A Framework for

Raising the Bar on Communication in Veterinary Medicine

By Suzanne Kurtz, PhD

How we think about communication has a significant impact on what we do, both in the practice of veterinary medicine and in our teaching of staff and students. Consequently, this article offers an overview of a practical, evidence-based 'conceptual framework' for thinking more systematically and intentionally about clinical communication (Silverman et al 2013 [in press], Kurtz et al 2005, Silverman et al 2005). [1] Understanding and using the framework are important starting points in our efforts to raise the bar on communication in veterinary medicine. [2]

The first part of the framework provides an important foundation by highlighting four *evidence-based underlying assumptions* that replace commonly held misperceptions:

Communication is an essential clinical skill, not an optional add-on and not 'simply' a social skill at which we are already adept.

An extensive body of research developed over the past forty years in human medicine and a small but growing body of research in veterinary medicine, shows that improving clinical communication in specific ways leads to:

a. More effective consultations for patients/clients and clinicians:
   - » Greater accuracy
   - » Heightened efficiency
   - » Enhanced supportiveness and trust
   - » Relationships characterized by collaboration and partnership

b. Better coordination of care (between healthcare professionals and with patients'/clients' families, etc.)

c. Improved outcomes of care:
   - » Greater patient/client satisfaction
   - » Better understanding and recall
   - » Greater compliance and follow-through
   - » Enhanced symptom relief
   - » Better physiological outcomes
   - » Enhanced patient safety and fewer clinician errors
   - » Greater clinician satisfaction
   - » Reduced costs, shorter hospital stays and fewer complications
   - » Reduced conflicts, complaints, and malpractice claims

Confirming communication as an influential clinical skill, these findings also answer the question of 'why bother' with communication in veterinary medicine.

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Like medical technical knowledge, physical examination or other procedural skills and clinical reasoning, clinical communication is a series of learned skills rather than a personality trait.

Some call clinical communication a set of procedures for improving outcomes of care. A brief illustration may be useful here. Half way into a senior veterinary specialist's 4-hour clinic that I was observing, a no-show patient allowed us twenty minutes to discuss issues the veterinarian raised concerning what, if anything, makes a difference when it comes to client understanding and compliance. We briefly discussed research findings from human medicine showing that: a) patients' recall and understanding can improve by 30% if they are asked to repeat important information (thus also giving clinicians immediate insight as to the clarity of their explanations and patient errors in recall or interpretation), b) compliance improved when physicians asked about the patient's beliefs regarding cause and other concerns and related subsequent explanations and plans to the patient's perspective, and c) compliance improved when physicians asked whether the patient would be able to follow through with plans made. For the rest of the afternoon, he changed his communication to incorporate all three suggestions and later reported that he could not believe what a difference the changes made, what he was finding out from familiar clients that he had never discovered before and how useful it all was!

Experience alone can be a poor teacher of clinical communication.

Although it is an excellent reinforcer of habit, experience tends not to discern very carefully between good and bad habits. Additional problems with relying on experience alone are that we tend to perceive our own communication inaccurately and often confuse intentions or feelings with actions (e.g. we may perceive that because we feel empathy we are demonstrating it).

Effective communication is possible in the time reasonably allotted for veterinary consultations.

A number of studies in human medicine confirm that once skills are mastered, effective communication usually results in greater efficiency. At some point consultations become too short to do the job well from a communication or medical perspective. True efficiency must take accuracy and quality of outcomes into account along with time required over time, not just time required for a single consultation.

A second part of the conceptual framework helps us decide what to focus on in order to enhance clinical communication skills. Contributing to these decisions, *three shifting paradigms* have influenced how we communicate in healthcare. The first is clinician centered care, wherein the clinician holds most of the control and tells essentially passive clients what to do. This corresponds to what Barbour (2000) called the 'shot-put' approach which views effective communication as content, delivery, and persuasion – you prepare your message carefully, heave it out there, and your job is done. Eventually healthcare moved to patient/client centered care (Stewart et al 2003), which requires that clinicians understand their clients' perspectives as well as their patients' problems. Client centered care places emphasis on eliciting and responding to the client's perspective: their thoughts, beliefs, feelings, expectations, and the effects of patients' problems on patient's and clients' lives. Building on patient/client centered care, a third paradigm shift is in progress. Focusing on the well being of clients *and* clinicians, relationship centered care (Tresolini 1994; Beach et al 2006) sees relationship as central to all health care and healing, including the clinician's relationship with patients, clients, self, colleagues, and communities.[3] This paradigm emphasizes that "...the privileges of the healer are founded on meaningful relationships in health care, not just technically appropriate transactions" (Beach et al 2006). Client and relationship centered care correspond to Barbour's 'Frisbee' approach in which confirming/acknowledging the other and developing mutually understood common ground are seen as essential foundations for trust and accuracy. The well-conceived, well-delivered message is still important, but emphasis shifts to feedback, interaction, and collaborative relationship. These are not competing paradigms. Each is more or less appropriate depending on the context and needs/preferences of individual clients. Clinicians need a full repertoire of relationships (i.e. paradigms) that they can employ skillfully and flexibly as appropriate (Lussier and Richard 2009).

Another way to decide what communication skills to focus on is to work from *'first principles' that characterize effective communication* (Kurtz 1989, Dance and Larson 1972, Dance 1969). Interestingly, these same principles characterize effective teaching. Effective communication (or teaching):

- Ensures interaction not just transmission – only giving information or telling someone what to do is insufficient; accuracy, efficiency, and relationship require two-way conversation, feedback, question and response from both client and clinician.
- Reduces unnecessary uncertainty – uncertainty distracts attention and interferes with accuracy, efficiency, and

relationship; for example, we can reduce uncertainty about the patient's problems and anticipated outcomes, the client's expectations for a visit, the clinician's expectations, the structure of the interview, how the team works, etc.

» Requires planning, thinking in terms of outcomes – effectiveness can only be determined in the context of the particular needs and outcomes the clinician and the client are working toward and consideration of the patient's needs at any given moment. If I am angry and want to vent that anger then I communicate in one way, but if I want to get at the misunderstanding that caused the anger, then to be effective I must communicate in an entirely different way.

» Demonstrates dynamism – this principle includes engaging with the patient/client, being present in the moment, and demonstrating flexibility; clinicians need to develop a repertoire of skills that allow different approaches with different individuals or with the same individual as circumstances change.

» Follows a helical rather than a linear model – saying something once is not enough; repetition and feedback are essential. Each reiteration moves us up the spiral to a higher level of understanding. Similarly the helix is an excellent learning/teaching model. Developing communication skills and maintaining competence requires reiteration as skills are deepened and applied in different contexts.

Thinking in terms of outcomes provides a third way to conceptualize what skills to focus on. In keeping with the evidence base and first principles, the *goals of communication in veterinary medicine* include:

» Ensuring increased accuracy, efficiency, and supportiveness

» Enhancing client and clinician satisfaction

» Improving outcomes of care

» Promoting collaboration and partnership (relationship-centered care)

But what are *the specific communication skills that enable everything else*? Whether enhancing our own clinical communication skills or assisting others, it is helpful to distinguish between three interdependent types of clinical communication skills – a weakness in one results in a weakness in all three:

» Content skills – what you say

» Process skills – how you communicate, e.g. how you structure interactions, ask and respond to questions, relate to clients and patients, use nonverbal skills, involve clients in decision making.

» Perceptual skills – what you are thinking and feeling, e.g. your clinical reasoning skills; the emotions you feel and what you do with them; your values, attitudes, biases, assumptions, and intentions; awareness and self reflection; inner capacities, such as integrity, respect, compassion, and mindfulness.

Still to enhance communication in veterinary practice, we need to be more specific. Ask any group of clinicians, learners, or clients and they quickly come up with a convoluted list of clinical communication skills they deem important. How do we combine their long lists with research findings and translate it all into a comprehensive, yet manageable, memorable delineation and definition of skills that can be put into practice in the real world?

One answer to this final part of the framework is the Calgary-Cambridge Guides, a teaching and learning instrument that has been evolving since the early 1980's and currently summarizes approximately 800 references in terms of 58 highly evidence-based communication process skills that make a difference in healthcare plus another 15 process and content skills related to common focuses in explanation and planning (Silverman et al 2013 [in press], Kurtz et al 2005, Silverman et al 2005, Kurtz et al 2003).

To make the list of skills more memorable and coherent, the Guides are organized in a way that corresponds directly to how we structure consultations in real life (Figure 1). We present the veterinary version of the complete Calgary-Cambridge Guides at www.vetmed.wsu.edu/ClinicalCommunication/.

Reflecting all elements of the conceptual framework described above, the Guides are used worldwide across a variety of cultures in human medicine, with everyone from students to highly experienced clinicians, and across the gamut of specialties. Along with all the other elements of this conceptual framework, we have been using the guides adapted for veterinary medicine with large and small animal veterinarians and at all levels from second year DVM through continuing education for over a decade.

Dr. Rick DeBowes' companion to this article on page 18 demonstrates how aspects of the conceptual framework can be applied in veterinary practice.

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1. For a more detailed discussion of the framework and the extensive evidence behind it, please see two companion books, entitled *Teaching and Learning Communication Skills in Medicine* and *Skills for Communicating with Patients*, created with my co-authors Jonathan Silverman and Juliet Draper, who need special acknowledgement for their contributions to the concepts presented here. Both books were first published in 1998 with revised 2nd editions appearing in 2005. The 3rd edition of the Skills book is forthcoming in September 2013 (Radcliffe Publishing). See also Kurtz (2006), a JVME article which condensed and adapted the conceptual framework for veterinary medicine. This paper is based on material originally published in these sources.
2. This same conceptual framework is the basis for our Clinical Communication Program in the College of Veterinary Medicine at Washington State University, including the work we do with DVM students, interns, residents, veterinary teams, faculty and practicing clinicians across the specialties.
3. See also Suchman, Slyter, and Williamson (2011) for useful descriptions of relationship centered skills and processes along with a series of in-depth case studies explaining how these relationship skills and processes have been used to promote significant changes in health care in a variety of contexts.