Module 7 – Unit 5

Applying PCC in the Appointment

Putting it all together

INSTRUCTOR'S GUIDE

Time for Unit: 1 hour

1. Goals
   - *Goal 1:* Review The Four Habits and the application of the associated key communication tasks in different clinical scenarios.
   - *Goal 2:* Introduce the SPIKES protocol for delivering difficult news.
   - *Goal 3:* Students study their own communication skills and reflect on areas to be strengthened.

2. Concepts to Master
   - The Four Habits can be applied in different clinical scenarios. The Four Habits can be viewed as a guide where the communication tasks are often interrelated and do not always follow a strict sequential order.
   - At the heart of person-centered care is our respect for the patients' values and their individual needs. This means we need to be flexible in our communication rather than being dictated by a strict structure.
   - To promote life-long learning and our value to consistently improve as clinicians, we must also regularly engage in self-reflection of our own communication habits.

3. Reading

   Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. The Oncologist, 5(4), 302-311.

   Buckman, R. (1984). Breaking bad news: why is it still so difficult?. British medical journal (Clinical research ed.), 288(6430), 1597.

   Buckman, R. A. (2005). Breaking bad news: the SPIKES strategy. Community Oncology, 2(2), 138-142.

   Frankel, R. M., & Stein, T. (1999). Getting the most out of the clinical encounter: the four habits model. Perm J, 3(3), 79-88.

4. Lecture

   PowerPoint: "Putting it All Together"

5. Activities
   - Activity 1: Video
   - Activity 2: Reflective exercise
   - Activity 3: Role-play

Activity 1: Video

The goal of this activity is to recognize person-centered skills and ways that clinicians can practice in person-centered ways more of the time.

Show the video "Putting it All Together"

Lead a group discussion:

- What aspects of the Four Habits did the clinician use?
- What worked well in this session?
- If this was your session, what would you have done differently?

Activity 2: Reflective exercise & role-play

This exercise is designed to encourage students to review their own communication in the 'difficult scenario' they described from Unit 1 prior to being introduced to the Four Habits. The goal of this exercise is to provide students with an opportunity to reflect their own communication as this is rarely done in clinic.

Ask the students to spend a few minutes watching the video-recording of their own interaction privately. Ask them to write down:

- What did you do well, and why?
- What didn't go so well, and why?
- How could you use the Four Habits to improve the interaction?

To help students recall the communication tasks for each of the habits, provide them with the feedback prompt handouts.

To prepare for the role-play session, the students should get into groups of three and find a quiet space in the classroom.

1. Share the challenging scenario that was video-recorded from unit 1. Each group should have three different scenarios.
2. Using what they have reflected on from Activity 2, ask the students to role-play the same scenario and incorporate the communication tasks from the four habits where appropriate.
3. Select one student will play the 'clinician', one student the 'patient', and the 'observer' will video-record the role-play using the clinician's smartphone.
4. Before commencing, spend time building the patient character for the scenario.
5. After the role-play has come to a stop, students should swap roles and perform the second scenario as described by the second student.

Habits 1 & 2

Areas to Improve	Good	Amazing!
Clinician needs to refer to chart continually to familiarize self with case or does not relate current visit with patient's history or chart.	Clinician makes some reference to past visits or history, but familiarity with these does not seem strong.	Clinician indicates clear familiarity with patient's previous clinical notes (e.g. mentions recent test performed or information based on previous notes)
Greeting of patient is cursory, impersonal, or non- existent.	Patient is greeted in manner that recognizes patient, but without great warmth or personalization.	Patient is greeted in manner that is personal and warm (e.g., clinician asks patient how s/he likes to be addressed, uses patient's name).
The clinician tries to identify the problem(s) using primarily closed-ended questions.	The clinician tries to identify the problem(s) using a combination of open and closed ended questions (possibly begins with open-ended but quickly reverts to closed ended).	The clinician tries to identify the problem(s) using primarily open-ended questions (asks questions in a way that allows patient to tell own story with minimum of interruptions or closed ended questions).
The clinician immediately pursues the patient's first concern without an attempt to discover other possible concerns of the patient's.	The clinician makes some reference to other possible complaints, or asks briefly about them before pursuing the patient's first complaint, or generates an agenda as the visit progresses.	The clinician attempts to elicit the full range of the patient's concerns by generating an agenda early in the visit (clinician does other than simply pursue first stated complaint).
Clinician makes no attempt/shows no interest in understanding the patient's perspective.	Clinician shows brief or superficial interest in understanding the patient's understanding of the problem.	Clinician shows great interest in exploring the patient's understanding of the problem (e.g., asks the patient what the audiological issue mean to him/her).
Clinician makes no attempt to determine/shows no interest in how the problem is affecting patient's lifestyle.	Clinician attempts to determine briefly/shows only some interest in how the problem is affecting patient's lifestyle.	Clinician attempts to determine in detail/shows great interest in how the problem is affecting patient's lifestyle (work, family, daily activities).

Adapted from: Krupat, E., Frankel, R., Stein, T., & Irish, J. (2006). The Four Habits Coding Scheme: validation of an instrument to assess clinicians' communication behavior. *Patient education and counseling*, *62*(1), 38-45.

Habit 3

Areas to Improve	Good	Amazing!
Clinician shows no interest in patient's emotional state and/or discourages or cuts off the expression of emotion by the patient (signals verbally or nonverbally that it is not okay to express emotions).	Clinician shows relatively little interest or encouragement for the patient's expression of emotion; or allows emotions to be shown but actively or subtly encourages patient to move on.	Clinician openly encourage/is receptive to the expression of emotion (e.g., through use of continuers or appropriate pauses (signals verbally or nonverbally that it is okay to express feelings).
Clinician makes no attempt to respond to/validate the patient's feelings, or possibly belittles or challenges them (e.g., It's ridiculous to be so concerned about ...)	Clinician briefly acknowledges patient's feelings but makes no effort to indicate acceptance/validation.	Clinician makes comments clearly indicating acceptance/validation of patient's feelings (e.g., I can see how that would worry you ...)
Clinician makes no attempt to identify patient's feelings.	Clinician makes brief reference to patient's feelings, but does little to explore them by identification or labeling.	Clinician makes clear attempt to explore patient's feelings by identifying or labeling them (e.g., How does that make you feel? It seems to me that you are feeling quite anxious about ...).
Clinician's nonverbal behavior displays lack of interest and/or concern and/or connection (e.g., little or no eye contact, body orientation or use of space inappropriate, bored voice).	Clinician's nonverbal behavior shows neither great interest or disinterest (or behaviors over course of visit are inconsistent)	Clinician displays nonverbal behaviors that express great interest, concern and connection (e.g., eye contact, tone of voice, and body orientation) throughout the visit.

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Habit 4 (continued on next page)

Areas to Improve	Good	Amazing!
Clinician frames diagnosis and information in terms that fit the clinician's frame of reference rather than incorporating those of the patient.	Clinician makes cursory attempt to frame diagnosis and information in terms of patient's concerns.	Clinician frames diagnostic and other relevant information in ways that reflect patient's initial presentation of concerns.
Clinician gives information and continues on quickly with giving patient opportunity to react (impression is that this information will not be remembered properly or fully appreciated by the patient).	Clinician pauses briefly for patient reaction, but then quickly moves on (leaving the impression that the patient may not have fully absorbed the information).	Clinician pauses after giving information with intent of allowing patient to react to and absorb it.
Information is stated in ways that are technical or above patient's head (indicating that the patient has probably not understood it fully or properly).	Information contains some jargon and is somewhat difficult to understand.	Information is stated clearly and with little or no use of jargon.
Clinician offers/orders tests and treatments, giving little or any rationale for these.	Clinician only briefly explains the rationale for tests and treatments.	Clinician clearly explains the rationale behind the tests and recommendations so that the patient can understand the significance of these management options.
Clinician makes no effort to determine whether the patient has understood what has been said.	Clinician briefly or ineffectively tests for the patient's comprehension.	Clinician effectively tests for the patient's comprehension.

Habit 4 (continued from previous page)

Areas to Improve	**Good**	**Amazing!**
Provider shows no interest in having patient's involvement or actively discourages/ignores patient's efforts to be part of decision making process.	Clinician shows little interest in inviting the patient's involvement in the decision-making process, or responds to the patient's attempts to be involved with relatively little enthusiasm.	Clinician clearly encourages and invites patient's input into the decision making process.
Clinician offers recommendations for treatment with little or no attempts to elicit patient's acceptance of (willingness or likelihood of following) the plan.	Clinician makes brief attempt to determine acceptability of treatment plan, and moves on quickly.	Clinician explores acceptability of treatment plan, expressing willingness to negotiate if necessary.
Clinician does not address whether barriers exist for implementation of treatment plan.	Clinician briefly explores barriers to implementation of treatment plan.	Clinician fully explores barriers to implementation of treatment plan.
Clinician makes no attempt to solicit additional questions from patient or largely ignores them if made unsolicited.	Clinician allows for additional questions from patient, but does not encourage question asking nor respond to them in much detail.	Clinician openly encourages and asks for additional questions from patient (and responds to them in at least some detail).
Clinician makes no reference to follow-up plans.	Clinician makes references to follow-up, but does not make specific plans.	Clinician makes clear and specific plans for follow-up to the visit.

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