

# Advanced Communication Strategies for Relationship-Centered Care

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## CME EDUCATIONAL OBJECTIVES

1. Know the concepts of patient-centered and relationship-centered care as well as interpersonal and communication skills.
2. Discuss personal reflection and everyday ethics, and how they enhance practice.
3. Discuss concepts and strategies from the Kalamazoo Consensus Statement framework and the Four Habits Model as guides to developing and enhancing relationship-centered care.

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*"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."*

—Sir William Osler, MD, 1932

The pediatric encounter requires skillful communication between patient and physician, expert communication with parents and other family members, and an understanding of family dynamics and

the child's cognitive and developmental stage. There is a direct association between the physician's interpersonal and communication skills and ability to reflect, and health care quality and outcomes. All encounters between patients and health care professionals, and among members of health care teams, take place within a broader moral universe that includes personal integrity, professionalism, and the everyday ethics of practice.

TABLE 1.  
Objectives of  
Patient-Centered and  
Relationship-Centered Care

#### Patient-Centered Care

- Focuses on patient/family needs, perspectives, values, culture.
- Emphasizes the patient's disease and illness experience.
- Views each patient and family as unique.
- Tailors approach based on knowledge of patient/family.

#### Relationship-Centered Care

- Moves beyond the patient-centered process to a focus on how patients and physicians relate to each other.
- Views relationships as therapeutic and as the medium of care.
- Both patients and physicians are active participants; what the physician brings to the relationship is important.
- The physician focuses on being 'present' for self and others.
- Awareness that the physician's interactions with patients and families influence the course and outcome of care; hence, the physician's capacity for reflection and self-awareness is important.

Source: Haber E.

## ENHANCE INTERPERSONAL AND COMMUNICATION SKILLS

In 1968, pediatrician Barbara Korsch established that physician-patient communication is an essential factor in the quality of patient care.<sup>1</sup> Numerous studies<sup>2-7</sup> demonstrate that good communication with patients leads to better health outcomes and improved quality of care, as well as increased patient satisfaction, adherence to treatment plans, symptom improvement, better management of chronic conditions, and fewer medical errors.

Studies also show that most malpractice suits arise from communication issues. Beckman et al<sup>8</sup> found that 71% of

malpractice depositions arise from patient-perceived problems with the physician-patient relationship. The authors identified four major themes: deserting the patient, devaluing patient and/or family views, delivering information poorly, and failing to understand the patient and/or the family perspective.<sup>8</sup>

The quality of communication and relationships between physicians and patients and their families influences all aspects of patient care. Good communication also allows more efficient, accurate, and supportive interviews, and has been shown to reduce diagnostic testing and referrals.<sup>9</sup>

Increasingly, children are seen most often by primary care providers for behavioral, developmental, and psychosocial problems.<sup>10</sup> Kahn et al<sup>11</sup> found that psychosocial issues motivate 65% of primary care pediatric visits, and 85% of mothers with young children indicate they would welcome or were open to being asked about psychosocial and emotional stressors. Parents highly value physicians who attend to their and their child's feelings and concerns,<sup>12</sup> and who seek to understand their perspective.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) declared residents must demonstrate proficiency in interpersonal and communication skills and professionalism. The American Board of Medical Specialties (ABMS), the Federation of State Medical Boards, and the Joint Commission now require practicing physicians to demonstrate mastery of these competencies.<sup>13</sup>

## PATIENT-CENTERED AND RELATIONSHIP-CENTERED CARE

Patient-centered care focuses on the patient's illness experience, acknowledges each patient and family as unique, and considers culture, personality, and related factors relevant to the process of health care. The patient, rather than the disease, is central.

Relationship-centered care enhances patient-centered care by taking the patient-centered focus a step further to include ways the physician and patient relate to one another. The physician understands that his or her interactions with patients influence the course and outcome of care. Hence, self-awareness and reflection become essential qualities for all health care professionals. Both types of care include cultural competence (see Table 1).

## DIFFERENCE BETWEEN INTERPERSONAL AND COMMUNICATION SKILLS

Although interpersonal and communication skills<sup>14,15</sup> remain components of the same competency, they are different, and the goal is to enhance both. Alone, neither can create nor sustain a therapeutic relationship. Communication skills (eg, greeting each person in the room, making eye contact, etc) — like manners — can be learned and applied for basic interviewing. However, moving beyond prescribed tasks and "scripts" allows physicians to fully appreciate their patients' stories and to develop a deeper relationship in the physician-patient encounter.<sup>13</sup> Sidebar 1 (see page 449) lists some important elements of interpersonal skills.

## ETHICS OF EVERYDAY PRACTICE

Berwick<sup>16</sup> notes that our current health care system tends to regard human interactions more as a "price" than as a "goal," and acts "... as if interactions were the burden it must bear so that it can deliver the care." With the current economics of health care, to survive financially, physicians are forced to see more patients, and they face the constant threat of moral erosion from factors inherent in the corporatization of medicine.<sup>17</sup>

Many advocate examination of the ethical and moral aspects of everyday practice. Epstein identifies the foun-

dation of professional excellence as knowledge of and respect for the patient as a person with needs and values.<sup>18</sup> Browning notes that clinicians and patients/family members live within the same moral universe of universal human standards that include: being fair, respecting others, and “discussing the right thing to do in any given situation.”<sup>19</sup> Similarly, Miller and Schmidt encouraged application of their “habits of humanism” to every patient and to the medical culture: identify multiple perspectives in each encounter (patient, support person, physician); reflect on possible conflicts that could aid or hinder forming a relationship with a patient; and choose to act altruistically supporting the patient’s perspective above all, even if it conflicts with the physician’s agenda or interest.<sup>20</sup> These everyday ethics and habits of humanism not only apply to how we treat patients, but also to how we interact with colleagues and health care team members.

Interpersonal skills are enhanced through reflection and self-awareness, which, in turn, allow physicians to understand their own reactions to patients, to observe the way others experience them, to be “present” in the moment, and to remain flexible and responsive in interactions with patients and family members.<sup>13,15</sup> Reflection and self-awareness can enhance the moral aspects of practice by helping physicians to contemplate their actions, to hold themselves responsible for their influence on patients, family members, and colleagues, and to consider the underlying ethical meaning of their work.

### NURTURING REFLECTION

Physicians’ attitudes and beliefs about many issues (eg, bad news, death, pain, etc) affect the ways they interact with patients.<sup>21</sup> Unrecognized attitudes and feelings can hinder a

physician’s ability to be empathetic, to discuss difficult topics with patients, to avoid under- or over-involvement with patients, and to obtain the data needed to diagnose a patient and agree on a treatment plan.

The ability to reflect is one factor that separates professionals from technicians.<sup>22</sup> Studies show that the physician’s self-awareness is essential for effective communication, good relationships with patients, accurate gathering of clinical information, and mastery of patient-centered interviewing.<sup>23</sup> Epstein<sup>18</sup> provides questions physicians and other health care professionals can ask themselves to enhance reflection on their interactions with patients (see Sidebar 2, page 450).

### EVIDENCE-BASED MODELS FOR RELATIONSHIP-CENTERED ENCOUNTERS

A number of communication models/frameworks exist and can be used or adapted for your clinical practice.<sup>13</sup> Some examples of techniques and strategies for working with children and their families include the Kalamazoo Consensus Statement framework and the Four Habits Model (Table 2, see page 450).

The Kalamazoo Consensus Statement<sup>24</sup> was developed by medical education leaders and communication experts. It identifies seven evidence-based “essential elements” of effective physician–patient communication, and provides tasks for each element. Calhoun, Rider, and colleagues<sup>25</sup> expanded the framework by adding two additional competencies: “demonstrates empathy” and “communicates accurate information.”

The Four Habits Model,<sup>26</sup> originally created for physicians in the Kaiser Permanente system, and derived from a blend of clinical experience and empirical literature, organizes communication tasks into four groups of skills, and provides techniques for performing these “habits,” as well as the benefits of each.

#### SIDEBAR 1.

### Essential Interpersonal Skills for the Patient-Physician Relationship

- Awareness of the importance of the relationship between physician, patient, and family members.<sup>27</sup>
- Ability to be “present” in the moment, paying close attention to the patient, working collaboratively and from strengths.<sup>14</sup>
- A caring intent to relieve suffering.
- Curiosity and interest in the patient’s ideas, concerns, and values,<sup>27</sup> and a sincere interest in human experience.<sup>15</sup>
- Capacity to provide a sustainable relationship that allows repair when mistakes are made and includes authenticity, honesty, admission of, and sorrow for, mistakes.<sup>14</sup>
- Respect for others and a habit of treating others as one would like to be treated.<sup>27</sup>
- Empathy, including an accurate understanding of patients’ feelings, and caring and emotional responsiveness.
- Capacity for flexibility, relational versatility,<sup>15</sup> and “differential use of self”<sup>13</sup>—ie, the ability to adjust interpersonal skills based on the needs of different patients and families.

Source: Rider E.

### ESSENTIAL COMPONENTS OF COMMUNICATION

#### Build Relationships with Every Encounter

The core skills for delivering quality pediatric health care remain: skillful communication; building and sustaining therapeutic, caring relationships with children, adolescents, and their families;<sup>28</sup> and upholding the ethics of everyday practice.

Rapport begins from the opening moments of the interview; if the interview starts on a negative note, it is challenging to recover.

An effective physician-child-parent relationship requires: getting to know the patient and parents; interest in the child as a person; attention to the child’s and

## SIDEBAR 2.

### Reflective Questions for Physicians

- How might my previous experience affect my actions with this patient?
- What am I assuming about this patient that might not be true?
- What surprised me about this patient? How did I respond?
- What interfered with my ability to observe, be attentive, or be respectful with this patient?
- How could I be more present with and available to this patient?
- What would a trusted peer say about the way I managed this situation?
- Were there any points at which I felt judgmental about the patient — in a positive or negative way?

*Adapted from: Borrell-Carrio F, Epstein RM. Preventing errors in clinical practice: a call for self awareness. Ann Fam Med. 2004;4(2):310-316.<sup>29</sup>*

family's values; and understanding the way each family member experiences the child's illness. The physician achieves these tasks via listening skills, respect, empathy, understanding the role of play and children's different developmental and cognitive stages, and effective non-verbal communication.<sup>30,31</sup> Congruence between words, tone, and body language is important for effective communication.

Children understand more about health and illness than previously thought, and can provide unique and valuable information about themselves.<sup>32,33</sup> Direct communication between physician and child contributes to improved relationships, treatment adherence, satisfaction with care, and better health outcomes.<sup>30</sup> Physicians can collaborate with parents to help children have a voice in medical encounters.

### Elicit Concerns and Set an Agenda

The short time available for many office visits may prove incompatible with the issues a parent desires to dis-

The Four Habits Model <sup>31</sup>	Kalamazoo Consensus Statement Framework <sup>32</sup>
<p><b>Habit 1. Invest in the beginning</b></p> <ul style="list-style-type: none"> <li>• Create rapport quickly.</li> <li>• Elicit the patient's concerns.</li> <li>• Plan the visit with the patient.</li> </ul>	<p><b>1. Build a relationship (throughout interview):</b></p> <ul style="list-style-type: none"> <li>• Greet and show interest in patient as a person.</li> <li>• Use words that show care and concern throughout the interview.</li> <li>• Use tone, pace, eye contact, and posture that show care and concern.</li> </ul> <p><b>2. Open the discussion.</b></p> <p><b>3. Gather information.</b></p>
<p><b>Habit 2. Elicit the patient's perspective</b></p> <ul style="list-style-type: none"> <li>• Ask for the patient's ideas.</li> <li>• Elicit specific request.</li> <li>• Explore impact on the patient's life.</li> </ul>	<p><b>4. Understand the patient's perspective.</b></p> <ul style="list-style-type: none"> <li>• Know the concepts of patient-centered and relationship-centered care as well as interpersonal and communication skills.</li> <li>• Discuss personal reflection and everyday ethics, and how they enhance practice.</li> <li>• Discuss concepts and strategies from the Kalamazoo Consensus Statement framework and the Four Habits Model as guides to developing and enhancing relationship-centered care.</li> </ul>
<p><b>Habit 3. Demonstrate empathy</b></p> <ul style="list-style-type: none"> <li>• Be open to the patient's emotions.</li> <li>• Make an empathic statement.</li> <li>• Convey empathy nonverbally.</li> </ul>	<p><b>Correlates to:</b></p> <ul style="list-style-type: none"> <li>• Build a relationship.</li> <li>• Understand the patient's perspective.</li> </ul> <p><i>(Demonstrates Empathy' is included in the Gap-Kalamazoo Communication Skills Assessment Form.<sup>34</sup>)</i></p>
<p><b>Habit 4. Invest in the end</b></p> <ul style="list-style-type: none"> <li>• Deliver diagnostic information.</li> <li>• Provide education.</li> <li>• Involve patient in making decisions.</li> <li>• Complete the visit.</li> </ul>	<p><b>5. Share information.</b></p> <p><b>6. Reach agreement.</b></p> <p><b>7. Provide closure.</b></p>

Adapted from: Rider EA. Communicating with children and families. In: Rudolph C, Lister G, Gershon A, First L, Rudolph A, eds. Rudolph's Pediatrics, 22nd edition. NY: McGraw-Hill © 2010. Reprinted with permission of The McGraw-Hill Companies.

cuss, as well as other complex concerns that frequently arise.

Planning the visit and setting an agenda with parents and patients can increase efficiency, save time, and improve care. Dyche and Swiderski<sup>34</sup> found that physicians who allowed patients to complete a statement of concerns and elicited the patient's agenda, reported patients' problems more accurately; failure to ask the patient's

agenda correlated with a 24% reduction in physician understanding.

The physician can take the lead in efficiently negotiating and prioritizing the agenda (see Table 3, page 451). Prioritizing everyone's concerns and being explicit about the time allowed for a visit, conveys respect to the patient and saves time. The child and parent can be invited to return for subsequent visits if concerns remain.<sup>26,30</sup>

TABLE 3.

**Agenda-Setting and Prioritizing Questions**<sup>26,31,35</sup>

**Agenda-Setting**

- "What concerns you today?"
- "Anything else?"
- "I see you have a list; is there anything else you would like us to talk about today?"
- "Your child was scheduled for a 15-minute visit. I want to make sure I've heard all your concerns and then we can decide together what we can accomplish today."

**Prioritizing**

- "We've talked about Jesse's stomachaches and some of your other concerns. Can you tell me what issues you think are most important for us to address today?"
- "What is at the top of your list?"
- "Let's make sure we discuss A and B; if we don't get to C, we can talk by phone or set up another visit."

Source: Rider E.

The words we choose are important. For example, a parent will experience the words "I wish we had time to talk about your concerns about your child's sleep today. Let's make a follow-up appointment to talk further," differently than the words, "I don't have time to deal with all these problems now."<sup>26,30</sup>

**Understand the Patient's and Family's Perspective**

Understanding the patient's perspective is one of the most important tasks of the clinical encounter, and it enhances cultural competency. It can help to consider the clinical encounter as a "meeting between experts," a partnership between physician, patient, and parent. Building the relationship establishes a trusting environment and encourages the patient's participation.

TABLE 4.

**Strategies that Convey Empathy and Facilitate Handling Emotions**

Strategy	Content and Words to Use
Elicit emotions	<ul style="list-style-type: none"> <li>• Recognize when the child or parent is not directly expressing their emotions: eg, the child hides behind the examination table, or clings to parent; parent seems distracted, skeptical.</li> <li>• Invite exploration of unexpressed feelings:                             <ul style="list-style-type: none"> <li>– For child: "Are you feeling scared (shy, mad, etc)?" "How are you doing right now?" "Anything else?"</li> <li>– For parent: "What are you most concerned about?" "What has this been like for you?" "Can you tell me more?" or note: "You look skeptical."</li> </ul> </li> <li>• Explicitly acknowledge and accept feelings. "You seem worried by this; you've been through a lot."</li> <li>• Accept children's expressions of upset or grief. Crying usually brings relief to the child. Avoid overreacting to tears or trying to distract children from their feelings. Ignore temper tantrums.</li> </ul>
Respond to the child's and parent's emotions	<ul style="list-style-type: none"> <li>• "I can see that this is bothering you."</li> <li>• "That sounds really hard."</li> <li>• "Most people feel overwhelmed when this happens."</li> <li>• "You must feel proud about that. That's great!"</li> <li>• "You were really brave. Good for you!"</li> <li>• "It's OK to cry. No one likes to have a shot."</li> <li>• "I am here to help you in any way I can."</li> <li>• "You must have been up all night too (with your child). I imagine you are tired."</li> </ul>
Reflect content and check in with child and parent	<ul style="list-style-type: none"> <li>• "What I am hearing is ... Do I have it right?"</li> <li>• "It sounds like you think..." "Did I leave anything out?"</li> <li>• "I want to make sure I understand what you have shared with me."</li> <li>• "Are you worried about having a shot?"</li> <li>• "You sound sad (or unhappy, skeptical, etc)."</li> </ul>

Adapted from: Rider EA. Communication and relationships with children and parents. In: Novack DH, Clark W, Szuzim R, Deteringer C, eds. *doc.com: an interactive learning resource for healthcare communication*. 2009. [webcampus.drexelmed.edu/doc.com/user/](http://webcampus.drexelmed.edu/doc.com/user/). Accessed August 2011; and from: Condehan JL, Platt FW, Egner B, et al. "Let me see if I have this right. . .": words to help build empathy. *Ann Intern Med*. 2001;135:221-227.

Listen to the patient's and family's story, identify their major concerns, and ask about their understanding of the causes of illness and possible treatment. Find out the effect of the illness on the patient and family. For example, ask how they are experiencing the child's illness and what concerns them the most. Explore their ex-

pectations about illness and treatment and respond directly to the patient's/parent's expressed thoughts and feelings.<sup>30</sup>

**Demonstrate Empathy and Openness to Emotions**

Studies suggest an association between the physician's caring and

## SIDEBAR 3.

### Resources for the Development of Communication Skills

- American Academy on Communication in Healthcare (AACH): [www.aachonline.org](http://www.aachonline.org).
- Children's Emotional HealthLink, Pediatrician-Parent Communication Training Program: [www.cehl.org](http://www.cehl.org).
- *doc.com*: [www.aachonline.org/?doccom](http://www.aachonline.org/?doccom).
- Institute for Healthcare Communication: [www.healthcarecomm.org](http://www.healthcarecomm.org).
- Institute for Professionalism and Ethical Practice: [www.ipepweb.org](http://www.ipepweb.org).
- Interpersonal Communication and Relationship Enhancement: I<sup>2</sup>CARE: [www.mdanderson.org/education-and-research/resources-for-professionals/professional-educational-resources/i-care/index.html](http://www.mdanderson.org/education-and-research/resources-for-professionals/professional-educational-resources/i-care/index.html).
- The American Balint Society: [americanbalintsociety.org/learn/balint-groups/balintgroups.html](http://americanbalintsociety.org/learn/balint-groups/balintgroups.html).

Source: Rider E. All sites accessed Aug. 25, 2011.

empathy and the effectiveness and appropriateness of care. Demonstrating empathy enhances efficiency, and increases diagnostic accuracy, patient adherence,<sup>36</sup> and both patient<sup>37</sup> and physician satisfaction.<sup>38</sup>

The ability to convey empathy with patients and families requires a mindful approach to interaction,<sup>39</sup> listening to feedback, reflective practice, and attention to everyday ethics. The words we use with patients and families and how we use them can promote empathic discussion, thwart it, or actually end it.<sup>40</sup> Developing strategies that convey empathy and facilitate handling patients' emotions is key (see Table 4, page 451).

#### Invest in the End of the Encounter

Studies show that involving the patient/parent in making decisions corre-

sponds with improved outcomes. Invite the child's and parent's collaboration and include them in decision-making and planning to the extent they desire. Most patients prefer information and discussion, and some prefer mutual or joint decisions. Share diagnostic and treatment information with kindness, and use words that are easy for the child and family to understand. Provide education for both child and parent, including the rationale for diagnostic tests and treatment options, expectations, and resources. Intersperse sharing information with asking about understanding and effect. Ask for additional questions or concerns, summarize what was discussed, and clarify follow-up plans.<sup>30</sup>

#### CONTINUING PROFESSIONAL DEVELOPMENT

Communication and interpersonal skills often receive limited attention in medical school and residency training curriculums. Practicing physicians may be unfamiliar with conceptual models and the research-based evidence for enhancing these skills. Continuing professional development programs provide various opportunities to develop communication skills and to enhance reflection, although the physician often must actively seek out these offerings. Examples include: local, regional, and national continuing medical education (CME) workshops; faculty development sessions and retreats given by outside or local experts; longitudinal CME and faculty development programs;<sup>13,41</sup> and the adjunct use of Web-based learning modules (Sidebar 3).

#### CONCLUSION

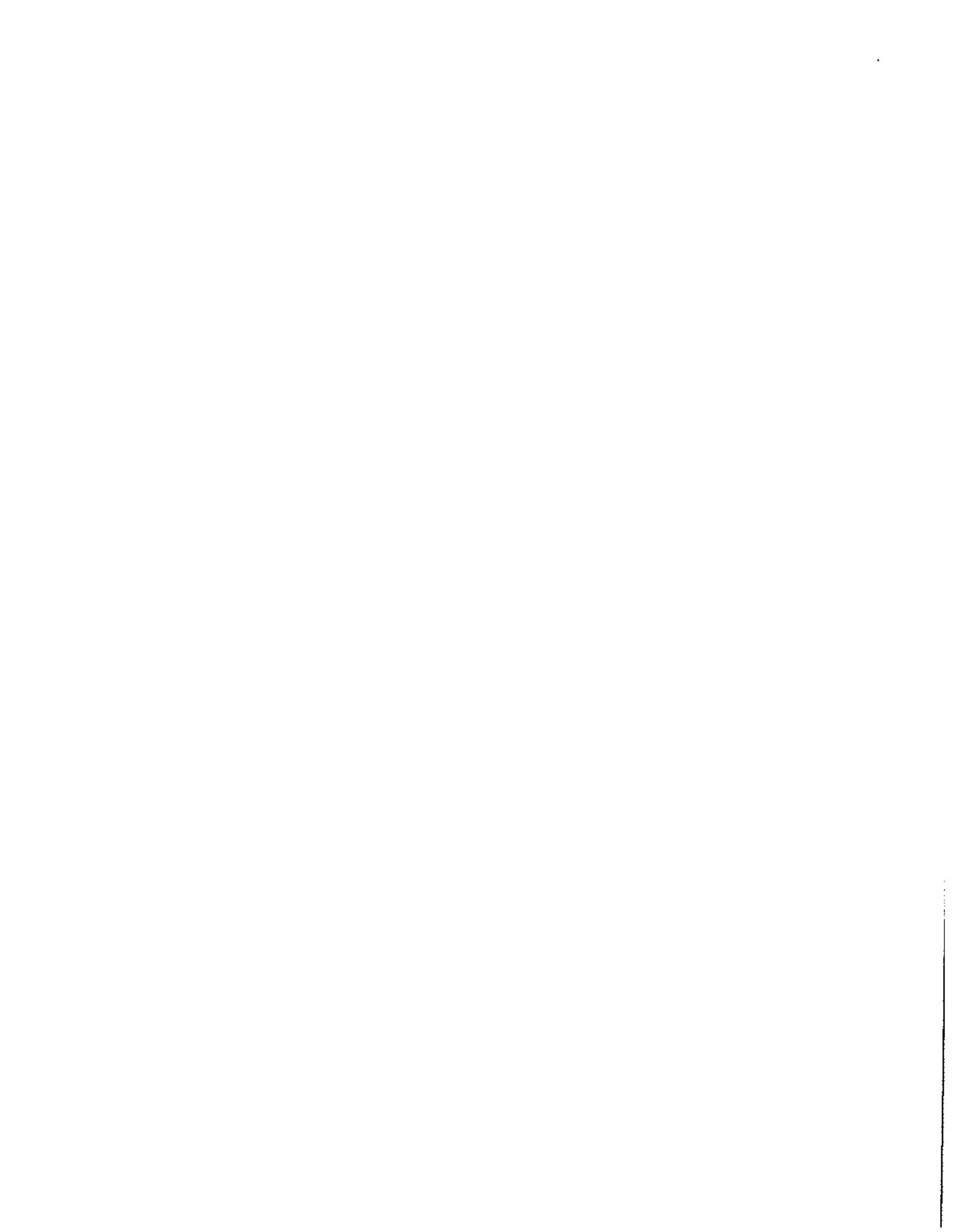
Skillful communication, relationship-centered care, and attention to everyday ethics are indispensable to practicing high-quality pediatric medicine. The physician's humanistic capacities—including the ability to reflect; to have self-awareness; to empathize; to remain

"present" for self and others; and to mind one's own behavior—are significantly associated with patients' perceptions of the quality of care.<sup>13</sup> If medical students and residents do not learn these skills in depth during their training, opportunities exist after residency training to acquire them in post-graduate continuing professional development programs. As we enhance our knowledge and understanding in these areas, our patient's satisfaction will increase, as will our own.

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# Difficult Conversations in Health Care: Cultivating Relational Learning to Address the Hidden Curriculum

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## Abstract

The authors describe the philosophy and pedagogical approach of an innovative educational program, grounded in principles of relational learning and designed to improve the preparedness of health care professionals for engaging in challenging conversations with patients and families. The Program to Enhance Relational and Communication Skills (PERCS) is a project of The Institute for Professionalism and Ethical Practice at Children's Hospital Boston, developed in collaboration with Education Development Center, Inc. The one-day workshop is interdisciplinary in its

structure, includes practitioners with varying levels of professional experience, uses trained actors to portray patients and family members, and involves learners in improvised case scenarios. The program responds to several developments in contemporary health care: medical education reform, changing definitions of professional competence, and calls for greater attention to qualities of compassion, trust, and respect in practitioners' relationships with patients and families. The program's pedagogy responds to these developments by creating a safe

climate for relational learning, by enacting emotionally challenging and ethically salient case scenarios, and by integrating patient and family perspectives in novel and substantive ways. By creating a curriculum and learning environment that explicitly embraces the moral experience of learners, the program's developers aim to exert a countercultural influence on the dehumanizing effects of the hidden curriculum.

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—In this sometimes hierarchical environment, it was a pleasure to leave one's badge at the door and allow ourselves to brainstorm and break down barriers with colleagues across departments and disciplines.

—What I learned is that one doesn't have to be perfect or have all the answers—one has to be genuine and real.

—I have learned that working together as a team means more than just inviting the nurse or social worker into the room, but also inviting them into the conversation. This insight has permanently changed the way I interact with families in the ICU.

—In an environment that places an enormously high premium on advancing surgical and technical standards, it was refreshing to devote collective intellectual energy to cultivating the other half of the medical equation—the emotional standard of care.

**T**hese comments were offered by an interdisciplinary group of health care professionals after their participation in a daylong workshop titled *Difficult Conversations at the End of Life*,

conducted by the Program to Enhance Relational and Communication Skills (PERCS) at The Institute for Professionalism and Ethical Practice, Children's Hospital Boston, developed in collaboration with Education Development Center, Inc. Their remarks are typical of the sentiments of the more than 600 physicians, critical care residents, nurses, social workers, psychologists, and chaplains who have participated in the workshop since its inception in 2002. PERCS is a continuing education effort, organized from the perspective of relational learning.<sup>1</sup> This article aims to unpack these participants' comments, and explore what they reflect about the learning experience that participants describe.

Our reason for launching this educational program was to help practitioners become more competent and prepared to engage in difficult conversations with patients and families. We chose to focus initially on challenging conversations in the pediatric context, such as when clinicians must communicate a very bad prognosis to parents about their child or assist them in making particularly difficult end-of-life decisions. Since the inception of the program, we have adapted and applied

the program's learning principles and pedagogy to other kinds of high-stakes conversations in medicine, such as discussing organ donation, disclosing medical error, and assisting family members during the invasive medical procedures of loved ones. In this article, however, we focus on the method as implemented in the inaugural program, which addresses end-of-life conversations with children and families. We describe the program's rationale, goals, value premises, structure, and format. We then explore *how* the program works, by providing an in-depth account from a typical workshop. We close with our reflections about *why* the program works, by exploring key features of our pedagogical approach.

A separate manuscript provides evaluative data documenting changes in knowledge, attitudes, and skills for program participants. We have completed a pre–post evaluation study including baseline, immediate follow-up, and five-month self-report questionnaires. Participants reported better preparation, improved communication and relational skills, greater confidence, and diminished anxiety when holding difficult conversations with patients and their

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families. Open-ended questions indicated that participants deepened their understanding of patient and family perspectives, learned a range of generalizable communication and relational skills, recognized inherent interpersonal capacities that could be drawn upon, and grew in their understanding of interdisciplinary teamwork (Meyer et al., under review).

## Overview of the Program

### Rationale

Concerned about erosion of altruistic ideals that typically motivate young people to choose health care as a profession, there is a growing chorus of voices expressing alarm about dehumanization and declining professionalism in the U.S. health care system.<sup>2,3</sup> For physicians especially, there is increasing documentation of a wearing away of empathy and other relational capacities that takes place over their years of professional training.<sup>2,4,5</sup> In our experience, this “breeding out” is a problem that is not unique to medical students, but rather one that is shared in large part by all health care professionals during their training and the unfolding of their careers. In response to these worrisome developments, there have been calls for new definitions and standards of professional competence,<sup>6</sup> for reform in the culture of medical education, including new pedagogies that better address the hidden curriculum and moral development of practitioners,<sup>2,7,8</sup> and for increased attention to interdisciplinary collaboration and knowledge sharing in the training of health care professionals.<sup>9</sup>

In an effort to understand this erosion and find workable solutions, many thoughtful commentators have discerned patterns of discrepancy between what is taught in formal educational settings and what is actually learned by practitioners in the informal flow of professional training and everyday practice.<sup>1,8,10,11</sup> This *hidden curriculum* has been defined by one observer as “what we *actually* do in our day-to-day work with patients and one another—not what we say *should* be done when we stand behind podiums in lecture halls.”<sup>2</sup> By creating a curriculum and learning environment that explicitly embraces the moral experience of practitioners as they engage in difficult conversations with colleagues, patients,

and family members, our goal has been to exert a countercultural influence in relation the dehumanizing effects of the hidden curriculum on everyday practice.

### Goals

Our program aims to embody and promote new and expanded definitions of professional competence in the medical world. We concur with Epstein and Hundert’s<sup>6</sup> perspective that competence depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence; that it includes the cultivation of emotions, values, and reflection in daily practice; and that it is developmental, impermanent, and context dependent. Working from their premises, we have identified a set of relational capacities and habits of mind (List 1) that, in our view, are tied to becoming competent in these conversations. Accordingly, the pedagogical design of the program is intended to promote the *discovery*, through experiential learning, of these relational capacities and habits of mind.

### Value premises and pedagogical approach

All approaches to professional education are premised on value assumptions about what constitutes learning and how it should occur. Often, educators describe programs and educational approaches without explicitly articulating the underlying values that have informed their pedagogical decisions. Our approach, which we call *relational learning*,<sup>1</sup> is based on the conviction that the learning that matters most in the professional development of health care professionals occurs in the context of relationships established among practitioners, patients, and family members. We wish to be explicit about

our value premises, to make clear why we hold them, and to articulate their pedagogical implications for a curriculum constructed to counteract value premises operating in the hidden curriculum. Haidet and Stein,<sup>8</sup> in their insightful examination of the impact of medical culture on the professional formation of physicians, uncovered several of these value premises, typically unacknowledged in medical culture, that contribute to the hidden curriculum of health care. Table 1 presents these five premises, juxtaposed with the value premises in our program and a description of key features of our pedagogical approach.

### Structure and format

The program is interdisciplinary in its structure, with physicians, nurses, social workers, psychologists, and chaplains in attendance. Participants with varying levels of experience, from beginning students to senior clinicians, take part in the workshop. Actors, specially trained to enact realistic scenarios corresponding to critical junctures in the trajectory of a life-threatening condition, portray patients and family members. Although the scenarios and roles of patients and family members are defined in advance, the unfolding of each conversation is improvised, varying substantially depending on the approach taken by providing the opportunity for direct practice. Interdisciplinary teams of two or more practitioners, and at times individual professionals, engage in improvised case scenarios while their colleagues observe on closed-circuit television. They then rejoin the larger group and are given the opportunity to reflect and receive feedback from colleagues, faculty facilitators, and the actors. Video playback is used to

## List 1

### Program Goals: Relational Capacities and Habits of Mind

- Sense of confidence and self-efficacy to engage in challenging conversations
- Capacity for reflective self-awareness in relation to values, thoughts, and feelings
- Validation of existing relational capacities (both recognized and unrecognized)
- Capacity to empathically “step into the shoes” of patients and family members
- Willingness to share the moral burden of decision making with patients and families
- Tolerance of imperfection, ambiguity, and vulnerability
- Appreciation of the contextual uniqueness of difficult conversations
- Integration of personal authenticity with one’s professional role
- Enhanced experience of professional integrity

Table 1

**Value Premises and Pedagogical Approach of a Daylong Workshop in Difficult Conversations in Health Care**

<b>Hidden curriculum: <i>The value premises underlying the culture of medicine suggest that . . .</i><sup>8</sup></b>	<b>Difficult conversations: <i>The value premises underlying competency in difficult conversations suggest that . . .</i></b>	<b>Implications for pedagogical design: <i>To counteract the effects of the hidden curriculum, educators must create an atmosphere in which . . .</i></b>
Doctors must be perfect.	Clinicians must be comfortable with their own imperfection and vulnerability.	There is sufficient safety and trust for learners to explore matters of personhood and professional integrity.
Outcome is more important than process.	Attention to process can be critical to the achievement of successful outcomes.	Exploration of moral and relational dimensions of difficult conversations are emphasized.
Hierarchy is necessary.	Hierarchy can hinder optimal learning across disciplinary lines and between less and more experienced clinicians.	Hierarchical structure and rules are suspended so that knowledge can be encountered on its own merits and not unduly influenced by power, authority, or level of experience.
Uncertainty and complexity are to be avoided.	Uncertainty, ambiguity, and complexity are to be expected.	The learning ethos is one of reflection, self-awareness, and tolerance for situations in which there is no single right answer.
Medicine takes priority over everything else.	Medicine finds its appropriate niche in interdisciplinary practice and optimal collaboration with patients and families.	The knowledge and insights of patients, family members, and clinicians from multiple disciplines are afforded appropriate status and authority in the learning process.

highlight particular teaching points. Brief didactic presentations, focused on the evidence base for practicing relational and communication skills and on ethical and legal considerations pertinent to the conversations being enacted, are interspersed throughout the day. Short films, developed by the Initiative for Pediatric Palliative Care,<sup>12</sup> portray the experience of children with life-threatening conditions and their families<sup>13,14</sup> and the experience of health care professionals who care for this population.<sup>15</sup> The films are used to highlight patient and family perspectives and to ground the learning process in the everyday relationships of clinical practice.

**How It Works: Teaching Example**

In every daylong workshop, the same two case scenarios, each involving a small cohort of actors who have become increasingly familiar with their roles and the improvisation process, are used as the primary focus for learning. Each scenario unfolds uniquely, because practitioners approach the conversation in their own distinctive ways, eliciting particular responses from the actors, which in turn elicits particular responses from the practitioners, and so on. In this respect, the contribution of the actors differs from programs that use predefined scripts or standardized performances. Predictable themes that are structured into the scenarios emerge consistently in the workshops, but the particular direction of learning is uniquely shaped

by each new group of learners. Characteristically, salient themes that develop early in each workshop reverberate throughout the day, as the learning connected to those themes deepens.

In the teaching example presented here, a female physician and male nurse, after reading the case scenario (Appendix 1) of a five-year old boy involved in a drowning incident, volunteer to meet with the boy’s parents shortly after their arrival in the intensive care unit (Conversation 1). Appendix 2 presents a transcript of their conversation. What follows is a description of the debriefing discussion, led by faculty facilitators, after the nurse–physician pair rejoins their fellow learners.

We initiate this dialogue with an open-ended question, such as “What was that like for you?” The question conveys a message to this nurse and physician that the ensuing conversation will be shaped by their particular experiences and learning needs, and encourages them to express “off the cuff” thoughts and emotions. Routinely, participants comment about how *real* and emotionally intense they found the conversation to be, how anxious they felt, and how relieved they are to have the experience behind them. By creating this “breathing space” and validating the emotional world of the practitioners, facilitators send a clear educational message that anxiety and vulnerability in

these conversations is normal, expected, and worthy of reflection.

The debriefing discussion focuses next on the manner in which information about Billy’s medical condition has been shared with the parents. This particular physician has been very direct and forthcoming in the way she presents Billy’s condition and prognosis to the parents, though clearly she has been compassionate at the same time. Facilitators and participants discuss the potential advantages and disadvantages of this directness. The tension in the conversation between wanting to be truthful, while at the same time supporting the hope of family members, is explored.

After these initial reflections, the actors who portrayed Mr. and Mrs. O’Brien join the discussion and are invited to offer feedback to the practitioners. They describe the directness of the physician’s approach as “a bit jarring,” but they also say they appreciated the honesty and compassion shown by both clinicians. They discuss how it might have helped if the physician had “eased into” the communication of bad news by reviewing the sequence of events from the time of the drowning incident up until the present, because they had only recently arrived at the hospital and this was their first contact with the clinical team.

Then, one of the facilitators comments on a juncture in the conversation when

she observed the nurse saying to the parents, “He’s still Billy.” These words were spoken twice, first in response to Mrs. O’Brien’s anguished question, “Can he hear us?” and then a bit later, with rather more conviction, as the nurse prepares the parents for seeing their son enveloped by the machines that are keeping him alive. The nurse responds by sharing that he was uncertain about the appropriateness of this comment and that he “started second guessing” himself. He opens himself to group feedback by revealing, “I didn’t know if that was the right thing to say or not.”

In response to his uncertainty, one of the faculty facilitators observes that, in her view, “you brought Billy right in that room—that was very powerful.” She is followed in her comments by the parent facilitator, who adds, “I thought that was a very effective comment—you gave expertise back to those parents.” Another participant agrees, reminding colleagues that in nursing report or rounds, Billy could easily be referred to as “the comatose patient in bed 12.” The actors explain that they appreciated both practitioners consistently referring to their son by name, and that the nurse’s words, “He’s still your little boy” helped them to remember that, even in this alien and intimidating intensive care setting, they still had a vitally important role to play as parents.

It is important to note that the very words that may have been most important to the parents are the same words that this nurse finds himself doubting and worrying about in terms of their *correctness*. As faculty facilitators, we have observed that when practitioners experience their own words emerging from a place of authenticity in these conversations, when they speak spontaneously without searching cognitively for what they imagine to be the “right words,” they often feel uncertain and wonder whether they have said the wrong thing.

There is an important kind of moral inquiry happening here. This nurse seems to be struggling with the paradox inherent in not knowing what to say, yet needing to say *something*. Perhaps he has decided the only morally credible things he *can* say in the face of unspeakable parental suffering must connect somehow to the affirming of parental

love. So, in response to the anguished parental plea, “Can he hear us?” he encourages the parents to “talk to Billy, just as you would earlier in the day.” Then, in a stronger voice, he reminds them, “He’s still Billy. . . . He’s still your little boy.” If his words are in some way *right*, as the consensus within this group of learners seemed to suggest, perhaps it is because they emerge from an intention to share, to the extent possible, the moral burden these parents must shoulder. By focusing on this practitioner’s effort to be morally and emotionally present in this challenging conversation, we explicitly emphasize the centrality of authenticity and professional integrity over technique or “how-to” skills. In these kinds of conversations, we have observed that it is often not the words themselves, but rather the authenticity and moral courage beneath their uttering, which seems to make the difference.

In this debriefing discussion, the personalization of the parents’ bond with their son leads to a spirited discussion about how patients and family members are, in the context of the hidden curriculum, habitually *depersonalized*. One of the faculty facilitators provides the illustrative example, from the intensive care unit where he is chief, of parents posting photographs of their child (taken outside the hospital, before the child was sick) at the bedside. He describes this as a “subversive strategy to keep clinicians engaged and remembering that this is really not just any child but a special child.” He adds frankly that this parental practice is disconcerting for him, in that “it drags me into a more emotional connection that makes it more draining to deal with.” The parent facilitator, who has been listening intently to the physician’s words, acknowledges that she herself always places a picture at the bedside every time her own daughter (who has had a chronic, life-threatening illness for many years) is admitted to the hospital, stating “I want to drag you in. I want you to know that this cranky, unresponsive person in pain has another life and has a place in the world.” The snapshot at the bedside is, indeed, a subversive strategy aimed at humanizing her child for the clinical team. “It’s not for me,” she tells the physician. “I *know* who she is.” The group laughs and nods in acknowledgement; the relational message in her comment is understood.

In the evolution of *this* debriefing discussion, the terrain of dialogue has expanded beyond an evocative conversation with two anguished parents into the complex moral and emotional geography of the health care setting in which it occurs. This cohort of learners is now engaged in exploring a rarely explored ethical–relational tension in the culture of pediatric intensive care in which, on the one hand, parents want practitioners to relate to them and to their children with compassion and authenticity and, on the other hand, practitioners wonder to what degree it is possible, or even desirable, to remain so humanly connected over the months and years of a demanding career. The tension is not resolved; rather, it is framed in the form of a closing question posed by one of the faculty facilitators: Should practitioners who must routinely engage in these kinds of high-stakes conversations demand from their professional cultures a new ethos, one that cultivates a more robust integration of personhood and moral reflection into the structures of professional education and everyday practice?

### Why It Works: Key Features of Our Pedagogical Approach

We have observed the unfolding of this type of case scenario and debriefing discussion in approximately 60 workshops, involving, as we noted above, nearly 600 health care professionals. As we reflect on our experience, five key features stand out that we believe account for the responsiveness of learners to our approach.

#### Creating safety for learning

Being willing to practice one’s interpersonal skills in a highly charged emotional context and to receive feedback from colleagues and faculty facilitators is a deeply vulnerable act. We have learned that the willingness of health care professionals to honestly explore their own feelings, doubts, and uncertainties as they approach these difficult conversations depends largely on our ability as facilitators to create a learning atmosphere that is welcoming, trustworthy, and respectful. Sadly, we have become accustomed to hearing from participants about previous professional learning experiences in which they were shamed or humiliated. Parker Palmer, a

sociologist and educator recognized by the Accrediting Council for Graduate Medical Education for his contribution to medical education, describes the normative process of academic education as one in which professionals are taught about the world as if it were a world they do not themselves inhabit.<sup>16</sup> This is especially ironic when applied to health care professionals who are committed to helping patients and family members cope with suffering and loss, because these are universal life experiences that all human beings must endure.

Our goal is to reverse this devaluation of relational knowledge and to awaken practitioners' sense of empathy toward—and solidarity with—patients and families. We have found that meeting learners at this personal–professional “learning edge”<sup>17</sup> effectively invites them to remember the motivations and aspirations that led them into their chosen professions in the first place. In this process, we hope to support these professionals in the reclaiming of “tacit knowledge”<sup>18,19</sup> and “practice wisdom,”<sup>20,21</sup> and thereby increase their moral and relational competence in everyday clinical practice.

### Emphasizing moral and relational dimensions of care

When we examine difficult conversations with pediatric patients and their families as events that evolve in real time,<sup>22</sup> the relative focus of learning shifts from content to process and relationship. We share Zoppi and Epstein's<sup>23</sup> concern that “skills-focused training is not always directed toward fostering a genuine, strong, compassionate, caring relationship between physician and patient.” Although we do spend a modest amount of time presenting the evidence base for helpful communication behaviors and providing guidance about key communication skills, the pedagogical emphasis is placed on communication as shaped by the moral terrain of difficult conversations,<sup>24</sup> wherein patients, family members, and practitioners alike are struggling to do their best in existential circumstances that might best be described as impossible.<sup>25</sup> Accordingly, the emphasis shifts from how to deliver news to the larger ethical challenge of how to support this particular patient or family in these often overwhelming life circumstances.

This connects to another salient facet of the hidden curriculum that we address directly in our program, described here by a physician-in-training:

It all goes back to that old adage, “monkey see, monkey do. . . .” The way you treat me as a student will set the tone for how I treat patients. So if you want me to take a personal interest in my patients and to treat patients as partners, the most powerful thing you can do is to treat me the same way.<sup>26</sup>

We accept as axiomatic that how practitioners relate to patients and families is directly influenced by how their teachers, supervisors, and mentors have related to them. Therefore, we take seriously the obligation to treat our “trainees” with the same compassion and respect we want them to extend to patients and families.

### Suspending hierarchy

The learning environment created in our workshops is shaped by the ground rules for relational learning established at the beginning of the day. We explain that we are coming together to learn as equals, and that hierarchical roles and relationships are “suspended” for the duration of the workshop. Our objective is to create a space for learning in which the knowledge of a social work intern in her first week of training will be valued on its merits equally alongside the knowledge of an attending physician with decades of experience. The inclusion of both novice and experienced practitioners is a particularly important pedagogical feature, because we are promoting the growth of relational capacities that the academic literature<sup>2,4</sup> suggests have been lost by many in the course of professional training. Indeed, our experience has been that beginners often offer compelling insights that may elude more senior clinicians, including the faculty facilitators. The participation of novice clinicians alongside seasoned practitioners has persuaded us to adopt a more nuanced understanding of expertise as it applies to these challenging conversations, and to appreciate the Buddhist insight that in the mind of the beginner, there are many possibilities, but in the mind of the expert, there are few.<sup>27</sup>

The suspension of hierarchical rules enables participants to explore the important question of whose knowledge matters, or should matter, in any

particular conversation. One salutary effect of this leveling process is that the burden and opportunity inherent in these challenging conversations becomes more of a shared interdisciplinary undertaking for practitioners, and the respective contributions of the various disciplines are better understood and appreciated. When the learning environment is fashioned in a manner that factors deleterious aspects of power and hierarchy out of the interactional equation, it becomes more likely that the group will benefit from whoever's knowledge—patient, family member, physician, nurse, social worker, or chaplain—is most relevant to the situation at hand. Our efforts to attend to issues of power, rank, and authority are congruent with other major change efforts in health care, including the patient safety movement<sup>28</sup> as well as calls for more sophisticated interdisciplinary collaboration<sup>9</sup> and greater transparency and democratization in health care organizations.<sup>29–32</sup>

### Valuing reflection and self-awareness

The practice of difficult conversations with patients and families is a potent reminder of the need to embrace uncertainty and complexity in the relational practice of clinical medicine. Because no two encounters are alike, and there is no single right answer in these situations, the ability to practice in contexts of uncertainty and complexity is critical. By focusing our pedagogical approach on direct practice in difficult conversations and on reflection immediately afterwards about the extent to which the encounter was meaningful or helpful, practitioners are required to examine what they are doing, to hold themselves accountable for the impact they have on patients, families, and colleagues, and to consider the deeper moral significance of their work. This emphasis on reflection and self-awareness connects to a substantial literature calling for change in these aspects of health care practice,<sup>33–35</sup> as well as ongoing documentation that many medical cultures remain averse to reform in this area.<sup>33</sup>

### Honoring multiple perspectives

In a health care culture where medicine is prioritized over everything else, a thoughtful exploration of difficult conversations offers physicians and their

interdisciplinary colleagues a unique opportunity to discover how and where to position themselves, in a moral and clinical sense, in their relationships with patients, families, and colleagues from other disciplines. Our experience, borne out consistently by the participant evaluations, is that this path of discovery depends on the thoughtful integration of multiple perspectives in the learning process. In this context, the perspective of patients and family members themselves is paramount. Perhaps the most troubling omission in the research on communicating bad news, as well as in many training programs built on this research, is that patients and family members—the persons to whom the bad news is communicated—are rarely included or even consulted.<sup>36</sup> In the patient safety movement, there is an oft-repeated axiom expressed by patients and families: “Nothing about us, without us.”<sup>28</sup> In developing the pedagogy for our program, we have taken seriously the moral challenge implicit in these words, because we believe it addresses a salient contradiction in the hidden curriculum of many medical cultures, wherein an overt endorsement of compassionate and patient-centered care is combined with an implicit culture in which patient and family knowledge is routinely devalued or ignored. When the expertise of patients and families is accorded its appropriate status in professional learning activities, a powerful message is conveyed about whom practitioners-in-training should consider their most important teachers. Such formative learning experiences can serve as a counterweight to the negative influence of the hidden curriculum.

In the design of our program, we have incorporated patient and family perspectives in several ways. First, our pedagogy is responsive to recent research documenting what matters to parents of children living with life-threatening conditions.<sup>22,37–40</sup> Second, scenarios are reviewed for accuracy and authenticity by parent advisors who have experienced the serious illness or death of a child. Third, parent advisors work closely with psychosocial and physician facilitators as core faculty for the program. Lastly, actors are chosen for their capacity to function effectively as “ethical understudies” for the patients and family members they portray. Actors are carefully selected for their roles and

mentored to provide honest, constructive feedback. Their skillful capacity to shed light, when offering feedback to learners, on the moral and relational nuances in these conversations, marks a difference from other programs using simulated or standardized patients.<sup>41</sup>

We have observed that our efforts to honor the life experience of patients and families in the learning process can have a salutary effect on a particular aspect of the hidden curriculum—how patients and families are talked about. Clinical conversations among professionals in health care settings can be prone to a certain moral and intellectual carelessness, leading to insensitive, judgmental, or overmedicalized characterizations such as “incompetent cervix,” “harvesting organs,” “pathological grief,” or “dysfunctional parents.” By encouraging learners to attend to their language, and by ensuring that patients and family members are physically present and involved in the learning itself, we hope to have a positive impact on this “ethic of representation,”<sup>42</sup> thereby increasing the potential for authentic patient-centered and family-centered care.

## Conclusion

Our knowledge as educators has deepened immensely as a result of our immersion in this project for the past several years. Experience has taught us that it is indeed possible, in the busiest of hospital environments, to fashion learning experiences that promote moral reflection and reconnection with one’s humanness, and that participation in this kind of relational learning can be transformative, both personally and professionally. We have learned from workshop participants, as evidenced in the comments that open this article, that becoming morally and relationally competent in these difficult conversations includes such skills and habits as leaving one’s badge at the door, learning to be genuine and real, inviting colleagues from other disciplines into the conversation, and better attending to the emotional side of caring for patients and families. The strength of our educational approach, developed initially to explore end-of-life conversations in the pediatric context, has led to its expanded application to a range of high-stakes conversations in pediatric as well as adult

medicine, including discussion of organ donation, disclosure of medical error, and assisting family members during the invasive medical procedures of loved ones.

William Carlos Williams,<sup>43</sup> the renowned American poet and family physician who found congruence throughout his career in the simultaneous practice of poetry and medicine, wrote:

It is difficult  
to get the news from poems  
yet men die miserably every day  
for lack  
of what is found there.

Dr. Williams’ insight applies to the challenges we have faced in constructing a pedagogy for exploring difficult conversations, and in articulating the substance of this pedagogy to others. In a medical world that places a premium on checklists, algorithms, and standardized interventions, it can be difficult for medical educators to know how to honor and elucidate the moral “news” inherent in the complex, actual conversations that unfold on a daily basis among practitioners, patients, and family members. It can be pedagogically challenging indeed to craft learning experiences aimed at excavating the hidden curriculum and unearthing the unique, irreducible, and poetic nature of these conversations. We are convinced we will miss the mark, however, and surrender a piece of our *own* humanity, every day we fail to do so.

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## Appendix 1

**Case Scenario: Billy O'Brien.** From a daylong workshop in difficult conversations in health care, using relational learning

Billy is a five-year old boy from an Irish American family. He arrives by helicopter from a nearby community hospital. He was playing on the beach with his family when he disappeared. Mr. O'Brien had been in the water with Billy, and went back to his blanket for a flotation device. After a 5- to 10-minute search, Billy was found submerged in shallow water, initially pulseless. CPR was performed at the scene by his mother; he was transported by EMS to the nearest hospital. On arrival he was unresponsive with GCS of 3 but with normal sinus rhythm, hemodynamically stable, on moderate ventilator settings. CT of head was normal, C-spine films normal, cervical collar in place.

Exam on arrival: pupils 4 mm bilaterally and poorly responsive, no spontaneous movements, no response to deep pain. Blood work sent and pending.

### Conversation 1 (Sunday morning)

The parents (Bill Senior and Lisa) have just arrived by car and are in the waiting room. The physician and nurse go to meet them. On the basis of the presentation, the clinicians know that the most likely outcome is death. If the child survives, he will probably be in a persistent vegetative state, or pvs (i.e., permanent unconsciousness). There is a small chance that he may regain some features of consciousness, but almost certainly he will never regain relational capacity.

### Conversation 2 (Monday afternoon, eight days after accident)

Billy's parents have been at his bedside since Sunday. Billy received standard medical management for increased ICP and had remained hemodynamically stable, on moderate ventilatory settings, with no spontaneous respiratory effort. CT showed diffuse cerebral edema. Neuro exam otherwise unchanged, without any detectable neurological function.

An examination for brain death was performed on Wednesday morning after rounds, but during the apnea test Billy started to make some respiratory efforts, so he was placed back on the ventilator.

The results of the test were explained to the family. Billy is not brain dead at this point, but other than this respiratory effort, he has no evidence of neurological function. His prognosis continues to be dismal, most likely either death or pvs. The chances for a better outcome are extremely slim.

Billy still shows no spontaneous motor activity, and he shows posturing in response to deep pain. When attempts are made to wean the ventilator, he makes occasional respiratory efforts, but he is still definitely ventilator dependent. If the ventilator were withdrawn at this time, Billy would likely die within minutes to hours (although one can never be sure). Otherwise, he will require a tracheostomy and g-tube with transfer to a rehabilitation hospital or nursing home. He may eventually wean from the ventilator, but is likely to remain in a vegetative or near-vegetative state.

The physician and nurse meet with the family to discuss options. Legally and ethically acceptable options cover a wide range. At one end of the spectrum, the family could opt to do everything possible to keep Billy alive, including tracheostomy, g-tube, and chronic ventilation. At the other end of the spectrum, the family could opt for comfort care only. This would involve removing the ventilator and providing only those treatments that contribute to patient comfort, including the administration of sedation and analgesia, titrated to any signs of pain or suffering. As noted above, this would probably (but not definitely) lead to Billy's death in a matter of minutes to hours.

Although these decisions do not need to be made emergently, this point represents an important "fork in the road," and the clinicians need to guide the family in choosing the path that is most consistent with their beliefs and values.

The physician and nurse stop by the bedside.

### Conversation 3 (Next day)

This is a continuation and completion of the conversation from the previous day.

## Appendix 2

**Transcript of Conversation 1 between Clinicians and Parents: Billy O'Brien Scenario.** From a daylong workshop in difficult conversations in health care, using relational learning

*Physician:* We've been taking care of Billy since he got here from your community hospital. He's in one of our resuscitation rooms and his condition is stable, but it's quite serious. His heart is beating on its own . . . but he is not responding to us. He is essentially in a coma. He is not responding. So we don't know—right now, I don't have a crystal ball, but this is a very serious situation, and. . .

*Father:* When you say *coma*, that means he could wake up at some point, or are you saying he's never going to wake up?

*Physician:* I don't know the answer to that for certain. Right now the indications are that . . . the near-drowning incident has caused significant damage to his brain, and there is a very, very real possibility that he may not wake up.

*Mother (crying):* Oh, God. . . .

*Physician:* I know this is the worst thing that you can hear right now. We'll talk for a few moments and then we'll take you in to be with him.

*Mother (imploring):* What can you do for him? How can we help him? His heart is beating, he's alive. What can we do? We'll do anything. I don't care. Anything we can do to help or try or—

*Physician:* I think that what we can do for you and for him right now is to have you be with him. We are supporting every part of him we can, but his brain is something that he has to heal or not heal on his own. There is no direct therapy.

*Father:* Is he thinking? Is he breathing, or what?

*Nurse:* Right now, we have him hooked up to a machine that is doing the breathing for him. Whether or not he'll be able to breathe on his own, we'll have to wait some time.

*Mother:* How long do you think it will take before we know a little more about what's going to happen?

*Physician:* I think the first 24 hours are the most critical period. And if there's no significant change, at that point the likelihood of improvement will be very, very small.

(Appendix continues)

## Appendix 2, continued

*Father* (crying): Oh, God, this is my fault. I swear I thought he was only in there for a minute.

*Nurse*: Try not to blame yourself.

*Physician*: Accidents happen. They just happen.

*Mother*: Can we stay with him overnight?

*Nurse*: You can stay with him the whole time.

*Mother*: Can he hear us?

*Nurse*: He might be able to hear you—he will not be able to express to you that he hears you. But I would encourage you to talk to Billy just as you would earlier in the day or as you always have talked to him. He's still Billy . . . he's still your little boy.

*Mother*: I just don't understand what's happened. . . . How could this happen . . . why did this happen?

*Physician*: I don't think any of us can understand that.

*Father*: Is this kind of thing common?

*Physician*: Unfortunately, it is not an uncommon occurrence for us.

*Father*: You're saying he's brain dead. He's just breathing or what. What's wrong with him exactly? His heart isn't working? His brain isn't working?

*Physician*: His heart is working on its own. His brain is not working normally. There is a possibility that he is brain dead. I don't know that now. That's something that will become clear over the next 24 to 48 hours.

*Father*: I assume brain dead means there's no recovery from that.

*Physician*: That is what that means.

*Nurse*: I want to prepare you for what you'll see when you go back to see Billy. We have him on a ventilator machine that's doing the breathing for him. So, he has a tube in his mouth that goes into his lungs, and you'll see that. He also has a couple of IVs in place to give him some medication, some fluid. His skin is probably going to look a little paler to you—he probably won't have the same kind of skin tone that you're used to seeing. But he's still Billy. He's your little boy . . . it might be disconcerting at first.

*Mother*: We can just hope for a miracle. I don't know what else.

*Father*: Doesn't that happen—I've seen things on TV where somebody wakes up out of a coma and they're fine again. Can that happen? Does that ever happen?

*Physician*: Things do happen that we don't expect or predict. That does exist.

*Father*: I came back to the water and I saw him face down and I thought he was playing. He does that at home in the little pool—he sometimes pretends to be drowning.

*Physician*: This is a tragic accident, and tragic accidents happen in the blink of an eye.

*Father*: Could we just have a minute and then go in?

*Physician*: Take as long as you need. . . . We'll be right here when you're ready.

## Sharing stories: narrative medicine in an evidence-based world

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Our lives are made up of stories. Stories have a direction and draw the reader into the mystery of what will happen next. Some of our earliest memories are of stories told to us at the end of the day by parents and loved ones. The practice of medicine is lived in stories: “I was well until . . .” “It all started when I was doing . . .” are common openings of the medical encounter.

But stories do more than facilitate conversation. Narrative probes the depths of medical experience [1], and allows for greater understanding of our patients [2], our work, and ourselves [3]. Stories, for the writer, and often for the reader, can be the work of meaning, and even creation [4–7]. This allows for great possibilities. “To do its work, writing creates and recreates the past in the present moment. It reaches into the shadows and pulls what cannot be seen or spoken onto the page where it is open to discussion and revision . . . . As writers write to represent, to understand, to integrate experience, they are free to try out alternatives, to see both experience and themselves as they are, as they were, as they might be [8]”. In this way, writing and narrative can be seen as an act of being, paying attention and capturing details of the present moment. Writing narrative is, simultaneously, an act of observing, of becoming, of predicting, and of making choices about how one might act differently or re-write the story, our part or that of others.

Yet stories have an uncertain place in the world of medicine. There is an increasing push toward evidence-based thinking. The anecdote is disparaged as “soft” in contrast with “hard” clinical data. But as details of disease are pursued, there are details of a life that may be left behind [9]. The language of biomedical disease conflicts with the details of patient illness [10,11]. More recently there have been calls for moving beyond “taking” a history from the

patient [12], for the integration of evidence-based medicine and patient-centered care [13,14]. But even patient-centered care is coming to be promoted as a science, and the risk continues of losing the story at the center of the encounter; the patients’, the providers’, the shared narrative that gives context or meaning to the illness for the patient and to the work for the provider [15].

Narrative, or the writing and telling of our story, when we look at it closely, has tangible health and behavioral benefits. The extensive work of Pennebaker and his colleagues demonstrates multiple physical and psychological benefits among varied populations dealing with significant transitions or stress [16–20]. Writing about prior trauma was shown to boost immune response to Hepatitis B vaccination among a sub-group of New Zealand medical students [21]. A recent report demonstrated clinical improvement in lung function (increased PEV1) in patients with asthma, and a reduction in disease activity (measured by disease severity score) in patients with rheumatoid arthritis who wrote about stressful experiences when compared to matched controls who wrote about neutral topics [22]. Writing, demonstrates benefits beyond the medical setting. Maximum security prisoners, crime victims, first time mothers, new college students and engineers who have lost their jobs have all benefited from writing [18–20].

Narrative fits into a broader framework, specifically as one method of reflection. Reflection includes “consideration of the larger context, the meaning, and the implications of an experience or action [23]” and allows the practitioner to integrate and re-work concepts, skills and values into their cognitive framework or understanding. Learning is a cycle of action and reflection [24]. The ability to reflect has emerged as an important physician characteristic for professional development and for learning in the clinical setting [25,26]. Reflective skills are associated with the ability to develop insight into self and learning needs, to direct one’s learning, and ultimately to ensure

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that the physician can practice well autonomously. Reflection allows physicians to become aware of the factors that influence their reactions to and ability to work with patients [27]. Without the opportunity to reflect and become self-aware, attitudes and feelings may go unrecognized, and physician–patient communication may be adversely affected. Unrecognized attitudes and feelings may interfere with the physician’s ability to experience and convey empathy [28]; meaningful discussions with patients about difficult topics (bad news, dying and others); engagement with certain patients [29]; and the physician’s ability to gather the information necessary to make an accurate diagnosis and to reach agreement with the patient about a treatment plan.

All of these concepts—reflection, narrative writing and collaborative care—are currently written about under the rubric of narrative medicine. The aim of narrative medicine is to develop the skills of fostering empathy, reflection, professionalism, and trust [30]. We need to make more progress toward defining a set of skills associated with narrative competence. For now, interest in hearing the patient’s story offers an opportunity to bridge cultures, allay patient fears and concerns, hear patient explanatory models, share uncertainty, and aid in adaptation to chronic illness [9]. These allow for physicians to serve as witness, as healer, or even as co-author of a joint patient–provider encounter [15,31]. *Patient Education and Counseling* seeks to give voice to such narratives to help represent valued viewpoints from the daily work of patients and their providers that may only partially be represented in other reports in the journal.

### Instructions for authors/call for papers

*Reflective Practice* is a new section that will appear periodically in *PEC* to provide a voice for physicians and other healthcare providers, patients and their family members, trainees and medical educators. The title emphasizes the importance of reflection in our learning and how our patient and self-care can be improved through regular practice, similar to other health provider skills. We welcome personal narratives from clinicians of all types on their perspective on caring, patients’ perspectives, the patient–provider relationships, humanism in healthcare, professionalism and its challenges, and collaboration in patient care and counseling. Most narratives will describe personal or professional experiences that provide a lesson applicable to caring, humanism, and relationship in health care.

Manuscripts should be 1200 words or less and follow the instructions in the *PEC* Guide for Authors. We welcome unsolicited manuscripts. No abstract is needed. Submit manuscripts through the *Patient Education and Counseling* online, electronic submission system at <http://ees.elsevier.com/pec>. In your cover letter, please indicate that your manuscript is for the *Reflective Practice* section.

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# Difficult conversations: Improving communication skills and relational abilities in health care\*

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**Background:** Communication skills and relational abilities are essential core competencies that are associated with improved health outcomes, better patient adherence, fewer malpractice claims, and enhanced satisfaction with care. Yet, corresponding educational opportunities are sorely underrepresented and undervalued.

**Objective:** To evaluate the impact of an interdisciplinary experiential learning paradigm to improve communication skills and relational abilities of pediatric critical care practitioners.

**Design:** Prepost design, including baseline, immediate follow-up, and 5-month self-report questionnaires.

**Setting:** Tertiary care pediatric hospital, Children's Hospital Boston.

**Participants:** One hundred six interdisciplinary clinicians with a range of experience levels and clinical specialties.

**Measurements:** Participants rated their sense of preparation, communication and relational skills, confidence, and anxiety. Open-ended questions asked participants about lessons learned, aspects of the training they found most helpful, and suggestions to improve the training.

**Main Results:** When questions were posed in a yes/no format, participants were nearly unanimous (93% to 98%) that the training had improved their sense of preparation, communication

skills, and confidence immediately after and 5 months posttraining. Ninety percent of participants reported improvements in establishing relationships immediately after the training and 84% reported improvements 5 months posttraining. Eighty-two percent reported reduced anxiety immediately after training and 74% experienced reduced anxiety 5 months posttraining. On Likert items, 70% estimated their preparation had improved; 40% to 70% reported improvements in communication skills, confidence and anxiety, and 15% in relationship skills. Four qualitative themes emerged: identifying one's existing competence; integrating new communication skills and relational abilities; appreciating interdisciplinary collaboration; and valuing the learning itself.

**Conclusions:** A 1-day experiential learning paradigm focused on communication skills and relational abilities was highly valued, clinically useful, and logistically feasible. Participants reported better preparation, improved communication and relational skills, greater confidence, and reduced anxiety. Participants deepened their understanding of family perspectives, recognized valuable existing competencies, and strengthened their commitment to interdisciplinary teamwork. (*Pediatr Crit Care Med* 2009; 10:352-359)

**KEY WORDS:** critical care; communication skills; relational abilities; difficult conversations

Conveying troubling news and engaging in difficult conversations with patients and their families are pivotally important, although anxiety-provoking compo-

nents of clinical practice (1-3). Clinicians who otherwise feel prepared and competent in their clinical duties may lack confidence and describe themselves as ill prepared for difficult interpersonal interactions (4-6). They may fear they will not be able to find the "right words" or will say too much, too little, or the wrong thing altogether. Further, clinicians worry that imparting difficult news may diminish hope, compound a family's suffering, or unleash emotional responses they feel unprepared to handle (1, 2, 7). Because of the complexities and challenges inherent in these difficult conversations, it is not uncommon for clinicians to delay, avoid, or delegate this vital area of clinical practice (8).

Patients and family members highly value effective communication and empathic relationships with their healthcare providers, and often base their perceptions of the quality of care on such indi-

ces (9-14). Poor communication is a commonly cited reason for compromised clinical care and coordination, diminished trust, and degraded overall satisfaction with care (15-17). For patients and family members facing life-threatening illness, communication can provide important information, promote better understanding, improve treatment adherence, and assist with challenging treatment decisions (5, 18, 19). Clearly, these discussions serve critical purposes in transferring information and developing optimal treatment plans, but beyond their practical functions lie vital emotional, relational, and human aspects of these conversations (10, 13, 20, 21). For patients to feel they have been understood and well cared for, it is recognized that clinicians must attend to healthcare conversations on a deeper, more relational level (4, 13, 19, 20, 22, 23). Generally, family members value and prefer cli-

**\*See also p. 414.**

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In general, how prepared do you (now) consider yourself to be to have difficult discussions with patients and their families?
In general, how would you (now) assess your own communication skills in having difficult discussions with patients and their families?
In general, how would you (now) assess your own ability to develop and maintain relationships with patients and their families?
In general, how confident are you (now) when having difficult discussions with patients and their families?
Do you (now) find yourself anxious regarding having difficult discussions with patients and their families?

Figure 1. Likert scale self-assessment items included in the baseline, immediate follow-up, and 5-month follow-up questionnaires. Five-point Likert scale was employed (1 = poor/not at all, 2 = minimal/a little, 3 = fair/somewhat, 4 = good/quite, 5 = very good/very). The immediate and 5-month follow-up questionnaires included the word *now* in the item.

Table 1. Socio-demographic characteristics of immediate follow-up participants

Characteristic	Doctors	Nurses	Other	Total
<b>Years of experience</b>				
0–1	0%	2%	12%	3 (3%)
2–5	67%	27%	35%	46 (44%)
6–15	26%	43%	35%	37 (35%)
16+	7%	27%	18%	19 (18%)
N	42	44	17	105
<b>Age</b>				
Mean (SD)	33 (5.3)	34 (9.7)	38 (11.5)	35 (8.6)
<b>Gender</b>				
Female	57%	86%	88%	74 (74%)
N	42	42	16	100
<b>Ethnicity</b>				
White	68%	91%	94%	83 (82%)
N	40	44	17	101
<b>Previous learning opportunities</b>				
Yes	81%	76%	71%	80 (75%)
N	42	45	17	106
<b>Observed difficult conversations</b>				
None	0%	5%	13%	4 (4%)
1–10	36%	32%	40%	35 (35%)
11–24	29%	20%	27%	24 (24%)
25+	36%	44%	20%	37 (37%)
N	42	41	15	100
<b>Led difficult conversations</b>				
None	10%	17%	33%	16 (16%)
1–10	60%	48%	47%	54 (53%)
11–24	16%	10%	13%	13 (13%)
25+	14%	26%	7%	18 (18%)
N	42	42	15	101
<b>Mentor/role model</b>				
Yes	50%	42%	63%	49 (49%)
N	42	43	16	101

nicians who reveal their own humanity and share their genuine emotions (4, 9, 10, 20). Indeed, these conversations and how patients and family members perceive they have been treated heavily influence satisfaction with care and are often long remembered (5, 9, 21, 22).

Educational opportunities and resources devoted to communication skills and relational abilities are sorely underrepresented and undervalued compared with others supporting technical skill acquisition. The purpose of this study was to evaluate the impact of an experiential learning paradigm to address these issues through the innovative integration of the perspectives of patients, family members and healthcare providers. The paradigm incorporates realistic enactments with professional

actors to improve communication skills and relational abilities. The paradigm is broadly applicable and has been adapted for conversations with pediatric and adult populations associated with end-of-life care, organ donation, family presence during invasive procedures and resuscitation, presurgical consults, and adverse medical outcomes.

## MATERIALS AND METHODS

*Design.* A prepost study design was used to evaluate the impact of the paradigm to improve healthcare providers' communication and relational skills during difficult healthcare conversations. The authors chose difficult conversations that arise in pediatric critical care as an example of particularly challenging conversations in which to evaluate the program. Participants completed baseline, immediate

follow-up, and 5-month follow-up self-report questionnaires to evaluate their preparation for difficult conversations, communication and relationship skills, confidence, and degree of anxiety. Open-ended qualitative questions inquired about lessons learned and reflections on the learning, what was most and least helpful about the program, and suggestions to improve training.

*Participants.* During 2004, participants included physicians, nurses, social workers, psychologists, and chaplains from Children's Hospital Boston who had a range of experience levels and clinical specialties, including pediatric and neonatal intensive care, oncology, cardiology, pulmonology, neurology, emergency medicine, anesthesiology, palliative care, and general pediatrics. Participants were recruited through e-mail invitations sent to unit and service medical directors, training and department directors, and nurse managers. Fliers were also posted on bulletin boards displaying educational opportunities. A Website ([www.ipepweb.org](http://www.ipepweb.org)) provided information about the program and offered on-line registration. Some participants were referred through word-of-mouth referral from previous participants.

*Intervention.* The Program to Enhance Relational and Communication Skills (PERCS) is an educational effort of the Institute for Professionalism and Ethical Practice, and is organized from the perspective of relational learning (14, 24). Relational learning is built on the premise that the learning that matters most deeply in the professional development of healthcare practitioners occurs in the context of relationships among clinicians, patients, and family members. There are five key features of our pedagogical approach: creating a safe and trustworthy learning environment; emphasizing ethical and relational dimensions of care; suspending hierarchy among participants; valuing reflection and self-awareness; and honoring multiple perspectives (24). Although the paradigm offers a variety of practical communication skills and relational strategies, we explicitly emphasized the centrality of personhood, authenticity, and professional integrity.

Before the training, participants received the day-long agenda (Appendix A) and guidelines for group discussions and debriefing. The program had the character of a "mini-retreat" whereby participants were expected to attend for the entire day and be relieved from their typical clinical and administrative duties. Continental breakfast and lunch were provided to set a tone of well-being and to nurture community. A typical training session included 10–15 interdisciplinary participants, and three faculty facilitators representing medical, psychosocial, and patient/family perspectives. Faculty facilitators cultivated an atmosphere of acceptance, humility, and curiosity that encouraged participants to feel comfortable and to reflect on their own clinical practice (24).

Table 2. Participation in 5-month follow-up

Characteristic	% of Immediate Follow-up Also Returning 5-Month Follow-up	N
Total	54%	106
Discipline		
Physician	55%	42
Nurse	49%	45
Psychosocial	65%	17
Years of experience		
0–5	47%	49
6–15	65%	37
16+	53%	19
Age		
21–30	47%	38
31–45	62%	48
46+	40%	15
Gender		
Men	62%	26
Women	53%	74
Ethnicity		
Non-white	61%	18
White	52%	83
Previous learning opportunities		
No	35% <sup>a</sup>	26
Yes	60%	80
Observed difficult conversations		
0–10	41% <sup>a</sup>	39
11–24	58%	24
25+	68%	37
Led difficult conversations		
0–10	51% <sup>a</sup>	70
11–24	54%	13
25+	72%	18
Mentor/role model		
No	56%	52
Yes	53%	49

<sup>a</sup>*p* < 0.05 on chi-square test of independence.

Early in the program, participants shared communication strategies and approaches they had found helpful in their clinical practice. This exercise highlighted the clinical experience and skill already present among participants and from which they were encouraged to draw. The curriculum incorporated brief didactic presentations summarizing established approaches for sharing difficult news with families (25, 26) and the evidence base for improving communication and relational skills (19, 27–30). Basic knowledge was presented regarding the ethical and legal guidelines for withdrawal of life-sustaining therapy (24, 31, 32). Participants also viewed educational videotapes (33–35) to enliven and emphasize the centrality of patient and family perspectives.

At the center of the program were two pediatric critical care case scenarios enacted with professional actors that unfolded clinically over several conversations with the “patient” and/or “family,” followed by debriefing and videotape review. The cases included 5-year-old Billy O’Brien who was the victim of a near-drowning incident (24) and 17-year-old Sandy Richards with relapsed acute myelogenous leukemia (Appendix B). Professional actors portrayed the parents in the O’Brien case, and the parents, grandmother, and adolescent

patient in the Richards case. Participants had the opportunity to engage in realistically enacted conversations, to review video clips and receive feedback, to observe others, and to participate in experiential collaborative learning with interdisciplinary colleagues (24, 36).

**Evaluation.** Both quantitative and qualitative methods were used to assess the impact of the educational effort on the participants’ communication and relational skills. All participants were asked to complete questionnaires before and immediately after the training. Five-month follow-up questionnaires were conducted by e-mail and standard mail. An identification number assigned to each respondent facilitated linkage of participant responses over the study time frame.

The baseline questionnaire included questions about the participant’s discipline, years of professional experience, previous training, and sociodemographic characteristics, such as age, gender, and race/ethnicity. In addition, each questionnaire included items about the number of times the respondent had observed or led difficult conversations. On all three questionnaires, participants were asked to assess, on five-point Likert scales, their preparation, communication skills, ability to establish and maintain relationships, confidence, and degree of anxiety about having difficult health-

care conversations (Fig. 1). The immediate and 5-month follow-up questionnaires also asked (in yes/no format) whether the program had improved the participants’ sense of preparation, communication skills, relational capacities, and confidence, or reduced the degree of anxiety when engaging in difficult conversations with patients and families. Several open-ended, qualitative questions were also included on the follow-up questionnaires regarding lessons learned and reflections on the learning, the most and least helpful aspects of the program, and suggestions to improve the training.

**Data Analysis.** Statistical analyses were completed in SAS v8.2 (SAS Institute, Cary, NC). Chi-square tests of independence and one-way analysis of variance were used to assess differences by discipline for categorical and continuous measures, respectively. Statistical significance was set at *p* < 0.05 for all comparisons.

The participants’ written responses to the open-ended questions were typed into an ACCESS database. Content analysis was conducted through a process of reading and marking key words and phrases to identify topics and issues of importance to participants (37–39). First author (E.C.M.) generated a list of themes identifying topics and issues of importance to participants based on initial reading and review of the responses. Coauthor (K.M.) then coded each of the open-ended responses according to the list of themes. Agreement about thematic content and labeling for the themes was reached through a process of discussion and successive refinement of language by senior authors (E.C.M. and D.M.B.).

**Research Ethics.** The study was reviewed by the Institutional Review Board of Children’s Hospital Boston, when determined the study met exemption criteria #1 under the Health and Human Services regulations 45 Code of Federal Regulations 46 (i.e., research conducted in established educational settings involving normal educational practices). Each participant was asked to sign a voluntary consent form granting permission to be videotaped during enacted case scenarios and for completed evaluation questionnaires to be used for educational and research purposes.

## RESULTS

One hundred ten individuals participated in PERCS training sessions. Of those, 106 (96%) completed both baseline and immediate follow-up questionnaires. Table 1 summarizes the demographic characteristics of these 106 participants. Approximately 41% of trainees were physicians, 43% were nurses, and 16% were psychosocial clinicians, including social workers, psychologists, and chaplains. Three participants did not indicate their discipline. Nurses and psy-

Table 3. Perceived impact of the program

Question	% Yes	
	Immediate Follow-up (n = 106)	5-Month Follow-up (n = 57)
Has the training program improved your sense of preparation to engage in difficult discussions with patients and their families?	98	93
Has the training program improved your communication skills to engage in difficult discussions with patients and their families?	98	98
Has the training program improved your ability to develop and maintain relationships with patients and their families?	90	83
Has the training program improved your sense of confidence when engaging in difficult discussions with patients and their families?	95	93
Has the training program reduced your sense of anxiety when engaging in difficult discussions with patients and their families?	82	74

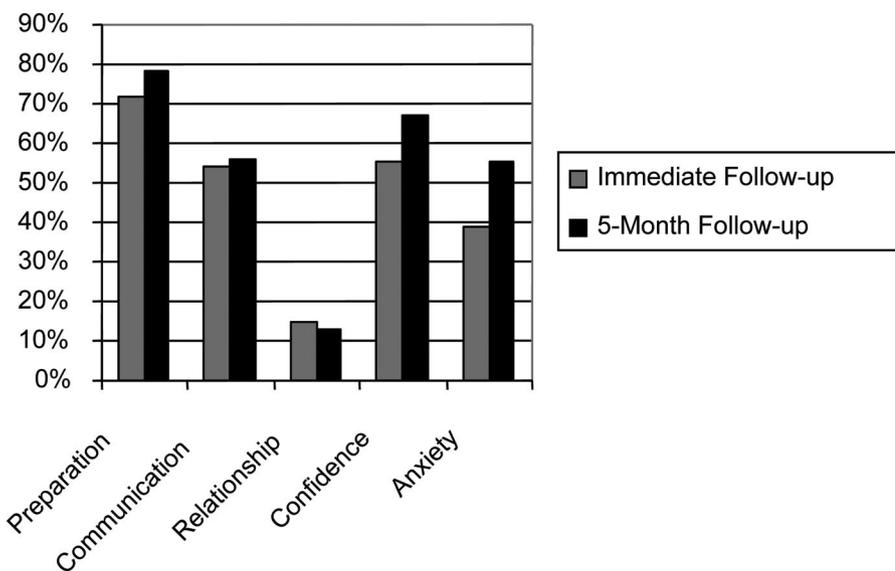


Figure 2. Percentage of participants' self-reported improvement from baseline to immediate and 5-month follow-up. Improvement was operationally defined as a change of one or more descriptive categories on the five-point Likert items (e.g., rating improved from 3 = fair to 4 = good).

chosocial clinicians were more likely than physicians to be women, white, and to have 6 or more years of experience. Physicians and nurses were more likely than psychosocial clinicians to have observed or led 11 or more difficult conversations in the past year.

As indicated in Table 2, 57 of the 106 (54%) who had completed both the baseline and the immediate follow-up questionnaires returned 5-month questionnaires. There were no significant differences in the rate of participation in the 5-month questionnaire by discipline, years of experience, gender, ethnicity, or presence of a mentor. However, participants with previous learning opportunities and more experience ob-

serving or leading difficult conversations were more likely to return the 5-month questionnaire.

When questions were posed in a yes/no format, participants were nearly unanimous (93% to 98%) in indicating that the training had improved their sense of preparation, communication skills, and confidence when having difficult conversations (Table 3). With respect to improving their ability to develop and maintain relationships with patients and their families, 90% and 83% of participants responded affirmatively on the immediate and 5-month follow-up, respectively. The training had a smaller impact on reducing anxiety, with 82% and 74%

indicating so at the immediate and 5-month follow-up, respectively.

Figure 2 depicts data derived from Likert items and indicates the percentage of participants whose self-assessment was improved; that is, their degree of perceived preparation, communication skills, ability to develop and maintain relationships, and confidence was higher and their degree of anxiety was lower in the immediate or 5-month follow-up questionnaire than at baseline. There were no differences by discipline for any of the areas of self-reported improvement. Improvement was operationally defined as a change of one or more descriptive categories on the five-point Likert items (e.g., rating improved from 3 = fair to 4 = good). The self-appraisal of preparation was the most likely to increase with about 70% of participants reporting a higher level after the training. The areas of communication, confidence, and anxiety showed moderate levels of improvement, with overall percentages ranging from about 40% to 70%. Some participants reported no change or even greater anxiety after the training, perhaps reflecting greater appreciation for the complexity and importance of challenging discussions. Participants were least likely to cite an increase in their ability to establish and maintain relationships, with about 15% reporting improvement by the criterion we had established.

The training was well received, popular, and viewed as useful and worthwhile (Table 4). Participants were unanimous (99% to 100%) in recommending the program to other colleagues. Similarly, more than 90% of participants rated the learning as quite useful or very useful, and the quality of the training as very good or excellent (4 or 5 on five-point Likert scales). There were no differences by discipline in the ratings of the program's usefulness or quality. As a testament to its worth and utility, participants suggested that the training be incorporated into orientation sessions, annual review criteria, and the promotion process. Some recommended that the case scenarios be "customized" for various clinical settings to further enhance the learning, and that regular "booster sessions and practice" be made available. Comments such as, "One can only get better at it...everybody should attend this" suggest the value of the program for new and seasoned clinicians alike.

**Qualitative Findings.** Four themes emerged in participants' responses to the

Table 4. Participant rating of the program

	% of Total N	
	Immediate Follow-up	5-Month Follow-up
Overall, how useful did you find the training program?		
Not at all	0	0
A little	2	2
Somewhat	6	7
Quite	42	43
Very	51	48
Total N	105	56
Overall, how would you rate the quality of the program?		
Poor	0	0
Fair	0	0
Good	4	5
Very good	38	42
Excellent	58	53
Total N	105	55
Would you recommend the program to others in your position?		
Yes	99	100
Total N	101	57

qualitative questions: identifying one's existing competence; integrating new communication skills and relational capacities; appreciating interdisciplinary collaboration; and valuing the learning itself (Table 5). The following participant quotations illustrate the qualitative themes.

*Identifying One's Existing Competence.* Many clinicians recognized that they had communication talents and relational abilities that were relevant and trustworthy during difficult conversations, but had never before been professionally validated or encouraged. In many cases, these same participants expressed a sense of relief and a greater willingness to rely more confidently on their inherent communication and relational abilities.

"I found that I could be direct and honest with families. I am usually so uncomfortable that I tend to skirt hard questions."

"My overall confidence in my abilities to be with families and their concerns has increased ten-fold. I am no longer hesitant to meet with families based on my own insecurities as a clinician. [The training] instilled a confidence in me that has been expressed in my everyday work and highlighted in my work with families with difficult decisions to make or news to hear."

*Integrating New Communication Skills and Relational Capacities.* Participants reported learning a valuable repertoire of generalizable communication skills, such as making introductions, remembering to use the patient's name, beginning conversations with the family's concerns, using understandable language, sitting rather than standing, lis-

tening attentively, and recognizing the value of silence.

"Work with the concerns of the patient and family. Use that as the starting point."

"Remember to always use the patient's name."

"Offer information in an easily understood manner without too much medical jargon."

Participants also reported greater insight about broader relational capacities they might bring to bear to enhance and deepen their relationships with patients and families.

"Allow for quiet or difficult moments for parents to express their emotions. Do not feel as if you have to have all the answers, but rather convey care and the information you do have... let the patient know that their feelings are okay and that they are not alone with them and do not feel you have to fix it."

"The power of undivided attention and listening! Step out of your own perceptions of situations/family meetings and put yourself in the others' shoes."

*Appreciating Interdisciplinary Collaboration.* Many participants reported that they learned a great deal about the roles of other disciplines by observing the enacted conversations. It was not uncommon to hear comments such as, "I'm never going to talk with a family in a tough situation without a nurse again" or "I never knew that's what chaplains did." Some reported greater clarity about their own role and responsibility to contribute their disciplinary perspective to conversations with families, with emphasis on improv-

ing teamwork, healthy reliance on others, and shared responsibility for communication and emotional care of the family. One participant wrote that she got "more vociferous" in her role as advocate for families and another noted he would no longer "be afraid to speak up" in future family meetings. Such insights suggest an enhanced understanding, respect, and potential for partnership among team members.

"Give space for all team members. Always listen more than you talk."

"Make sure to let other team members know that they need to cover (your) clinical responsibilities while (you) are having the discussion so there are no interruptions."

*Valuing the Learning Itself.* The program afforded a rare opportunity for busy practitioners to reflect on their communication strengths and areas in need of improvement in the company of others who understood the healthcare culture. Participants emphasized the value of having the opportunity and time to devote to learning in a practice setting where no patient or family would be harmed or inconvenienced, and where, as learners, they would not be shamed or humiliated.

"Just having the opportunity to practice this type of conversation was invaluable. We have so few opportunities to do that, and when we do, it is usually in an actual crisis situation."

"In all my years of learning, I cannot remember a single experience that has made such an impact and provided such a growth experience that will definitely affect my practice in a positive way...I cannot wait to get this up and running..."

## DISCUSSION

Our data demonstrated that a 1-day interdisciplinary experiential learning paradigm focused on communication and relational learning had sustained educational and clinical merit, and was logistically feasible. The training was most effective in improving the participants' sense of preparation to hold difficult conversations. Clinicians reported they learned a variety of communication skills, broadened their relational capacities, and grew in clinical confidence. Most participants reported a reduction in their sense of anxiety, although some experienced heightened anxiety perhaps because of a greater appreciation of the complexity of difficult conversations. The combination of newly acquired skills and greater trust in and access to existing

Table 5. Qualitative themes

Theme	Illustrative Quotation
Identifying one's existing competence	"I realized that my communication skills and ability to talk with families are not as terrible as I had originally thought. Hearing and seeing scenarios worked out with/by others made me realize that I might have said/felt the same in the situation"
Integrating new communication skills and relational capacities	"I hope I can help families through interactions of this type with a little more grace, more comfort with silence, and more solid support"
Appreciating interdisciplinary collaboration	"Give space for all team members. Always listen more than you talk"
Valuing the learning itself	"Just having the opportunity to practice this type of conversation was invaluable. We have so few opportunities to do that, and when we do, it is usually in an actual crisis situation"

relational abilities was described as empowering by participants, and buoyed their sense of confidence when approaching difficult conversations. Participants reported valuing learning about challenging conversations, deepening their understanding of patient and family perspectives, recognizing valuable existing relational competencies, and strengthening of their appreciation and commitment to interdisciplinary teamwork.

Participants reported learning communication and relational skills that have been highlighted in models of healthcare communication (40), approaches for breaking bad news (25, 26), and by families themselves (9–13, 15–17, 19, 29). To provide a "roadmap" for challenging discussions, established approaches for conveying bad news (25, 26), and the evidence base describing what matters most to families in their communication and relationships with clinicians (9, 10, 12, 13, 19, 21, 27–30, 41) were presented during brief didactic sessions. Participants reported they better understood the importance of listening, granting silence, and providing ample time for family members to speak, factors that have been associated with greater family satisfaction and less conflict with practitioners (19). Participants also reported improvements in their willingness and ability to elicit family perspectives, to inquire about psychosocial concerns, and to show empathy and caring in their interactions, all of which have been highlighted as important to families (9, 10, 13, 41).

Communication training approaches vary considerably with regard to their length and intensity, participant characteristics, teaching methods, role of faculty, and choice of outcome measures. Most programs tend to focus on "high-stakes" conversations and pivotal clinical junctures that occur in high-intensity settings, such as critical care, oncology, and emergency departments (42–46). Briefer educational

programs typically focus on initial encounters between the clinician and patient/family (42, 43), whereas longer, more intensive training efforts address communication and relational issues across the disease trajectory (46, 47). As a 1-day program, longer than some and shorter than others, PERCS aims to strike a balance within a reasonable time frame by holding two to three conversations with the same actor-patients and families over the course of the training day.

PERCS emphasizes interdisciplinary training across varying levels of clinical experience, unlike most training programs that enroll participants from the same medical subspecialty and similar experience level. Although physicians have commonly been viewed as the bearers of difficult news, our approach integrates the valuable roles of nurses, psychosocial clinicians, and chaplains who typically help families to understand and emotionally process difficult news (41, 48). Although single-discipline training efforts have shown favorable outcomes (42, 43), PERCS aims to better approximate the actual interdisciplinary culture in which clinicians practice. Our paradigm has similarities in this regard to the work of Williams et al (44, 45), who convened teams of physicians, nurses, chaplains, and organ transplant coordinators together in simulated role plays with actors, with the goal of increasing consent rates.

Communication training efforts using simulation face complex challenges and vary considerably with respect to the specificity, rigor, and nature of their evaluation designs and outcome measures (36). Some programs, including our evaluation, have reported on treatment acceptability and participant self-appraisal to measure changes in knowledge and confidence level to hold difficult conversations (42, 47). Our evaluation also included 5-month outcome questionnaires and incorporated a broader self-assessment incorporating open-ended qualitative questions. Some programs (42,

43) have tracked observable changes in participants' communicative performance through videotaped pretraining and post-training simulation case scenarios. Fallowfield et al (48) have reported impressive 12-month outcomes based on differences between participants' pretraining and post-training communication behavior during actual family meetings. Williams et al (44, 45) measured organ donation consent rates as the primary outcome measure, distinguishing their outcome from more general communication training programs that rely on self-report measures and individual communication performance.

The study had several limitations that must be acknowledged. The study design did not include a comparison group and was limited to pre, post, and follow-up self-assessment of participants. The quantitative and qualitative assessment instruments focused exclusively on participant self-evaluation and appraisal and did not use multiple informants. The impact of the experiential learning paradigm on participants' clinical interactions with patients and their families remains to be investigated. The program was evaluated in a single pediatric institution, which may diminish the generalizability of the findings. Participants were largely self-selected and, thus, the issue of selection bias is relevant. Just over half of the participants returned the 5-month follow-up questionnaires and that group was more likely to have had previous learning opportunities and more experience observing or leading difficult conversations than the entire sample. Finally, the study was subject to the limitations of all studies that rely on self-report questionnaires.

## CONCLUSION

In summary, our findings suggest that a 1-day experiential learning paradigm focused on communication skills and relational abilities was highly valued, clin-

ically useful, and logistically feasible for interdisciplinary pediatric critical care practitioners from a range of experience levels and clinical specialties. Participants reported better preparation, improved communication and relational skills, greater confidence, and reduced anxiety immediately on completion and 5 months after the training. There were no differences by discipline among any of the areas of self-improvement or the program's usefulness or quality, suggesting its applicability across disciplines and experience level. Participants deepened their understanding of patient and family perspectives, learned and practiced a range of communication and relational skills, recognized valuable existing competencies, and strengthened their commitment to teamwork. Virtually all participants recommended the program to other colleagues, a testament to its significant value and relevance. Furthermore, the training generated enthusiasm and commitment to make changes in everyday clinical practice. The experiential nature and realistic enactments of the program have been vital to its success, engaging participants emotionally and providing opportunities for practice. The experience was described by one participant as both "humbling and inspiring," conveying the richness and depth of learning that is available in these challenging but essential conversations. Indeed, good communication and relational abilities matter deeply to patients and their families and are long remembered. Relational learning opportunities can help practitioners bring their very best selves to these difficult encounters with confidence, clarity, and a sense of purpose.

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## Appendix A

### Program to Enhance Relational and Communication Skills (PERCS) Day Agenda

8:30–8:45	Welcome and Introduction
8:45–9:45	Introduction to PERCS Review of the Literature Videotape: "Speaking the Same Language" PERCS Principles and Guidelines
9:45–10:45	Withdrawal of Life Support Case Simulation
10:45–11:00	Break
11:00–11:30	Withdrawal of Life Support Ethics Lecture and Discussion
11:30–12:15	Withdrawal of Life Support Case Simulation
12:15–12:30	Break
12:30–1:00	(Lunch Session) The Experience of Professional Caregivers Videotape: "I Need It to Make Sense"
1:00–1:45	End-of-Life Conversations with Children and Families Case Simulation
1:45–2:00	Break
2:00–2:15	Videotape and Response: "Big Choices, Little Choices"
2:15–3:00	End-of-Life Conversations with Children and Families Case Simulation
3:00–3:15	Reflections on the Workshop
3:15–3:30	Evaluation

## Appendix B

### Sandy Richards

Sandy Richards is a 17-year-old adolescent who has a history of acute myelogenous leukemia. She has presented to the emergency department with some weight loss over the past few months, a cough of several weeks' duration, and increasing dyspnea. Chest radiograph suggests a diffuse infiltrative disease, most likely *Pneumocystis carinii* pneumonia.

Additional history: Sandy has been a Children's Hospital patient for a long time, and is well known to house staff, with frequent admissions and clinic/emergency department visits for chemotherapy and for episodes of fever and neutropenia. Since her diagnosis 5 years ago, she has received aggressive chemo-

therapy, including a bone marrow transplant. She has been seemingly disease free for much of the past few years, has been accepted at a prominent university, and plans to enter one of the healthcare professions.

Sandy was admitted to the intensive care unit a few hours ago for treatment of her pneumonia. Her initial color blood count is discouraging—her white count is 34K with 45% blasts indicating that her cancer has returned. Oncology has consulted and a bronchoscopy, central venous line placement, and bone marrow biopsy under anesthesia are planned for the next day to assist with treatment planning.

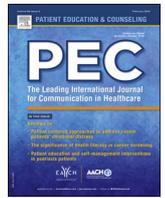
Sandy lives with her parents and grandmother, whom she calls Nanna. Her grandfather, whom she calls Poppa, died 2 years ago from cancer. His last days were not managed well in the hospital, and he died in pain. Grandmother had struggled with her husband's physicians for several weeks to withhold his prognosis. She watched her husband "go downhill" after he was told there was no treatment for his cancer, and is convinced that he would have lived longer if the doctors had not told him the truth.

### Conversation One

The nurse and physician caring for Sandy meet with her parents and paternal grandmother to discuss her condition, the results of initial blood work results and what it means, and the limited options for treatment. Mr. and Mrs. Richards react with shock and dismay on hearing that Sandy's cancer has come back. The parents and grandmother realize that this is very serious, and they have some understanding that this is a "turning point" in Sandy's illness.

### Conversation Two (that evening)

Sandy's social worker/nurse/physician team is working the evening shift, and has been told that Sandy has been upset and withdrawn most of the evening. Sandy had a visit earlier with her family, but it is not entirely clear what, if anything, she has been told about her situation. The social worker/nurse/physician team enters the room to check in with her. Sandy is lying on the bed, with her back facing the door.



## The International Charter for Human Values in Healthcare: An interprofessional global collaboration to enhance values and communication in healthcare



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### ABSTRACT

**Objectives:** The human dimensions of healthcare—core values and skilled communication necessary for every healthcare interaction—are fundamental to compassionate, ethical, and safe relationship-centered care. The objectives of this paper are to: describe the development of the *International Charter for Human Values in Healthcare* which delineates core values, articulate the role of skilled communication in enacting these values, and provide examples showing translation of the Charter's values into action.

**Methods:** We describe development of the Charter using combined qualitative research methods and the international, interprofessional collaboration of institutions and individuals worldwide.

**Results:** We identified five fundamental categories of human values for every healthcare interaction—Compassion, Respect for Persons, Commitment to Integrity and Ethical Practice, Commitment to Excellence, and Justice in Healthcare—and delineated subvalues within each category. We have disseminated the Charter internationally and incorporated it into education/training. Diverse healthcare partners have joined in this work.

**Conclusion:** We chronicle the development and dissemination of the *International Charter for Human Values in Healthcare*, the role of skilled communication in demonstrating values, and provide examples of educational and clinical programs integrating these values.

**Practice implications:** The Charter identifies and promotes core values clinicians and educators can demonstrate through skilled communication and use to advance humanistic educational programs and practice.

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### 1. Introduction

The human dimensions of healthcare—the core values and communication skills that should be present in every healthcare interaction—are fundamental to the practice of compassionate, ethical, and safe relationship-centered care. Well-developed values

and effective communication are essential in all healthcare settings and in all aspects of healthcare, from prevention and health maintenance to illness diagnosis, treatment, and recovery [1–10]. Accrediting organizations internationally require teaching and assessment of both humanistic skills and communication skills [7]. Studies show that effective communication, grounded by core values, improves health outcomes, quality of care, and patient and clinician satisfaction [11–15]. However, these human dimensions of care have not yet received the emphasis necessary to make them central to every healthcare encounter.

The *International Charter for Human Values in Healthcare* [16] is the result of a rigorous, three-year process of international collaborations to identify and develop a framework for values relevant across cultures and languages. The objectives of this paper are to: (a) describe the conceptualization, development, and dissemination of the *International Charter for Human Values in Healthcare* which arose out of an international, interprofessional collaboration to identify core values that should be present in every healthcare interaction, (b) systematically describe how these values can be realized through skilled communication, and (c) show the translation of the *International Charter's* values into action by providing examples of a faculty education program and a research-based intervention that embed human values in healthcare interactions. Our overarching aim is to develop ways to better cultivate and enhance the human dimensions of care in all healthcare relationships including clinician-patient, interprofessional/team, colleague-colleague, and others within and between healthcare systems and stakeholders.

## 2. Methods

### 2.1. Development of an international collaboration for communication in healthcare

In 2010, two of the authors (DS, ER) decided to bring together healthcare communication experts and leaders to explore the critical role of communication and relationships in healthcare across different cultures and settings around the world. In March 2011, the First International Symposium and Roundtable on Healthcare Communication was convened at Hong Kong Polytechnic University. The Roundtable brought together 30 invited experts from medicine, nursing and other health professions, medical/healthcare education, interprofessional training and practice, health policy and leadership, health sciences, linguistics, health communication, and sociology. This group formed the International Collaborative for Communication in Healthcare, created intentionally with an international and interprofessional perspective considered essential to the effort. The goal was to develop a multidisciplinary, international collaborative of experts working together to bridge the gaps between healthcare research, education and practice in order to better understand and enhance communication and relationships in healthcare systems worldwide. Focusing initially on Asia and the Pacific Rim, we quickly expanded to a more global perspective.

In June 2013, the international collaborative was formally launched as the International Research Centre for Communication in Healthcare (IRCCH) [17,18], co-sponsored by Hong Kong Polytechnic University and the University of Technology Sydney, Australia. Curtin University, Western Australia, became a strategic partner in July 2013. IRCCH currently has 80 members from 15 countries.

What makes IRCCH particularly distinctive is that, first, it brings together highly regarded healthcare professionals and academics with linguists and communication experts; second, it is committed to translational research that focuses on applying the findings to practice and educational development; and third, the *International*

*Charter for Human Values in Healthcare* is used as a foundational document to inform and focus IRCCH's research, education, and practice initiatives.

### 2.2. Development and refinement of the International Charter for Human Values in Healthcare

During our work together at the First International Symposium and Roundtable on Healthcare Communication in March 2011, we recognized that the nature and quality of communication in healthcare was fundamentally influenced by the values of healthcare professionals, clinicians, educators, administrators, organizations, and institutions—i.e. the values of essentially all healthcare players and stakeholders. Representing diverse cultural backgrounds, languages, and perspectives, we quickly learned that clinicians, patients, caregivers, and healthcare communities across the world share many human values. We decided to identify these common core values.

An international, interprofessional working group of Roundtable participants met to explore the human dimensions of care in healthcare relationships, to identify important values for healthcare interactions, and to begin the development of an international healthcare charter addressing core values that would provide an explicit underlying foundation for healthcare relationships.

Using qualitative research methods, iterative content analyses, focus groups, Delphi methodology, and expert consensus, we created and refined the *International Charter for Human Values in Healthcare*. We used an expert focus group model to develop our questions for study and to identify an initial list of values, followed by identification of additional values, and review and consensus by the full Roundtable group of 30 participants. The expert focus group expanded into the ongoing Human Dimensions of Care Working Group (14 international, multidisciplinary members) of the International Collaborative for Communication in Healthcare (the precursor to IRRCH).

Using expert iterative consensus, a subgroup of the working group (ER, WB, and MH), as well as a second subgroup of applied linguists in healthcare communication (DS, JKHP, and others), identified fundamental categories of values and classified sub-values within each category. Further review and consensus by the larger group followed. In mid-2011, the resulting document became the first version of the *International Charter for Human Values in Healthcare*.

The *International Charter* was further refined using additional qualitative data from a number of interprofessional groups internationally. Two questions, identified and refined by group consensus earlier, were used:

1. Drawing on your professional experiences and your experiences as a patient, what are the core human values that should be present in every healthcare interaction?
2. From your list above, what are the top 4 values you think should be present in every healthcare interaction?

Healthcare professionals and medical educators as well as patients and caregivers attending major interprofessional healthcare conferences identified, prioritized, and discussed core values for healthcare interactions. Their responses were used, via iterative consensus of a subgroup of the Human Dimensions of Care Working Group, to further refine the *International Charter*. The conferences included: National Academies of Practice (NAP) Annual Forum and Meeting, March 2011; International Conference on Communication in Healthcare (ICCH) November 2011; Interprofessional Patient-Centered Care Conference, "Patient-Centered Care: Working Together in an Interprofessional World", September 2012; and the American Academy on Communication in Healthcare Research

and Teaching Forum, October 2012. The National Academies of Practice group (70 members from 10 healthcare academies) also identified and prioritized values for interprofessional interactions.

In October 2012, the Human Dimensions of Care Working Group used Delphi methodology to further refine *International Charter* value categories and subvalues. Additional data were gathered through two focus groups of Harvard Macy Institute scholars and faculty in January 2013. The final iteration of the fundamental values categories and the subvalues within each for the *International Charter for Human Values in Healthcare* was completed by iterative consensus of an expert subgroup (ER, WB, DS, SK, HL, and MH) of the Working Group.

A separate working group of the Roundtable reviewed the literature and enunciated the critical role of skilled communication in implementing effective healthcare. During the development of the *International Charter*, it was evident that values alone, without demonstration through communication, were insufficient. Discussions between the working groups clarified the relationships between the *International Charter* values and skilled communication.

### 3. Results

#### 3.1. The International Charter for Human Values in Healthcare

Using qualitative data gathered as noted above, we identified five fundamental categories of human values that should be

present in every healthcare interaction—Compassion, Respect for Persons, Commitment to Integrity and Ethical Practice, Commitment to Excellence, and Justice in Healthcare—and categorized subvalues within each category. These are presented in Table 1.

The *International Charter* consists of the values noted and a Preamble [19] that was created by members of the Human Dimensions of Care Working Group using iterative consensus (Box 1).

#### 3.2. Dissemination and translation of the International Charter into action

The *International Charter* has been presented nationally and internationally over 20 times to date [16] to hundreds of healthcare clinicians, academics, experts, leaders, patients, and caregivers from numerous countries and cultures. Participants in a majority of these presentations were invited to identify, prioritize, share, and discuss their core values for healthcare interactions, in response to the two questions noted above. In addition, the *International Charter's* values have been incorporated into the curricula of eight courses, including interprofessional and specialty faculty development courses and trainings, fellowships, experienced clinician courses, and others. Individuals across the world, representing 22 countries, have signed the *International Charter*.

**Table 1**

The International Charter for Human Values in Healthcare: fundamental values and subvalues [16].

Five fundamental values	Values within each category
<p><b>Compassion</b> Compassion should be central to human relationships. Compassion means to understand the condition of others, and to commit oneself to the healing and caring necessary to enhance health and relieve suffering. These values underlie our efforts to be compassionate.</p>	<ul style="list-style-type: none"> <li>• Capacity for caring</li> <li>• Capacity for empathy</li> <li>• Capacity for self-awareness</li> <li>• Motivation to help, heal</li> <li>• Capacity for kindness</li> <li>• Capacity for genuineness</li> <li>• Capacity for generosity</li> <li>• Capacity for flexibility and adaptability in relationships</li> <li>• Capacity for acceptance</li> <li>• Capacity for curiosity</li> <li>• Capacity for altruism</li> <li>• Capacity for mindfulness</li> </ul>
<p><b>Respect for Persons</b> Respect should form the basis of all of our relationships.</p>	<ul style="list-style-type: none"> <li>• Respect for patient's and their significant others' viewpoints, opinions, wishes, beliefs</li> <li>• Respect for cultural, social, gender, class, spiritual, and linguistic differences</li> <li>• Respect for autonomy</li> <li>• Respect for privacy and confidentiality</li> <li>• Respect for all colleagues of the interprofessional team</li> <li>• Humility</li> </ul>
<p><b>Commitment to Integrity and Ethical Practice</b> The healing professions are built around integrity and ethical practice. These must underlie and permeate all actions in the health professions.</p>	<ul style="list-style-type: none"> <li>• Commitment to honesty and trustworthiness</li> <li>• Commitment to reliability</li> <li>• Commitment to accountability and responsibility</li> <li>• Commitment to the patient's well-being</li> <li>• Commitment to doing no harm</li> <li>• Capacity to acknowledge one's limits and seek guidance; awareness of own limitations</li> <li>• Commitment to tolerance and non-judgmental care</li> </ul>
<p><b>Commitment to Excellence</b> We must dedicate ourselves to achieving excellence in all aspects of healthcare. Without excellence, no matter how well intentioned, our efforts to heal will fall short.</p>	<ul style="list-style-type: none"> <li>• Commitment to providing the best, most effective care (scientifically and psychosocially)</li> <li>• Commitment to communication excellence</li> <li>• Commitment to relational excellence</li> <li>• Commitment to self-awareness and reflective practice</li> <li>• Commitment to life-long learning, expertise, and professional development</li> <li>• Commitment to serve the patient's best interest</li> </ul>
<p><b>Justice in Healthcare</b> We believe that healthcare professionals should embrace the values of justice in healthcare, and commit themselves to advocating for and putting these values into action.</p>	<ul style="list-style-type: none"> <li>• Right to healthcare (information, access, quality)</li> <li>• Right to equality</li> <li>• Commitment to advocating for the patient</li> <li>• Absence of discrimination and prejudice</li> <li>• Attention to social factors, constraints, and barriers to care</li> <li>• Commitment to social justice</li> </ul>

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**Box 1.** Charter Preamble of the International Charter for Human Values in Healthcare [19]

**Charter Preamble**

**The International Charter for Human Values in Healthcare is a collaborative effort involving people, organizations, and institutions around the world working together to restore human values in healthcare.** These fundamental values include Compassion, Respect for Persons, Commitment to Integrity and Ethical Practice, Commitment to Excellence, and Justice in Healthcare. They embody the human dimensions of healthcare and are fundamental to the practice of compassionate, ethical and safe relationship-centered care. These values represent the overarching goals that motivate scientifically sound, effective methods of care.

**We believe that fundamental human values, such as those listed above, are both essential and universal.** These fundamental values underpin a relationship-centered approach, and can be embraced by healthcare systems around the world—across cultures, languages, professions and disciplines. They are indispensably present in every healthcare interaction.

**We believe that effective and caring communication is essential to restoring human values in health care.** Values are realized by and manifested in language and the interaction process. Skilled communication underpins healthcare interactions and relationships, and plays an essential role in making values visible.

**We believe these core human values that define the goals and processes of healthcare have yet to receive the emphasis necessary to make them central to every healthcare encounter.** Placing emphasis on our core values and their ongoing development will help to solve many problems in delivery of care—ranging from excessive cost and profit to inadequate care for the less fortunate and underserved.

**The Charter is meant to inspire a movement to improve care by restoring the primacy of human values, to place them at the center, and to make them the goal of every effort in healthcare.**

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A number of diverse institutions and organizations—from Asia, Australia, Brazil, The Netherlands, New Zealand, United Kingdom, to Uganda and the US—have joined this international effort by becoming *International Charter* partners and endorsing the *International Charter* (Table 2) [20]. We are developing ways of working together to enhance attention to the *International Charter's* values in healthcare systems internationally.

In the US, a major partner is the National Academies of Practice (NAP). Founded in 1981, NAP serves as the US forum addressing interprofessional healthcare education, practice, policy, and research. NAP is comprised of distinguished, elected members in 14 healthcare Academies. NAP voted unanimously to endorse and become a partner of the *International Charter for Human Values in Healthcare*. In addition, the *International Charter* is a partner of, and works closely with, the Charter for Compassion [21] and its healthcare sector. The Charter for Compassion represents a major worldwide movement working to promote principles of compassion through practical action in a variety of sectors including healthcare, education, science/technology and research, environment, business and others [22].

### 3.3. Relationships between values and skilled communication

The *International Charter for Human Values in Healthcare* purposefully includes the essential role of skilled communication in the demonstration of values. Skilled communication translates

values from perceptions and feelings into actions by bringing those values and capacities to life and making them visible to others. The *International Charter* framework provides a foundation for defining and thinking more systematically and intentionally about clinical communication and human values, and for understanding the relationships between them.

## 4. Discussion and Conclusions

### 4.1. Discussion

The *International Charter for Human Values in Healthcare* is a collaborative international, multi-disciplinary effort to restore the human dimensions of care—the core values and skilled communication that should be present in every healthcare interaction—to healthcare around the world. The role of the *International Charter* is to stimulate reflection and dialogue about the essential place of values and skilled communication in every healthcare interaction. It is not meant to be an absolute or final compilation of human values in healthcare interactions, but a true working document to help facilitate the efforts of clinicians, educators, researchers, policy makers, and leaders, as well as patients and caregivers, in improving healthcare delivery in systems and institutions worldwide. The *International Charter* invites organizations, groups, and individuals to reflect on the listed values, to bring them into every healthcare interaction, and to offer additional values that are essential to their care systems and patient populations. The *International Charter* was designed to be dynamic and inclusive. Indeed, the *International Charter* articulates the essential nature of core human values that underpin all human relationships. In this way, the *International Charter* can be used to discuss and teach values and embraced across cultures, languages, professions, and systems globally. Work remains to be done for the *International Charter* values to become standard across healthcare systems at all levels. We recognize that values espoused by the *International Charter* may be challenged in healthcare environments that have other incentives for alignment.

The *International Charter* explicitly honors the relationship-centered [9,23,24] nature of healthcare and the role skilled communication plays in enabling relationships. In so doing the *International Charter* addresses the fundamental role of partnership and two-way relationships between patients and physicians/clinicians, and between interprofessional healthcare team members. Honoring these partnerships reflects the respect that grounds all other interactions.

#### 4.1.1. Delineation from other healthcare charters and statements

Other notable charters or agreements relevant to values, rights, and responsibilities in healthcare exist, including the Charter on Medical Professionalism [25], Charter for Compassion (endorsed by countries, cities, partners in various sectors including healthcare and others, and over 108,000 individuals worldwide) [22], Charter of Compassion for Care in The Netherlands [26], and the Salzburg Statement on Shared Decision Making [27]. These important initiatives have inspired numerous efforts to improve healthcare. Groups such as the Human Values in Healthcare Forum [28] in the UK, the recently created Global Network in Spirituality and Health [29] which partially grew out of the US National Consensus Conference on Creating More Compassionate Systems of Care convened in 2012 by the George Washington University Institute for Spirituality and Health [29,30], and many others are working to promote ethical and humane healthcare.

The *International Charter for Human Values in Healthcare* joins other charters articulating the importance of professionalism and values to guide healthcare professionals. Among the best known is the Charter on Professionalism written by members of the Medical Professionalism Project group that was comprised of leaders of the American

**Table 2**  
Partners of the International Charter for Human Values in Healthcare.

Charter partner	Country
International Research Centre for Communication in Healthcare (IRCCH) Jointly sponsored by Hong Kong Polytechnic University, Hong Kong and University of Technology Sydney, Australia; Curtin University, Western Australia is a strategic partner. Includes 80 members from 15 countries.	International
The National Academies of Practice <i>Includes 14 Academies representing:</i> Dentistry, Medicine, Nursing, Optometry, Osteopathic Medicine, Pharmacy, Podiatric Medicine, Psychology, Social Work, Veterinary Medicine, Audiology, Occupational Therapy, Physical Therapy, Speech and Language Therapy	USA
Charter for Compassion Includes cities, countries, partners in healthcare, education, science/technology and research, environment, religion/spirituality, peace and non-violence, and business sectors; signed by over 108,000 individuals worldwide	International
Children's Emotional HealthLink (CEHL)	USA
The George Washington Institute for Spirituality and Health (GWish), George Washington University	USA
The Good Worker: Mindful Professionalism	The Netherlands
Alabama College of Osteopathic Medicine	USA
Hands of Action Uganda	Uganda
Hearts in Healthcare	New Zealand
Hong Kong Society for Nursing Education	Hong Kong
Human Values in Healthcare Forum	United Kingdom
Institute for Professionalism and Ethical Practice, Boston Children's Hospital	USA
Sigma Theta Tau International (STTI) Honor Society of Nursing, Pi Iota Chapter	Hong Kong
SOBRAMFA—Medical Education and Humanism (former Brazilian Society for Family Medicine)	Brazil
Taiwan Association of Medical Education	Taiwan
Transcendent Endeavors	USA

Board of Internal Medicine Foundation, the American College of Physicians—American Society of Internal Medicine, and the European Federation of Internal Medicine [25]. The result of multiple inputs from a range of national and international organizations, forums, and individuals, the *International Charter for Human Values in Healthcare* described in this paper substantiates and supports the principles espoused in the Charter on Professionalism. Published in 2002, the Charter on Professionalism was crafted to address concerns regarding potential erosion of professional ethical underpinnings throughout the industrialized world by the growing healthcare corporate models. Comprehensive and detailed, the principles and commitments of the Charter on Professionalism provide important ethical guidelines for physicians in a shifting, challenging healthcare environment progressively dominated by corporate rules. The *International Charter for Human Values in Healthcare* fundamentally endorses the Charter on Professionalism through its independently, internationally derived set of five fundamental categories of values and subvalues within each. Indeed the similarity of the values and subvalues of the *International Charter* to the principles and commitments of the Charter on Professionalism lend credence to both. We see both charters as complimentary and fundamental to healthcare.

The *International Charter for Human Values in Healthcare* adds perspectives that complement the Charter on Professionalism in several ways. First, the *International Charter* specifically addresses the importance of values in therapeutic relationships and the care all healthcare clinicians give their patients, thus responding to the evolving interprofessional, team-based nature of care in today's environment. Second, the *International Charter* addresses the crucial nature of values in team and colleague relationships, recognizing that the quality of interprofessional relationships within the care team has a powerful effect on the quality of the physician–patient and other clinician–patient relationships and on the outcomes of

care. Third, the *International Charter* was created from the input of numerous groups, forums, organizations, and individuals worldwide and is intentionally broadly global, in recognition that the values we identified are likely core human values, not a reflection of western concepts or beliefs of a particular group, culture or belief system. Finally, and perhaps most important, the *International Charter* purposefully addresses the essential, fundamental role of skilled communication in the demonstration of values and, in doing so, emphasizes the connection between values and communication skills. The *International Charter* thus provides a unique lens to refocus on core values that are fundamental to optimal healthcare, as well as the essential role of communication skills in achieving this outcome.

#### 4.1.2. Core values and skilled communication to enhance the human dimensions of care

The intrinsic relationship between skilled communication and explicit attention to expression of human values in all healthcare interactions may seem obvious, though the requirement for the demonstration of capacity for both values and communication skills needs to be articulated. We have found it useful to think of communication as three interdependent types of skills [31]:

- Content skills—what you say.
- Process skills—how you communicate, e.g., how you structure interactions, ask questions, listen and respond, relate to patients and others, use nonverbal skills/behavior, involve patients in decision making, etc.
- Perceptual skills—what you are thinking and feeling, e.g., your clinical reasoning and other thought processes; feelings (including what you do with them); attitudes, biases, assumptions, intentions; values and capacities (including compassion, mindfulness, integrity, respect, etc.).

These somewhat overlapping skill sets are interdependent—a weakness or strength in one weakens or strengthens all three. Developing communication process and content skills, without ongoing and commensurate awareness and development of the values, personal ethics, and capacities that underlie those skills, can lead to manipulation rather than effective interaction. On the other hand, developing our values, capacities, and other perceptual skills without ongoing development of the process and content skills needed to demonstrate those values and capacities is inadequate, and the risk is that patients and others will not see nor experience that we hold these values (e.g. we may incorrectly perceive that because we feel empathy we are demonstrating it, or because we intend to listen carefully, we are doing so) [31].

Communication is an essential *clinical* skill with considerable science behind it, 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, shows that improving clinical communication in specific ways leads to numerous significant outcomes of care [4,13,32] (Box 2).

Our values, capacities, and communication skills also help us discern which way of relating is called for at any given moment. Developing and enhancing the capacity for flexibility, relational versatility, and “differential use of self”—i.e., the ability to adjust interpersonal skills based on the needs of different patients, families, the changing nature of the problem, and context—is central [7,9,33,34].

Through actions and words, clinicians espouse values in healthcare. Given our responsibilities and involvement with people’s lives at their times of greatest vulnerability, clinicians need to live by these values. We need to develop learning environments and practice settings that strengthen and reinforce our values. The values espoused in the *International Charter for Human Values in Healthcare*, and the specific clinical communication skills needed to demonstrate them, underpin efforts to strengthen the ongoing development of core values in medical/healthcare education and clinical programs at all educational levels. Two such programs that reflect *International Charter* values are briefly described below, as a means of demonstrating the potential impact of the *International Charter* and the translation of its values into action.

**Box 2. Summary of Research Findings on Communication in Healthcare [4]**

Improving clinical communication in specific ways leads to better outcomes, including:

**1. More effective consultations for patients and clinicians**

- Greater accuracy
- Heightened efficiency
- Enhanced supportiveness and trust

**2. Better relationships characterized by collaboration and partnership**

**3. Better coordination of care** (within healthcare teams, between other professionals, with patients’ significant others, etc.)

**4. Improved outcomes of care**

- Better understanding and recall
- Improved adherence and follow-through
- Enhanced symptom relief
- Better physiological outcomes
- Enhanced patient safety and fewer clinician errors
- Greater patient and clinician satisfaction
- Reduced costs, shorter hospital stays, and fewer complications
- Reduced conflicts, complaints, and malpractice claims

**4.1.3. Faculty development to strengthen core values in medical education**

For some time, Branch and others have worked to study and implement ways to enhance core values in medical education [12,13,35–37]. Noting the deterioration of communication skills and humanistic attitudes in their former students while in residency training, Branch et al. identified a need to strengthen trainees’ commitment to values and their sensitivity to situations in which values are at stake, and devised an approach to positively influence the residencies’ learning climates through better faculty role models in their clinical settings [12].

The faculty development program developed by Branch et al. [12] aims to enhance values and skilled communication by developing more humanistic faculty role models. The program for training faculty role models employs three mutually synergistic elements [12,36–38]. The method resulting from this synergism appears highly effective in developing faculty members’ capacities for the values, attitudes, and communication practices espoused by the *International Charter for Human Values in Healthcare*. Teaching strategies used include:

- (1) Mastering communication skills through active learning: Patient-interviews and simulated educational scenarios allow participating faculty members to master skills and adopt effective communication practices, while providing opportunities to reflect on the values that underlie these interactions.
- (2) Reflective learning: The faculty development program uses exercises, such as narrative writing followed by reflective discussion, to explore and work through the moral, professional, and value-laden components of interactions with patients, learners, and others that occur as part of the active learning process.
- (3) Longitudinal group-process: The trust and community that develops over time in regular small-group meetings of faculty teachers/role models synergizes with experiential and reflective learning to strengthen commitment and sensitivity to values. Support of the group members for each other reinforces the ethos of the group, which invariably embraces skilled communication and values like empathy, compassion, integrity, and respect.

This faculty development program has been applied or is currently ongoing at 25 medical schools, and plans are in place to expand it. Branch and colleagues found statistically significant superior humanistic teaching by faculty participating in the program, compared to matched controls [12]. Of perhaps equal importance, this faculty development program addressing skilled communication and values meets strong needs expressed by the faculty at multiple medical schools. A number of the schools have now adopted the program as a sustained and regular component of faculty development for their most promising teachers. One site has developed a Faculty Education Fellowship in Medical Humanism and Professionalism, and has created and implemented a values curriculum based on the *International Charter* [39].

Faculty members can transform medical and healthcare education by encouraging moral and professional growth at all levels for every trainee. The development of the *International Charter for Human Values in Healthcare*, and its articulation of human values, supports and amplifies the importance of this approach.

**4.1.4. Translating research findings into training and practice**

The second example showing the translation of the *International Charter’s* values into action involves a research-based training intervention that embeds human values in healthcare interactions during nursing handovers, and also exemplifies the *International Charter’s* ideal of relationship-centered care where patients have the

opportunity for active inclusion in decisions about their care and are included with respect, compassion, and integrity.

Clinical handover—the transfer between clinicians of responsibility and accountability for patients and their care [40]—is a pivotal and high-risk communicative event in hospital practice. Research identifies poor communication during handovers as a major risk for error and adverse outcomes [41,42]. An increasing number of public and private hospitals in Australia now require that nursing shift handovers take place at the bedside, so that patients can hear and contribute to the handover, with the end goal of improving the continuity and safety of patient care and making it more patient-centered [32].

Eggs and Slade, [43] as part of a national research project entitled *Effective Communication in Clinical Handover* (ECCHO), studied the effectiveness of mandated nursing handovers at the bedside at a large metropolitan Australian hospital through review and linguistic analysis of more than 200 hours of audio and video recordings of actual handovers. Analysis of the audio and video recordings showed that, without training, the nurses only nominally changed their behavior, with few handovers occurring at the bedside and even fewer involving direct patient engagement. Patient contributions were not invited and often not welcomed, and patients felt objectified or ignored.

From their research findings, Eggs and Slade developed training workshops that included four key components: (1) creating engagement to develop new practice, (2) self-reflection, (3) input in the form of practical communication protocols and strategies, and (4) role play activities to practice and reinforce new communication skills. A unique feature of these workshops was the use of high quality, professionally produced DVDs of re-enactments by professional actors replicating transcripts of actual bedside handovers recorded on site. The workshop progressively introduced communication protocols, with explicit language examples, to strengthen participants' skills in (1) managing the interactional dimension of handover (*how you talk*) and (2) the informational dimension (*what you say*). The *International Charter* values underpin the design of the intervention. This research suggests that, for nurses to involve the patient effectively in a respectful, compassionate and ethical manner, the focus of training and education for nurses (and physicians) needs to include how to effectively communicate both the interpersonal and informational dimensions of language.

#### 4.2. Conclusions

The *International Charter for Human Values in Healthcare* has as its focus the values that should be present in, and inform, every healthcare interaction. We have described the development and dissemination of the *International Charter* and the core values it identifies, conceptualized the role of skilled communication in demonstrating these values, and provided examples of educational and clinical training programs that translate values into action by using skilled communication to make these values visible. These efforts underscore the importance of providing ongoing training and practice opportunities along with expectations for healthcare professionals to explicitly articulate, teach, learn and continue to enhance personal values and evidence-based communication skills during the early years of medical/healthcare education, and throughout their careers.

The *International Charter for Human Values in Healthcare* is designed to foster a movement to improve care by restoring the primacy of human values, to place them at the center, and to make values, and the communication skills necessary to demonstrate them, the foundation of every effort in healthcare. The *International Charter* represents an international, interprofessional, cross-cultural endeavor, engaging healthcare clinicians, educators, researchers, leaders, patients, and caregivers in the demonstration of these

values in all healthcare relationships. Significantly, we go beyond delineation and endorsement of core values in the *International Charter*, to the translation of those values into action through intentional use of specific communication skills, and offer examples of approaches in both educational interventions and practice itself.

#### 4.3. Practice implications

The *International Charter for Human Values in Healthcare* identifies and promotes core values healthcare clinicians and educators can demonstrate through skilled communication and use to advance humanistic educational programs and practice strategies. We believe that placing emphasis on both core values and evidence-based communication skills will help to solve significant problems in the delivery of care, ranging from excessive cost and profit, inadequate care for the less fortunate and underserved, to increasing patient safety issues, and interprofessional challenges.

#### Conflict of Interest

The authors declare no conflicts of interest.

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