence. The investigators retrospectively analyzed the communication skills ratings of 68 residents at the University of Illinois at Chicago (UIC). Each resident encountered six standardized patients (SPs) portraying six cases. SPs rated the performance of each resident using the CIS Scale—an 18-item rating instrument asking for level of agreement on a 5-category scale. A many-faceted Rasch measurement model was used to determine how effectively each item and scale on the rating instrument performed. The analyses revealed that items were too easy for the residents. The SPs underutilized the lowest rating category, making the scale function as a 4-category rating scale. Some SPs were inconsistent when assigning ratings in the middle categories. The investigators modified the rating instrument based on the findings, creating the Revised UIC Communication and Interpersonal Skills (RUCIS) Scale—a 13-item rating instrument that employs a 4-category behaviorally anchored rating scale for each item. The investigators implemented the RUCIS Scale in a subsequent communication skills OSCE for 85 residents. The analyses revealed that the RUCIS Scale functioned more effectively than the CIS Scale in several respects (e.g., a more uniform distribution of ratings across categories, and better fit of the items to the measurement model). However, SPs still rarely assigned ratings in the lowest rating category of each scale.

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Keywords Validity · Rating scale · Communication skills · Many-faceted Rasch measurement · OSCE

Introduction

Communication and interpersonal skills are one of the six core competencies for which residency programs have to demonstrate training outcomes (Accreditation Council for Graduate Medical Education 1999). An assessment of residents' communication skills that can provide valid inferences about their ability to exchange information and ally with patients requires an observed interaction with patients. The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) recommend using an assessment format that asks residents to interact with standardized patients (SPs) in an Objective Structured Clinical Examination (OSCE) as the most desirable approach for communication skills assessment (Bashook and Swing 2000).

The rating instrument that a standardized patient uses to record his/her observations of a resident's performance during a communication skills OSCE plays a critical role in providing valid inferences from an assessment. A rating instrument not only guides the observation but also dictates the scoring of the performance of individual residents. Several rating instruments for the assessment of medical communication skills by SPs in OSCE settings have been developed and validated, including the Interpersonal and Communication Skills Checklist (Cohen et al. 1996), the Interpersonal Skills Rating Form (Schnabl et al. 1991), the Arizona Clinical Interview Rating Scale (Stillman et al. 1976, 1986), the Brown University Interpersonal Skill Evaluation (Burchard and Rowland-Morin 1990), the SEGUE Framework (Makoul 2001), the Liverpool Communication Skills Assessment Scale (LCSAS) (Humphris 2002; Humphris and Kaney 2001), and the Patient-Centered Communication and Interpersonal Skills (CIS) Scale (Yudkowsky et al. 2004, 2006).

Despite the many available rating instruments for communication skills assessment in OSCE settings, choosing an appropriate instrument to score residents' performance in a communication skills OSCE is not an easy task. Validity evidence that supports the use of scores obtained from these rating instruments is quite limited. Researchers conducting validity studies of these instruments have focused mainly on reporting internal consistency reliability, inter-rater reliability, and correlations of scores with measures of other variables. According to the *Standards for Educational and Psychological Testing* (American Educational Research Association et al. 1999), such validity research only provides evidence based on internal structure and relations to other variables, leaving out evidence based on test content, response processes, and consequences.

In this study, we evaluated validity evidence related to the use of one of the existing communication skills OSCE rating instruments—the Patient-Centered Communication and Interpersonal Skills (CIS) Scale. We focused on evidence based on response processes, a source of validity evidence that test score users often overlook. In the context of a communication skills OSCE, the validity evidence based on response processes refers to the evaluation of the extent to which the SPs apply rating criteria to rate the residents' performance in a manner that is consistent with the intended interpretation and uses of scores (American Educational Research Association et al. 1999).

There are several approaches that researchers can use to gather validity evidence based on response processes. Researchers can collect some pieces of evidence before the OSCE

administration (e.g., documenting the rating criteria and the processes for selecting, training, and qualifying SPs). Researchers can collect other pieces of evidence at the time a SP rates the performance (e.g., engaging SPs in verbal think-aloud during the rating process, thus allowing researchers to know what SPs are thinking while deciding what rating they will assign (Heller et al. 1998)). The focus of this study was on gathering validity evidence related to response processes after an OSCE administration (i.e., when all the ratings were available to us). That is, we carried out a psychometric analysis of ratings to investigate to what extent the OSCE ratings were consistent with the intended uses of the scores. OSCE ratings are the result of the interaction between residents, cases, items (and their rating scales), and SPs. A comprehensive validity study of response processes for an OSCE would require close examination of responses related to all these components of an OSCE. In this study, we limited the scope of our analyses to response processes related to items and scales on the rating instrument. That is, we investigated the extent to which SPs used the rating instrument to rate the residents' performance in a way that was consistent with the intended uses of the scores.

This study looked at the use of the CIS Scale in the scoring of internal medicine residents' performance in communication skills OSCEs carried out at the University of Illinois at Chicago (UIC). The purposes of our study were (1) to evaluate the effectiveness of the CIS Scale in scoring the residents' performance in the communication skills OSCE, (2) to use the findings obtained from the analysis to determine whether the rating instrument needed to be revised to improve its effectiveness, (3) to use the results from the analysis to guide the instrument revision process, and (4) to compare the original CIS Scale to the modified rating instrument to determine whether the modifications helped improve the scale's functioning, thus in effect enhancing the validity of the inferences made from scores on the communication skills OSCE. In the course of evaluating the effectiveness of these two rating instruments, we demonstrate how researchers can analyze OSCE rating data to provide validity evidence related to response processes.

Method

Research design

We carried out the study in two phases. The first phase was a retrospective analysis of the communication skills OSCE ratings for internal medicine residents obtained in 2003, in which SPs used the CIS scale to rate the performance of residents. We identified certain items and scales on that rating instrument that did not function effectively and revised the rating instrument to address those weaknesses. We piloted the revised instrument with a small group of SP trainers and medical faculty members and then further revised the instrument based on the comments obtained from the pilot study. This led to a development of a revised rating instrument for communication skills assessment called the Revised UIC Communication and Interpersonal Skills (RUCIS) scale.

In the second phase of the study, we implemented the RUCIS scale in the 2007 communication skills OSCE for internal medicine residents. We carried out an analysis to evaluate the effectiveness of the revised rating instrument in order to determine whether the instrument modifications helped improve the effectiveness of the instrument. Both the 2003 and 2007 communication skills OSCEs were mandatory formative assessments conducted as part of the standard curriculum of the residency program.

Participants

Participants in the 2003 communication skills OSCE included 68 internal medicine residents (51% PGY-2 and 49% PGY-3; 66% male and 34% female) and 8 SPs (38% male and 62% female). Participants in the 2007 communication skills OSCE included 85 internal medicine residents (54% PGY-1 and 46% PGY-2; 47% male and 53% female) and 17 SPs (29% male and 71% female).

Rating instruments

The CIS Scale, which SPs used to rate the performance of residents in the 2003 communication skills OSCE, is an 18-item rating instrument. Each item asks SPs to provide an agreement rating using a 5-category rating scale, in which 1 corresponds to "strongly disagree" and 5 corresponds to "strongly agree." Since all items are statements of desirable communication behaviors, higher ratings indicate higher level of communication competence (See Appendix A).

The RUCIS Scale, which SPs used to rate the performance of residents in the 2007 communication skills OSCE, is a 13-item rating instrument. Each item contains a short description of the particular aspect of communication under consideration and four behaviorally anchored rating categories unique to each item. For each item, the lowest rating category always describes the least appropriate behavior for that aspect of communication, while the highest rating category always describes the most appropriate behavior for that aspect. In addition to the four rating categories for each item, six items also have a "not applicable" option that SPs could use when they did not observe the behavior related to that aspect of communication (See Appendix B).

SP training

In the 2003 communication skills OSCE, all the SPs took part in an intensive training program to learn how to portray the cases and how to rate resident performance before participating in the OSCE. The training program included a review and discussion of the case script and repeatedly practicing the appropriate portrayal of the cases under the supervision of a trainer. Training on the CIS scale included a review and discussion of the scale and practice using it to rate a videotaped or observed performance. There was no attempt to reach agreement between the SP and trainer in the ratings they assigned, but divergent ratings were noted and discussed. The trainer ensured that each SP could portray the case consistently and rate the performance of residents to the trainer's satisfaction before the SP was allowed to participate in the communication skills OSCE.

In the 2007 communication skills OSCE, all the SPs also took part in an intensive SP training program similar to the training for the 2003 communication skills OSCE to ensure an accurate portrayal of the cases before participating in the OSCE. However, this time we employed a frame-of-reference (FOR) approach in training the SPs to provide ratings (Bernadin and Buckley 1981). Prior to training, a group of SP trainers reviewed selected videotaped OSCE sessions and provided a consensus "gold standard" rating for each item in each encounter. During the training sessions SPs rated the selected videotaped OSCE sessions using the RUCIS scale, compared their ratings to the trainers' "gold standard" ratings, and discussed the rationale for the gold standard. By practicing and receiving feedback from several videotaped OSCE sessions, the SPs developed a common rating standard (i.e., frame) by which to evaluate residents' performances.

OSCE administrations

Both OSCEs employed the same cases and the same administration format. Six residents were assessed in each half-day session. In each session, each resident encountered six different SPs in six different clinical scenarios (cases). In each case, residents spent 10 min in the encounter with the SP, 5 min reviewing task-related educational materials while the SP rated the performance, and another 5 min receiving verbal feedback from the SP. The task-related educational materials consisted of printed documents describing effective ways to interact with a patient in the situation they just encountered. The verbal feedback session provided SPs and residents with the opportunity to discuss effective and ineffective behaviors observed during the encounter, and to practice techniques that the SP suggested. The SP did not inform the resident of his/her specific ratings. The six communication tasks that residents encountered were: (1) providing patient education, (2) obtaining informed consent, (3) dealing with a patient who refuses treatment, (4) counseling an elderly patient who has been abused, (5) giving bad news to a patient, and (6) conducting a physical examination. We repeated the OSCE sessions once or twice a week until all residents had the opportunity to participate in the OSCE, which took 2 and 4 months, for the 2003 and 2007 communication skills OSCE, respectively.

Analyses

Because the OSCE is a multi-faceted assessment method where the rating of a resident's performance depends upon many factors, including the communication competence of the resident, the difficulty of the item on the rating instrument, the severity of the SP, and the difficulty of the case, we used a many-faceted Rasch measurement (i.e., Facets) model (Linacre 1989) to analyze the data. The Facets model uses a logarithmic function of the odds of receiving a rating in a given category as compared to the odds of receiving a rating in the next lower category to define the communication competence of residents, the difficulty of items, the severity of SPs, and the difficulty of cases. All measures of these four facets are reported on the logit scale, which is a linear, equal interval scale. Higher logit measures indicate more competent residents, more difficult items, more severe SPs, and more difficult cases. Because there were multiple rating categories for each item, the Facets model also calculated a set of *step thresholds* for each item. (A step threshold is the transition point between two adjacent categories, where the probabilities of receiving a rating in the two categories are equal.) We used the Facets computer program (Linacre 2005) to conduct the analyses.

To ensure that the analyses to obtain validity evidence based on response processes would be based on reliable data, we first examined the degree of reproducibility of residents' communication competence measures—validity evidence related to the internal structure of test scores. We calculated a measure of internal consistency reliability, the resident separation reliability, which is an index analogous to KR-20 or Cronbach's Alpha. Because ratings of multiple items on the same case by the same SP can be dependent on one another, which could lead to overestimation of reliability (Sireci et al. 1991; Thissen et al. 1989), we used cases (rather than items) as scoring units. That is, we averaged the ratings a SP gave to all items in a given case to produce a case score, which we considered as one rating in the Facets analysis.

An effective rating instrument for an OSCE should produce ratings that satisfy two tests related to response processes. The first one involves determining whether each rating scale functioned appropriately (i.e., were the categories on the scales that the SPs used

well-defined, mutually exclusive, and exhaustive). The second one involves determining whether each item on the rating instrument functioned properly (i.e., when evaluating each resident's performance, did SPs assign ratings for each item in a consistent fashion).

We used the following six criteria (Linacre 2004) as guidelines for determining whether each rating scale category for each item functioned effectively (i.e., to determine whether the rating categories of each item were well-defined, mutually exclusive, and exhaustive):

(1) There should be at least 10 ratings in each rating category to allow accurate calibration of step thresholds.
(2) The frequency distribution of ratings across categories should have a uniform or unimodal pattern. If SPs use only a few of the rating categories and rarely use other rating categories, the resulting irregular distribution of ratings indicates a poorly functioning scale that cannot effectively differentiate residents according to their levels of communication competence.
(3) The average measures of residents' communication competence should increase as the rating categories increase. In other words, residents who receive ratings in higher categories should have higher overall communication competence measures than those who receive ratings in lower categories.
(4) The step thresholds should increase as the rating categories increase. This criterion mirrors the third criterion. Failure of step thresholds to increase as the rating categories increase is called *step disordering*, which suggests that SPs may have difficulty differentiating the performance of residents in those categories. One or more of the rating categories for a particular item may not be clearly defined.
(5) The step thresholds should advance at least 1 logit, but not more than 5 logits. The finding that two step thresholds advance by less than 1 logit would suggest that those two rating categories are practically inseparable. That is, SPs may not be able to reliably differentiate between them. On the other hand, step thresholds that are too far apart are an indication of a possible dead zone on the scale where measurement loses its precision.
(6) The outfit mean-square value for each rating category should be less than 2.0. An outfit mean-square value is a statistical index that indicates how well the ratings in each category fit the measurement model. Its value can range from 0 to infinity, with an expected value of 1. A high outfit mean-square value for a rating category is an indicator that some SPs used that rating category in an unexpected or surprising manner that was inconsistent with the way that other SPs used that category.

In addition to evaluating the functioning of the scale categories, we evaluated fit statistics for each item on the instrument to determine whether SPs provided aberrant ratings on any items, which might indicate problematic response processes. These fit statistics are indices that indicate how well the rating data for each item fit the measurement model. In this study, we examined both outfit and infit mean-square statistics for each item. We calculated an outfit mean-square value for each item by dividing the sum of the squared standardized residuals for the item by its degree of freedom. (A residual is the difference between the rating a SP assigned a resident on an item and the rating the measurement model predicted the SP would assign.) This calculation produces a value that can range from 0 to infinity, with an expectation of 1.0. Values larger than 1.0 indicate the presence of unmodeled noise in the ratings for that item (i.e., unexpected ratings that SPs assigned when evaluating residents, given how SPs assigned ratings for other items). By contrast, values less than 1.0 indicate that there was too little variation in the ratings SPs assigned for that item (Linacre and Wright 1994; Wright and Masters 1982). However, outfit

mean-square values are very sensitive to outlier ratings. To reduce the influence of outlier ratings, we weighted each squared standardized residual by its information function before we summed them. (This involved applying differential weights to standardized residuals. That is, residuals that resulted from SP ratings of items and cases that were far too easy or too difficult for residents received less weight than those that resulted from SP ratings of items and cases that were at the appropriate difficulty level for residents.) This calculation produced an infit mean-square statistic that has the same distribution and interpretation as an outfit mean-square statistic, but is more immune to the influence of the ratings for residents on items or cases that are far too easy or difficult for them. Wright and Linacre (1994) recommended that an appropriate mean-square fit statistic for judge-mediated ratings should be in the range of 0.4–1.2.

From the analysis of the 2003 communication skills OSCE ratings, we identified the items and rating categories on the CIS Scale that did not function effectively according to one or more of these criteria. We then used these findings to guide the development of a modified rating instrument—the RUCIS Scale. We implemented the RUCIS Scale in the 2007 communication skills OSCE and evaluated the effectiveness of the revised instrument using the same criteria to determine whether the modifications helped improve the effectiveness of the instrument, thus in effect enhancing the validity of the score interpretation.

Results

Evaluating the effectiveness of the CIS scale

The analysis of the 2003 communication skills OSCE revealed that this group of residents was highly competent relative to the items and cases on the CIS Scale (Table 1). The average resident communication competence measure was higher than the average item and case difficulty measures, and there were few items or cases appropriate for measuring the communication competence of residents who were in the upper range of the communication competency continuum (i.e., in the 0.75–2.5 logits range). These findings suggest that these items and cases were not very well suited to measuring the communication competence of this group of residents (i.e., it was a relatively easy assessment for them). Using cases as scoring units, our analysis yielded a resident separation reliability of 0.74.

Table 1 Summary of measures obtained from the analysis of the communication skills OSCEs

Measurement facets	Minimum (logits)	Maximum (logits)	Mean (logits)	SD (logits)
A. 2003 Communication skills OSCE				
Resident competence	−0.40	2.44	0.78	0.61
Item difficulty	−0.71	0.83	0	0.44
Case difficulty	−0.45	0.30	0	0.25
B. 2007 Communication skills OSCE				
Resident competence	−1.85	1.68	−0.17	0.68
Item difficulty	−0.91	0.98	0	0.60
Case difficulty	−0.99	0.65	0	0.49

The problematic alignment between the resident communication competence measures and the item and case difficulty measures is clearly demonstrated in Fig. 1, a simplified construct map we obtained from the analysis, showing the relationships between three of the four facets in our analysis. The first column displays the equal interval logit measures. The second column shows the resident communication measures. More competent residents appear higher in the column, while less competent residents appear lower in the column. The third and fourth columns show the cases and items ordered by difficulty. Difficult items and cases appear higher in the columns (e.g., items 18, 16, and 9, and cases 3 and 6), while easy items and cases appear lower in the columns (e.g., items 1, 12, and 2, and case 4). Columns 5–22 show how SPs used the 5-category rating scale for each item on the CIS Scale. A horizontal line across a column indicates the point at which the probability of a resident receiving the next higher rating begins to exceed the probability of receiving the lower rating (i.e., a step threshold). According to this construct map, the most likely rating that SPs assigned on all the CIS items was a 4 or 5. Another interesting finding is SPs did not use the scale in an identical fashion when assigning ratings on these 18 items, as demonstrated by having different ranges of communication competence measures for each rating category across items (e.g., the region of rating category 3 is not the same across all items).

The analysis of the 2003 communication skills OSCE revealed that the CIS Scale did not meet several of Linacre's (2004) guidelines for evaluating rating scale category effectiveness. We summarized these results in Table 2. First, only five items had more than 10 ratings in all five categories. The 5-category agreement rating scale actually functioned as a 4-category rating scale. SPs rarely assigned ratings of 1. The items on the CIS Scale

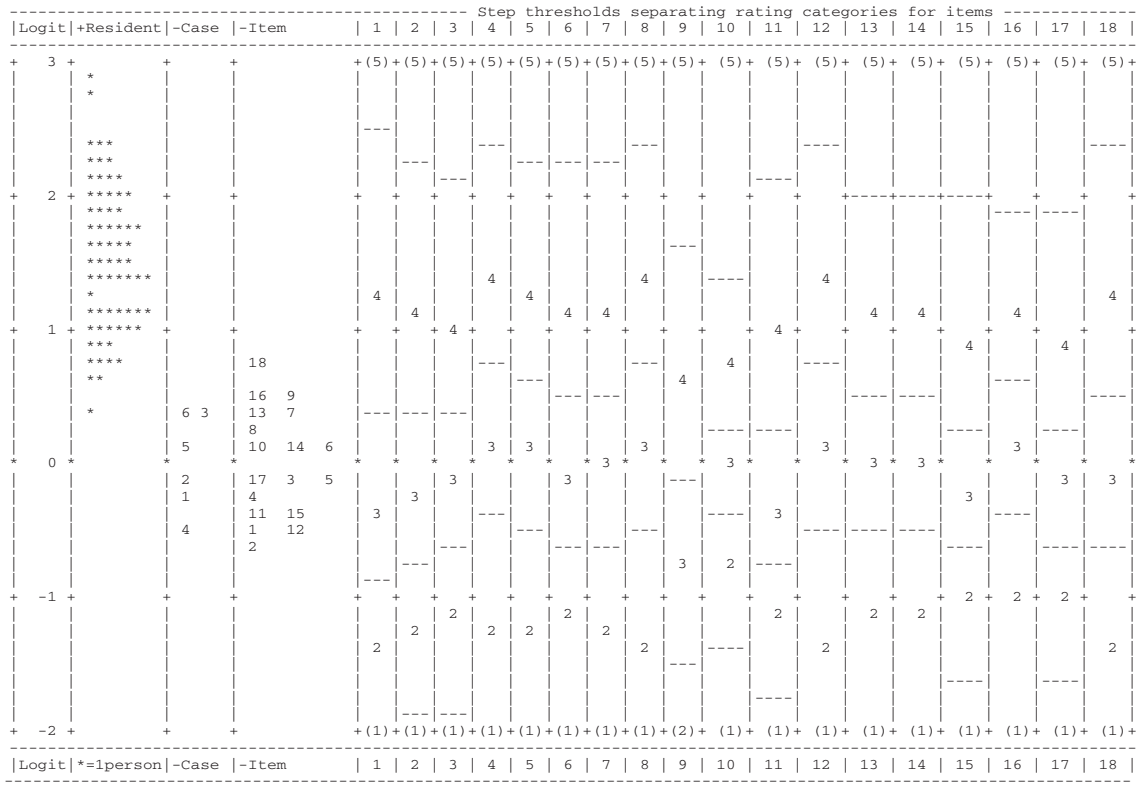

Fig. 1 A construct map showing the misalignment between the resident communication competence measures and the item and case difficulty measures for the 18 items on the CIS Scale

Table 2 Comparing the functioning of the CIS scale (2003) and RUCIS scale (2007) using Linacre's (2004) guidelines

	CIS scale 5-category scales 18 items	RUCIS scale 4-category scales 13 items
Resident separation reliability	0.74	0.71
Criteria for evaluating the functioning of the categories on each rating scale		
At least 10 ratings in each category	5 items (28%)	6 items (46%)
Uniform/unimodal distribution of ratings across categories	1 item (6%)	12 items (92%)
Residents with higher category ratings have higher overall communication competence measures	7 items (39%)	12 items (92%)
No step disordering	9 items (50%)	11 items (85%)
Step thresholds advance by at least 1 logit, but not more than 5 logits	1 item (6%)	10 items (77%)
An outfit mean-square value <2.0 for each rating category	11 items (61%)	13 items (100%)
Criteria for evaluating the functioning of the items on the instrument		
Outfit mean-square values <1.2	14 items (78%)	12 items (92%)
Infit mean-square values <1.2	16 items (89%)	13 items (100%)

appeared to be relatively easy for these residents, resulting in an unbalanced distribution of ratings across the five rating categories: about 70–80% of all ratings were 4 s or 5 s. The only item that exhibited an acceptable rating distribution was item 18, which showed a unimodal distribution that peaked in the middle categories.

The analysis also revealed that some SPs experienced difficulty in differentiating between the middle categories of the 5-category agreement scale, as demonstrated by the failure of the average measures and step thresholds to increase properly along with the rating categories. Only seven items (items 4, 5, 6, 9, 11, 16, and 18) exhibited proper advancement of average resident communication competence measures as the rating categories increased. Nine items (items 2, 4, 6, 10, 11, 13, 14, 15, and 17) showed disordered step thresholds. Seven items (items 7, 8, 9, 10, 13, 14, and 15) had one or more rating categories with outfit mean-square values equal to or greater than 2, reflecting inconsistent use of the categories. Only one item (item 12) had all adjacent step thresholds separated by at least one logit. The other 17 items had one or more step thresholds that were too close to adjacent thresholds, especially for step thresholds in the middle of the scale. However, none of the 18 items had step thresholds that advanced by more than five logits, suggesting that there were no significant gaps between the categories.

We summarized item fit statistics in Table 3. Four items (items 3, 5, 10, and 15) had outfit mean-square values higher than 1.2, indicating that some SPs assigned ratings for those items that were unexpectedly high or low, given the other ratings that the SPs assigned. Items 10 and 15 had infit mean-square values higher than 1.2. A close examination of the unexpected ratings for items 10 (I felt you encouraged me to ask questions) and 15 (I felt you were careful to use plain language) revealed that six out of eight SPs were inconsistent in rating item 10, and seven out of eight SPs were inconsistent in rating item 15. Apparently, the SPs did not have a shared understanding of what they were evaluating when using these two items. This finding suggested that we needed to revise these items to make them clearer to SPs.

Table 3 Summary of item fit statistics

Item fit statistics	Minimum	Maximum	Mean	SD
A. 2003 Communication skills OSCE				
Outfit mean-square values	0.71	2.35	1.08	0.37
Infit mean-square values	0.76	1.72	1.00	0.23
B. 2007 Communication skills OSCE				
Outfit mean-square values	0.86	1.22	1.00	0.08
Infit mean-square values	0.86	1.16	1.00	0.07

Modifying the rating instrument

The findings from our validity study revealed that there were several aspects of the CIS Scale that did not function well. Using these findings as our guide, we worked with medical faculty and SPs to revise the CIS Scale in several ways. Instead of using a single Likert-style agreement rating scale that was applicable to all items on the instrument, we devised a behaviorally anchored rating scale (BARS) (Bernardin and Smith 1981; Smith and Kendall 1963) that provided a detailed description of the specific communication behavior characteristic of each rating category for each item. Our expectation was that the change in the scale format would make each rating scale more specific to the context of a particular item and less open to SPs' idiosyncratic interpretations.

Because our analysis revealed that the lowest rating category on the CIS Scale was a non-functioning category, we decided to change the scale format from 5-category scales to 4-category scales. To address the problem of an unbalanced rating distribution in which 70–80% of ratings were positive ratings, while only 20–30% of ratings were neutral or negative ratings, we developed 4-category scales that were saturated on the positive side. In other words, we created a separate rating scale for each item with only one category describing inadequate performance and three categories describing satisfactory communication behaviors that exemplified progressively higher levels of performance.

We also provided a "not applicable" option for six items. Our goal was to eliminate some unexpected ratings that SPs assigned in the neutral category of the agreement scale when they found themselves unable to rate a certain aspect of communication during the encounter because they did not observe any evidence that the resident engaged in that aspect.

Although we did not change the content coverage of the rating instrument, we revised the items to eliminate redundancy and improve their clarity. We combined into one item the redundant items that addressed the same aspect of communication. Specifically, we combined items 1 and 2 into an item on friendly communication; combined items 7, 8, and 9 into an item on discussion of options; combined items 10, 11, and 12 into an item on encouraging questions; and combined items 13 and 14 into an item on providing a clear explanation. We created a new item on physical examination to allow SPs to separate the act of providing an explanation of a physical examination from the act of providing an explanation about medical conditions.

Finally, we attempted to make several items more difficult by requiring that residents demonstrate communication behaviors that are more sophisticated and/or difficult to perform to qualify for a rating in the highest category.

These modifications led to the development of a revised rating instrument, called the RUCIS Scale (Appendix B), which we later used in the scoring of residents' performance in the 2007 communication skills OSCE.

Evaluating the effectiveness of the RUCIS scale

The analysis of the 2007 communication skills OSCE revealed that this set of items was better targeted for measuring the communication competence of the residents (See Table 1 and columns 2–4 of Fig. 2). The distribution of resident communication competence measures was better aligned with the distributions of item and case difficulty measures than was the case for the 2003 communication skills OSCE. Using cases as scoring units, our analysis yielded a resident separation reliability of 0.71. Despite fewer numbers of items on the RUCIS Scale, the ratings on this revised instrument could achieve the same level of internal consistency reliability as the level obtained from the CIS Scale.

Table 2 provides a point-by-point comparison of the findings from our analyses of the functioning of the CIS Scale and the RUCIS Scale. We found that seven items on the revised instrument still had fewer than 10 ratings assigned in the lowest category. Beyond this, nearly all the items and rating scales appearing on the RUCIS Scale satisfied Linacre's criteria. All items but one had a uniform distribution of ratings that peaked in the middle or at the high end. Item 5 (interest in me as a person) was the only item that had a rating distribution that peaked in rating category 1. Item 2 (respectful treatment) was the only item that did not show increasing average measures as rating categories increased. The rating categories for all items fit the measurement model (i.e., all outfit mean-square values for the rating categories were less than 2). Items 7 and 12 were the only two items with disordered step thresholds. Some of the distances between step thresholds for Items 5, 6, and 10 were too narrow (i.e., less than one logit apart). However, all the step thresholds for

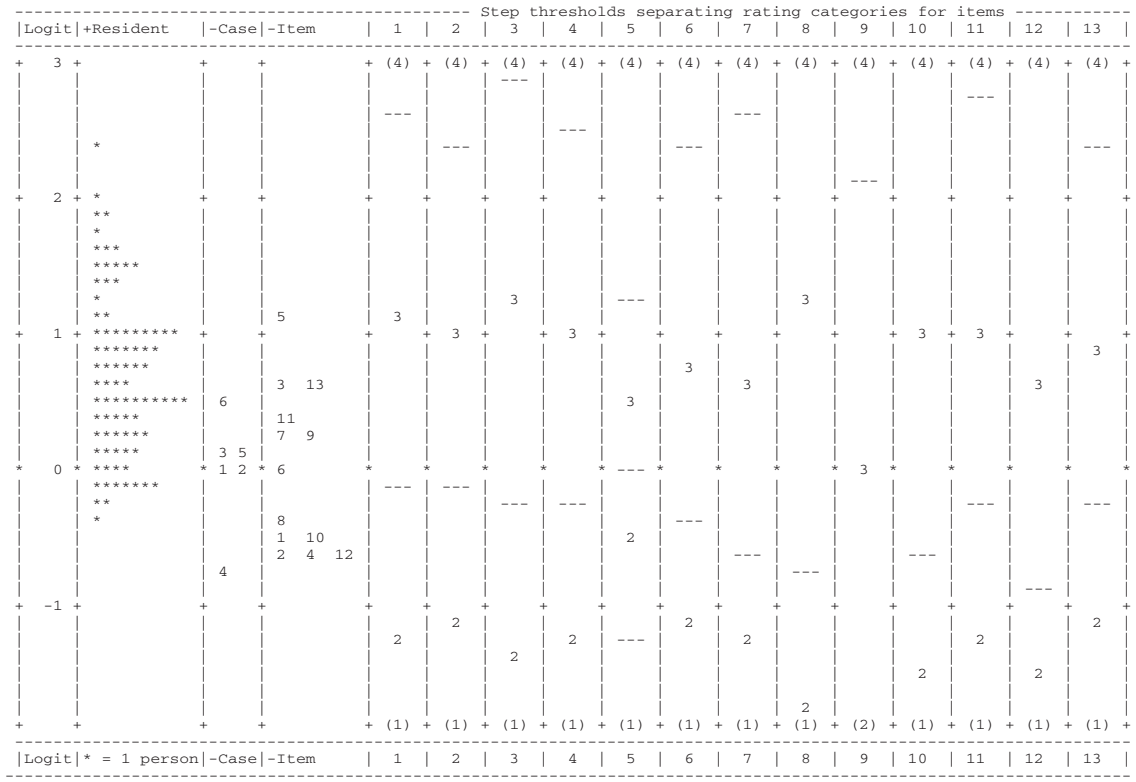

Fig. 2 A construct map showing the better alignment between the resident communication competence measures and the item and case difficulty measures for the 13 items on the RUCIS Scale

the other items were appropriately ordered and advanced by more than one logit but less than five logits.

We summarized item fit statistics obtained from the analysis of the 2007 communication skills OSCE in Table 3. All items showed good fit to the measurement model according to their infit mean-square values. Item 5 (interest in me as a person) was the only item with an outfit mean-square value higher than 1.2, indicating too much unexplained variance in the ratings that SPs assigned for this item. Thus, it was the only item that needed close examination to try to determine what made it difficult for SPs to use the item's behaviorally anchored rating scale to assign consistent ratings.

Discussion

This study demonstrated the process of using validity evidence obtained from a Facets analysis to help revise an assessment instrument such as an OSCE rating scale. Validation is a continuing process of gathering and evaluating various sources of evidence to determine whether that evidence supports (or refutes) the proposed score interpretation. The two phases of this study correspond to the two stages of validation that Kane (2006) described. In the first phase of the study, we focused on finding ways to build a measurement instrument that possessed appropriate psychometric properties that would support the intended uses of OSCE scores. This phase corresponds to the *development stage* of validation. In the second phase, we critically evaluated whether the newly developed rating instrument actually functioned as predicted. This phase corresponds to the *appraisal stage* of validation.

In the first phase of our study, validity evidence based on response processes helped us identify several aspects of the CIS Scale that did not function as intended. The validity evidence suggested that the 5-category Likert-style agreement scale functioned as an unbalanced 4-category rating scale (i.e., most of the ratings were positive ratings, while only a few ratings were neutral or negative). This finding indicated that the items on the CIS Scale were too easy for this sample of residents. Results from our analyses also suggested that some SPs were unable to differentiate performance in the middle categories of the scale. Additionally, we found that some SPs assigned a number of surprising or unexpected ratings for item 10 (I felt you encouraged me to ask questions) and for item 15 (I felt you were careful to use plain language), suggesting that these SPs were not able to consistently apply the rating criteria for these two items to rate some residents' performances. All these pieces of validity evidence provided useful information to guide the development of a revised rating instrument in our attempt to address these weaknesses of the CIS Scale.

In the second phase of our validity study, we implemented the revised instrument in a later administration of the communication skills OSCE and carried out the same types of analyses that had revealed the inadequacies of the CIS Scale. We considered this as a test of whether the revised instrument could withstand the same validity challenges as its predecessor. We found that in many aspects the RUCIS Scale helped improve score interpretability. The SPs more consistently applied the rating criteria to rate residents' performances. The items on the RUCIS Scale fit the measurement model quite well. Providing a clear description of communication behavior that was appropriate for each rating category for the two misfitting items on the CIS Scale (items 10 and 15) helped eliminate confusion among SPs in rating these two aspects of communication (as demonstrated by good item fit statistics for items 7 and 10 on the RUCIS Scale).

However, the modifications we made to the rating instrument did not address all the validity issues we identified in the CIS Scale. There was one area in which the revised instrument did not show significant improvement over its predecessor. When using the behaviorally anchored rating scales, SPs still assigned only a few ratings in the lowest rating category of many items. This could be due to a restricted range of communication competence among the particular sample of residents assessed. We developed the RUCIS Scale with a broad range of communication competence in mind—from very incompetent physicians to very competent physicians. The subjects included in the 2007 communication skills OSCE were a single group of residents in one residency program. This limited the range of observable communication skills that SPs were likely to see. If we were to assess a broader range of subjects, ranging from medical students in their early years of training to experienced physicians practicing in various specialties from geographically diverse medical settings, the SPs would be more likely to observe a broader range of communication behaviors and would be more likely to employ the full range of rating categories appearing on each behaviorally anchored rating scale. Testing this hypothesis would require that researchers conduct additional studies to evaluate validity generalization (American Educational Research Association et al. 1999). That is, we are suggesting that researchers carry out studies to determine the extent to which variations in situational facets (e.g., residents from different residency programs, different SPs, etc.) may affect the assignment of ratings. The studies would help us determine how generalizable the results we obtained are across subjects that differ in education and experience, and across SPs.

Another possible explanation for non-uniform distributions of ratings is that SPs may have been uncomfortable assigning very low ratings to residents. If this were the case, then SP trainers could address this issue during the training, helping SPs understand that it is appropriate (and expected) that they will assign low ratings if they see evidence of physician behaviors that warrant those ratings. However, we would be a bit cautious in following this criterion too strictly. For a formative assessment or in a summative assessment where residents had not been properly trained, a uniform distribution of ratings is to be expected. However, in a summative assessment where the majority of residents have practiced the skills so that they are well prepared for the communication tasks, a skew distribution of ratings where only few residents would have ratings in lower categories can be obtained, which might not suggest a problem with the rating instrument.

The evaluation of item fit statistics for the RUCIS scale revealed that item 5 (interest in me as a person) was the only item with too much unexplained variance in its ratings. Interestingly, two of the SPs were responsible for 65% of the statistically significantly unexpected ratings (i.e., ratings with an absolute value of their standardized residuals larger than 2.0) for this item. This finding suggests that the source of error in the ratings of item 5 might be due to the inconsistency of only two SPs, and that the fit of the item might be improved through additional training of these two SPs to clear up any confusion they might have experienced when rating this item.

Although we carried out the study in two phases that addressed both the development and appraisal stages of validation (Kane 2006), this study by no means presents a complete validation effort. Validation is an ongoing process of gathering various sources of evidence to support proposed score interpretations. One could consider the findings from the second phase of this study as input to further modify the rating instrument to craft an even more psychometrically sound assessment, thus cycling back to the development stage of validation once again. For example, our results suggest that item 5 on the RUCIS Scale is still problematic, since it continues to show inadequate fit to the measurement model. Additional modification on this item is a potential area for further instrument improvement.

There are some limitations related to the interpretation and application of the findings from this study. The first limitation is the instrument's limited focus on patient-centered medical communication skills. The ACGME's (1999) definition of communication skills emphasizes the importance of the ability to communicate not only with patients but also with other members of a healthcare team. The RUCIS Scale does not address the skills needed to communicate effectively with other members of a healthcare team. The psychometric properties of the RUCIS Scale demonstrated in this study might only apply to its use in an OSCE setting where SPs are trained properly on how to use the rating instrument. Another limitation of this study is the homogeneity of the resident samples we examined. Since our participants were internal medicine residents from a single training program, they were relatively homogeneous in their medical communication experience. Communication behaviors that were not observed in these residents might be evident when other groups of physicians are assessed. A multi-center trial of the rating instrument that involves medical schools from various geographical regions could study how the RUCIS Scale functions with a more heterogeneous group of physicians.

We hope that the findings from our study will benefit the medical education community in several ways. First, the product of this validation effort—the RUCIS Scale, along with validity evidence that supports its uses in the communication skills OSCE, should serve the needs of many residency programs, especially given the increasing interest in communication skills assessment that the ACGME Outcome Project has generated. Second, our study provides a concrete example of how to use a many-faceted Rasch measurement approach to improve the quality of SP rating instruments and to provide validity evidence based on response processes as outlined in the 1999 *Standards for Educational and Psychological Testing* (American Educational Research Association et al. 1999). Finally, this study generated many interesting ideas for future research.

Appendix A

Items on the Patient-Centered Communication and Interpersonal Skills (CIS) scale

1. I felt you greeted me warmly upon entering the room.
2. I felt you were friendly throughout the encounter. You were never crabby or rude to me.
3. I felt that you treated me like we were on the same level. You never "talked down" to me or treated me like a child.
4. I felt you let me tell my story and were careful to not interrupt me while I was speaking.
5. I felt you were telling me everything; being truthful, up front and frank; not keeping things from me.
6. I felt you showed interest in me as a "person." You never acted bored or ignored what I had to say.
7. I felt that you discussed options with me.
8. I felt you made sure that I understood those options.
9. I felt you asked my opinion, allowing me to make my own decision.
10. I felt you encouraged me to ask questions.
11. I felt you displayed patience when I asked questions.
12. I felt you answered my questions, never avoiding them.

13. I felt you clearly explained what I needed to know about my problem; how and why it occurred.
14. I felt you clearly explained what I should expect next.
15. I felt you were careful to use plain language and not medical jargon when speaking to me.
16. I felt you approached sensitive/difficult subject matters, such as religion, sexual history, tobacco/drug/alcohol history, sexual orientation, giving bad news, etc., with sensitivity and without being judgmental.
17. I felt the resident displayed a positive attitude during the verbal feedback session.
18. If given the choice in the future, I would choose this resident as my personal physician.

Note: All items are rated on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree).

Appendix B

Revised UIC Communication and Interpersonal Skills scale

Instruction

Please choose the option that best describes how you feel toward the resident's communication skills. Some items also have a "not applicable" option. Select this option when the context of the case does not allow you to observe that aspect of the resident's performance.

(1) **Friendly communication**

- You did not greet me, or greeted me perfunctorily, or communicated with me rudely during the encounter.
- Your greeting and/or behavior during the encounter was generally polite but impersonal or distant.
- You greeted me warmly and communicated with me in a friendly, personal manner throughout the encounter.
- Your greeting and overall communication were friendly and compassionate. Your tone of voice was appropriate for the situation. Overall, you created an exceptionally warm and friendly environment that made me feel comfortable to tell you all of my problems.

(2) **Respectful treatment**

- You showed an obvious sign of disrespect during the encounter. You treated me as an inferior.
- You did not show disrespect to me. However, I observed some signs of condescending behavior. Although I believe it was unintentional, it made me feel that I was not at the same level with you.
- You gave several indications of respecting me. If there was a physical exam, this includes draping me appropriately.
- You were exceptionally respectful throughout the encounter. Your verbal and non-verbal communication showed respect for my privacy, my opinions, my rights, and my socioeconomic status.

(3) **Listening to my story**

- You rarely gave me any opportunity to tell my story or frequently interrupted me while I was talking, not allowing me to finish what I said. Sometimes I felt you were not paying attention (for example, you asked for information that I already provided).
- You let me tell my story without interruption, or only interrupted appropriately and respectfully. You seemed to pay attention to my story and responded to what I said appropriately.
- You allowed me to tell my story without interruption, responded appropriately to what I said, and asked thoughtful questions to encourage me to tell more of my story.
- You were an exceptional listener. You encouraged me to tell my story and checked your understanding by restating important points.

(4) **Honest communication**

- You did not seem truthful and frank. I felt that there might be something that you were trying to hide from me.
- You did not seem to hide any critical information from me.
- You explained the facts of the situation without trivializing negative information or possibilities (e.g., side effects, complications, failure rates).
- You were exceptionally frank and honest. You fully explained the positive and negative aspects of my condition. You openly acknowledged your own lack of knowledge or uncertainty, and things you would have to consult with others. When appropriate, you also suggested I seek a second opinion.
- Not applicable. There was no information for the resident to provide.

(5) **Interest in me as a person**

- You never showed interest in me as a person. You only focused on the disease or medical issue.
- In addition to talking about my medical issue, you spent some time getting to know me as a person.
- You spent some time exploring how my medical issue affects my personal or social life.
- You were exceptionally interested in me as a person. You not only explored how my medical problem affects my personal and social life, but also showed your willingness to help me address those challenges.

(6) **Discussion of options/plans**

- You did not explain any options or plans; you just told me what you would do without asking for my opinion.
- You explained options to me, but did not involve me in decision making. If you solicited my opinion, you just ignored it. You made all the decisions for me based on your medical opinion.
- You discussed options with me, made recommendations, solicited my opinion regarding the options/plans, and incorporated my opinion into your medical planning.

- You not only solicited my input, but also explored the reasons for my choice and showed your understanding and respect for my decisions by negotiating a mutually agreeable plan.
- Not applicable. There were no decisions to be made in this case.

(7) **Encouraging my questions**

- You did not solicit questions, or frequently avoided my questions, or did not provide helpful answers.
- You sometimes asked if I had questions, but seldom waited at least 5 seconds to allow me to formulate questions. You addressed my questions briefly without avoiding them.
- You actively encouraged me to ask questions, paused to allow me to formulate them, and provided clear and sufficient answers to all of my questions.
- You actively encouraged me to ask questions several times during the encounter, with sufficient wait time. You spent significant time and effort to answer my questions clearly and confirmed that I understood the answer and that my concerns were addressed.

(8) **Providing clear explanation**

- You rarely explained things to me; you did not help me better understand my situation.
- You gave me only brief explanations of my situation; you did not help me understand what would happen next.
- You gave me a full and understandable explanation of my situation, pertinent findings, and important next steps.
- You gave me a full explanation of my situation, your thinking about it and your recommendation, and probed my understanding by letting me summarize pertinent information.
- Not applicable. There was nothing to be explained in this case.

(9) **Physical examination**

- You never or rarely warned me about what you were going to do with my body. You also never or rarely explained what you found from the physical examination.
- You did not warn me about what you were going to do with my body, OR did not explain to me pertinent findings (both negative and positive) from your physical examination.
- You told me what you were going to do to my body AND described what you found.
- You helped me understand clearly what you were going to do to my body. You also provided clear explanation of what you found from the physical examination and the implications of your findings for my situation.
- Not applicable. There was no physical examination in this case.

(10) **Appropriate vocabulary**

- You used vocabulary that was too simple or too complex for me, or frequently used medical terms without explaining them to me. Sometimes I could not understand what you told me without asking for explanations of terms you used.

- Your vocabulary was generally appropriate but you sometimes inadvertently used medical terms without explaining them to me.
- Your vocabulary was appropriate and if needed you provided brief explanations of any medical terms you used without need for prompting.
- Your vocabulary was appropriate and you always provide clear and full explanation of relevant medical terms you used. In addition, you helped me better my understanding of my condition with the medical terms you explained to me.

(11) **Sensitive subject matters (e.g., sexual history, tobacco/alcohol/drug use, religious/cultural issues, giving bad news, or difficult emotional states)**

- You never warned me before approaching sensitive subject matters. You seemed judgmental and clearly expressed your disapproval of my positions or feelings, making me feel uncomfortable about discussing these subjects or feelings with you.
- You were careful and non-judgmental in discussing sensitive subject matters. However, you did not express understanding of my feelings and did not provide much emotional support.
- You were sensitive about discussing difficult subjects and were respectful of my feelings. I never sensed that you were judgmental or disapproving of my positions or feelings on these subjects. You showed empathic understanding of my position or feelings and provided appropriate emotional support.
- You were unusually empathic, sensitive and respectful of me and of my feelings and provided exceptional emotional support. In addition, you verbally reflected these back to me (e.g., "You sound sad") to show your understanding.
- Not applicable. There were no sensitive subject matters in this case.

(12) **Receptiveness to feedback**

- You did not seem open to my feedback about your performance. You responded defensively or dismissively too many of my comments.
- You listened to my feedback agreeably but passively. You did not actively participate during the feedback session.
- You were able to describe some of your own effective and ineffective behaviors, were attentive to my comments, and had an open discussion with me about alternative behaviors.
- You actively solicited additional feedback and showed signs of integrating my feedback into your behavioral repertoire. For example, you tried to role-play the communication techniques I suggested.
- Not applicable. I provided no feedback.

(13) **Do I want to see you again as my personal physician?**

- I did not feel comfortable in communicating with you at all. I would rather see a different physician.
- I think you were okay in general and might come see you again.
- I was impressed by the way you communicated with me. I would like to see you again.

- I was very impressed with you. I think you are one of the best physicians I have ever seen. I would feel very comfortable discussing any medical problems with you, and would recommend you to my friends.

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Question & Comments

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