1 TAKING YOUR SKILLS TO THE NEXT LEVEL

The challenge

Telling a mother of two that her colon cancer has returned – and it's incurable. Explaining to a schoolteacher that to continue working, she will need portable oxygen. Giving the news to an accountant with chronic hepatitis that his incidentally discovered hepatocellular cancer is unresectable, so he's off the transplant list. Explaining to a father with refractory congestive heart failure that he needs hospice.

For those of us who care for these patients, these conversations are part of the territory that we learned to navigate mostly by trial and error. Even after years of experience, we still need to take a deep breath before getting started, to prepare for a conversation that will change the life of the person before us.

Patients and their families remember these conversations like they happened yesterday. They can remember what the doctor said, often word for word. They remember whether the doctor rose to the challenge with honesty, kindness, and resourcefulness, or whether the doctor filled an awkward silence with medical jargon. They remember whether they left the visit hopeful or confused.

How clinicians handle these difficult conversations can make or break a therapeutic relationship. We have seen clinicians who take on the challenges and others who sidestep them. Most of those who steer clear of tough encounters have good intentions but don't know how to act on them. They worry they'll say the wrong thing, that the patient or family will break down or freak out, or that they are opening a Pandora's box that will take way too much time in a busy day.

How do you talk with patients and their families about balancing hope versus reality, triumph versus disaster, or trust versus suspicion? Do you wish you were more confident about where to go with the conversation? Do you feel stuck when the patient asks, "Why me?" Do you get into arguments with a son who is angry? If so, this book is for you.

Does better communication really make a difference?

Let's be honest. As interns we were taught – in the hidden curriculum – that as long as the patient was getting the right tests and treatments, nothing else really mattered. Sure, it was important to be nice to patients. But, at the end of the day, attendings pimped us about the labs, the scans, or the treatments – they didn't pay attention to whether we had explained the diagnosis in a way that the patient could understand. Their implicit message was that communication is like the cherry on top of a sundae – a nice touch but expendable.

We were misled. The research shows that communication is central to the work a physician accomplishes. Good communication improves a patient's adjustment to illness, lessens pain and physical symptoms, increases adherence to treatment, and results in higher satisfaction with care. Poor communication skills are associated with increased use of ineffectual treatments, higher rates of conflict, and less adherence. What's more, good communication doesn't just affect patients; it also

affects you. It helps you enjoy and thrive in your work. Better communication skills are associated with less stress, less burnout, and even fewer malpractice claims. Suboptimal communication creates a vicious spiral that makes us feel more like hamsters on a wheel than like healers.

Moreover, clinical practice is changing in a way that puts a premium on communication skills. With the Internet, patients have more access to medical information than ever before, and they are avid consumers of this information. In addition, advances in biomedical technology have made decision making much more complicated. Patients and families need physicians to help interpret the information and add the clinical judgment and experience that they cannot get from a Web site. Thus, communication between patients and physicians is more complex, and has more layers, because physicians must integrate a mountain of biomedical information with their patients' values, hopes, and priorities. The Internet has a place but does not substitute for a skilled, caring physician.

Can doctors really learn to communicate?

When we give lectures on this topic, one of the comments we hear most frequently is, "You can't teach communication. You pick up what you need from experience. Besides, some people are simply better at it than others." Well, it's true that some clinicians start out better than others. But communication is a skill that can be taught, and when it's not taught properly, the learning that occurs through trial and error is not always productive.

As physicians progress in their careers, they don't see how others communicate – the interactions are usually private – and they only get feedback when they've been really good, or really bad. So, most physicians settle into communication routines. These habitual patterns are not necessarily bad, because they help us routinize our world.

However, the downside is that we may charge along in our work and overlook patients' individual needs. The patient worries about quality of life and the doctor talks about survival. Or the patient wants information and the physician keeps asking questions about coping. Either way, the routine leaves patients at least a bit frustrated and, worse, feeling isolated.

Like the golfer who needs a lesson to correct his swing, clinicians need to consciously shed these bad habits. This can only be accomplished through learning some new techniques and gaining experience using them. The good news is that sophisticated research shows that physicians can indeed learn to communicate better. But not by doing the same old thing over and over. You need to see the medical encounter in a new way and make better observations about what is happening. Then you can be more intentional about what you are trying to accomplish and more versatile with a wider array of communication tools. And as a result, your patients will be more satisfied – and you will be too.

What better communication will do for you?

After our work was profiled in the *New York Times*, a physician wrote to describe his experience learning to communicate. As a young resident in the emergency room, he remembered asking his supervisor how to tell a parent that her child had died in a car accident. The attending physician's advice: "Don't let the family get between you and the door." It's a sad commentary on how physicians learn, and reminds us of the study in which oncologists cited "traumatic experiences" as the most influential source of learning communication.

Compare this to the feedback we received from one of our Oncotalk Fellows. He wrote:

It remains clear that these conversations are difficult to have. Being surrounded by bad news does not necessarily make a person skilled at delivering it with compassion or clarity. Still, I listen to myself speaking to patients and using the tools I learned during my week in Colorado. I feel less flustered and my words are less tangled; I can focus on the person across from me and find out what is needed from me in that moment – and that seems like progress.

This seems like progress to us, too. Our measure of success for skilled clinicians is that they will be more capable about finding a way through a difficult conversation. We don't promise that the conversations will always feel simple or smooth or that better communication will enable you to escape sad situations. We can say however that, many of the doctors we trained feel more engaged with their work, more connected to their patients, and get more joy from their practice. It's exhilarating to watch. We see physicians who become more flexible and more resilient and develop a greater capacity for the work medicine requires.

What's our philosophy?

Over the past two decades, we have watched waves of terminology and ideology break over the practice of medicine. Terms such as "shared decision making," "patient-centered," and "relationship-centered" have all been used in support of better communication. In this book, we are going to ignore the labels. For these situations, we think that the critical task for clinicians is to find a way to integrate complicated biomedical facts and realities with emotional, psychological, and social realities that are equally complex but not very well represented in the language of medicine. Working with life-threatening illness is a cross-cultural experience. As a clinician, you need to understand both the

biomedicine and the personal story, and you need to be able to speak in both languages.

In these situations, communication is not about delivering an information pill and seeing how much the patient can swallow; it is about sending messages to the patient and receiving messages in return. This back-and-forth model of communication has some important implications. First, paying attention to the process of communication is what will lead to a good outcome. So the preparatory steps we outline in the roadmaps may seem obvious to you – but to a patient who has never been in your clinic before, they can make a big difference. Second, communication is a two-way process. You have to think specifically about the messages you send and those you receive. If you are too busy sending messages to read the replies, chances are that the other person will stop bothering to send. And as a clinician, you may miss hearing important data.

Our basic principles

Throughout the book, we will illustrate a few basic principles, but we've collected them here to give you the big picture. These are more than pearls – they're the bedrock of our work.

1. Start with the patient's agenda. (This does not require that you ditch your own agenda; you just need to find out where the patient is.)
2. Track both the emotion and the cognitive data you get from the patient. (Don't look past the emotion.)
3. Stay with the patient and move the conversation forward one step at a time. (Never speak more than one step ahead of the patient.)
4. Articulate empathy explicitly. (You are creating a safe conversational space.)
5. Talk about what you **can** do before you talk about what you **can't** do. (You need to show you are working for the patient.)

6. Start with big-picture goals before talking about specific medical interventions. (Ensure that you have aligned your goals with the patient's goals before offering details about the interventions.)
7. Spend at least a moment giving the patient your complete, undivided attention. (When the patient tells you something big, put down your pen, stop typing on your computer and show him you are listening.)

A word about emotion

In this book, we emphasize a distinction between "cognitive" and "emotion" data. Since both of these words have a variety of uses, we would like to clarify what we mean when we use them in this book. By "cognitive" data, we are referring to conscious intellectual processes like thinking, reasoning, and judging. When you are talking to Mrs. E about prognosis and she mentions that she read on the Internet that the 5-year survival for her cancer was 50%, that is a piece of cognitive data. This particular piece of cognitive data tells us that she has consciously sought out information and tried to understand and comprehend it. Cognitive data tells us what patients understand rationally. On the other hand, when she flushes while she mentions this and you catch a look of distress flashing across her face, this is a piece of emotion data. Emotion is not under conscious control; it is involuntary. Mrs. E's flash of worry is a piece of emotion data tells us that this patient is having a tough time reporting to you what she has read because she is concerned about what it means for her. Emotion data tells us about a process of integration occurring in the parts of the brain that have to do with appraising value and creating meaning, because emotion processing prepares the brain and the rest of the body for action.

What does all this have to do with communication? In medical settings, we often hear physicians frustrated, irritated, or overwhelmed

with the emotion patients show, or we notice them trying to ignore emotion altogether. They dismiss emotion as human frailty and assume it has less value than cognition. In fact, emotion plays an important role: it determines how we decide what is valuable. And when you are talking to a patient with a life-threatening illness, figuring out what is truly valuable is often the most important underlying communication task. We consider emotion data to be as important as cognitive data and will emphasize recognizing and responding to emotions.

How to use this book?

You can use this book in two ways. You can flip straight to the chapter that addresses a challenge you currently face. Each chapter contains a step-by-step guide, or cognitive roadmap, that you can use to find your way through a difficult conversation. Alternatively, you can read the book straight through. Read in order, the chapters are designed to build a set of skills that will build a repertoire of communication tools that is powerful and flexible.

Maximizing your learning

During our retreats, we teach through interaction because the research shows that feedback is critical to put new communication skills into practice. On your own, there are other ways for you to learn the skills we teach at a course:

Record yourself. Listening to yourself or watching yourself is a humbling experience. (Does my voice really sound like *that*?) But it's worth the hassle. Don't forget to have your patient sign something that gives permission, but make it clear that you are doing this to become a better doctor. Even cynical patients will be impressed that you are trying to improve. Listen for what you say and what you sound like when

you're saying it. Better yet, have someone you trust watch or listen to the video or audio. Ask them to comment specifically on something you are working on.

Refine your observational skills. We have found that many physicians before communication training do not collect as much observational data – they are less skilled at recounting what happened. Lacking this observational data, they see communication as magical rather than a series of intentional observations, decisions, and words or gestures. So try to watch exactly what happens in your conversations. What did you say that worked? Or didn't work?

Practice one new skill at a time. Communication is a complex psychomotor skill, and until you've mastered one thing, it's hard to focus on something else. You wouldn't try to learn to use your new mobile phone while driving a new car, would you? Pick **one** skill. And the first time, pick something that doesn't look too hard. Remember that the best learning happens in situations that offer a bit of a challenge, yet aren't overwhelming.

Ask for feedback. Find someone else to watch you and give you feedback. Keep in mind that many medical professionals do not have highly developed feedback skills: they ignore your goals, don't notice your strengths, and tend to say something nice just before they say something mean. Therefore, don't open yourself up to a known character assassin. Give the person something specific to watch for. Tell them you really just want two or three observations relevant to a skill you are working on. Tell them you don't want their opinion about what you should have said – you want their observations (what happened?) about what you did say.

Do your own private debriefing. After a difficult conversation, find a couple of blank sheets of paper and, for a few minutes, write down everything you can remember about what happened. Include snippets of what you said and what the patient said, as well as reactions,

emotions, body language, and the effect of the conversation on you personally. Don't censor anything, just get it all down on paper. We try to put our pen on the paper and just keep writing for two or three pages. If other thoughts intrude, just write them down, then get back to the conversation. Later, see if a lesson or an insight emerges.

Be patient with yourself. Even though we are supposed to be experts, we still find ourselves chagrined because we lack patience, feel insufficiently spiritual, distract ourselves with petty ambitions, and remain perplexed about some things. Anne Lamott said wisely that "perfectionism is the enemy," so remember that you just need to stay on the path. Your mistakes can be portals to new learning. And remember, if you are trying to improve, you've already distinguished yourself from most physicians.

Pay attention when someone tells you that you did a good job. Working with life-threatening illness has a long learning curve, but it has its rewards. When you get positive feedback, pay attention. Don't brush off a compliment ("it was nothing," "it's my job"). Breathe deeply, take it in, enjoy the moment, and say "you're welcome."

You're ready to begin.