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# Taking Your Skills to the Next Level

## The Challenge

Telling a mother of two that her colon cancer has returned – and it's incurable. Explaining to a schoolteacher with chronic lung disease that to continue working, he will need portable oxygen. Helping the parents of a five-year-old girl with metastatic neuroblastoma after treatment decide whether to enroll her in a clinical trial. Giving the news to an accountant with chronic hepatitis that her incidentally discovered hepatocellular cancer is unresectable, so she's off the transplant list.

These conversations are territory that many of us learned to navigate mostly by trial and error. Even after years of experience, we still take a deep breath before getting started and prepare for a discussion that will change the life of the person before us.

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

How clinicians handle these difficult conversations can make or break a therapeutic relationship. We've seen colleagues who take on the challenges and others who sidestep them. Most of those who steer clear of tough encounters have good intentions but don't know how to act on them. They worry they'll say the wrong thing, take away a patient's hope, cause a patient or family to break down or get angry, or open a Pandora's box that will take way too much time in a busy day. Or, they feel like no matter what they do, the patient (or family) doesn't hear them and gets upset anyway.

Compare those colleagues with expert clinicians who excel even during the toughest encounters. They seem to intuit what the patient needs. They know when to offer information, when to ask an open-ended question, and when to make an empathic comment. Rather than randomly "winging" it, they have a framework that guides their communication.

How do you talk with patients and their families about balancing hope with reality … or trust with caution? Do you wish you were more confident about where to go with the conversation? Do you feel stuck when a patient asks, "Why me?" Do you get into arguments with angry family members? Do you find yourself unsuccessfully trying to convince some seriously ill patients that effective disease-directed therapies are no longer an option? And do you wish you had a more effective human response to patient suffering? If so, this book is for you.

## Does Better Communication Really Make a Difference?

Let's be honest. Through the hidden curriculum, many of us were taught that if a patient gets the right tests and treatments, nothing else really matters. In medicine, attendings "pimped" us about the labs, the scans, or the treatments, and quality metrics focused on clinical outcomes – they didn't pay attention to whether we had explained the

diagnosis in a way that patients could understand. The implicit message was that communication is like the cherry on top of a sundae – a nice touch but expendable.

We were misled. Research shows that communication is central to the effective work of a clinician. Good communication improves a patient's adjustment to illness, lessens pain and physical symptoms, increases adherence to treatment, and results in higher satisfaction with care. Poor communication skills are associated with increased use of ineffectual treatments, lower adherence to therapy, and higher rates of conflict. What's more, good communication doesn't just affect patients; it also affects you. It helps you enjoy and thrive in your work. Better communication skills are associated with less stress, less burnout, and even fewer malpractice claims. Suboptimal communication creates a vicious spiral that makes us feel more like hamsters on a wheel than like healers.

Clinical practice is changing in ways that put a premium on communication skills. Patients now have more access to medical information than ever before, and they are avid consumers of this knowledge. They Google their illness and raise questions about the most recent research advances. As biomedical advances have made decision-making much more complicated, patients and families need clinicians to add the judgment and experience that they cannot get from a website. Communication between patients and clinicians is more complex, and has more layers, as clinicians must integrate a mountain of biomedical information with their patients' values, hopes, and priorities. The Internet does not substitute for a skilled, caring clinician.

Finally, communication helps to build trust. Over the past 10 years, the public's trust in professionals has decreased for a variety of reasons – sensationalized cases of bad actors, political polarization, the rapid spread of misinformation, and the controversies around COVID. Trust is particularly a problem among patients of color for whom a long history of structural racism has led to inequities in care. Good communication skills cannot fix these societal problems. However, the

data suggests that communication skills are associated with increased trust – a critical component of good care.

## Can Clinicians Really Learn to Communicate?

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

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

However, the downside is that we may charge along in our work and overlook people's individual needs. The patient worries about quality of life and the clinician talks about survival. Or the patient wants information and the clinician keeps asking questions about coping. Either way, the routine leaves patients at least a bit frustrated and, worse, feeling isolated. Like the golfer who needs to correct their swing, clinicians need to consciously shed these bad habits. This can only be accomplished through learning new techniques and gaining experience using them. The good news is that sophisticated research shows that clinicians can indeed learn to communicate better. But not by doing the same old thing over and over. You need to see the medical encounter in a new way and observe differently what is happening. Then you can be more intentional about what you are trying to accomplish and more versatile with a wider array of communication tools. And, as a result, your patients will be more satisfied – and you will be too.

## Communication Deconstructed

As with learning any skill, we benefit when we can break down communication into its component parts. Playing the piano is a lot more difficult without an understanding of notes, keys, and scales. In talking to patients, words are like the notes we play at particular moments, and each phrase we express in a clinical encounter, just like a melody, plays an important role in how the patient experiences our presence. Beyond the words is a wide range of nonverbal behavior that may be even more important in how we convey our message. Communication scientists study recorded encounters using sophisticated methods and their work has contributed tremendously to our understanding of these human interactions. For those interested in a deeper understanding of the nuance of interactions, we encourage you to explore some of this literature. At the same time, a deep understanding of the complexity of the clinical encounter may not be necessary for clinicians who just want to focus on effectively managing their way through challenging conversations. We like to break down communication into three broad domains: skills, cognitive roadmaps, and capacities.

*Skills* are small, bite-size components of a conversation that serve a very specific purpose. For example, asking patients what they understand about their illness before giving medical information is a skill. Another skill might be responding to a patient's plaintive request, "Isn't there anything else you can do?" with the empathic comment, "I wish there was a treatment that would make this cancer go away." Sitting silently can also be a skill. Different skills have unique effects on patients and the flow of conversations. Numerous such skills exist, and experienced communicators know where and how to string them together to effectively convey a particular message or respond to patients' needs.

***Cognitive roadmaps*** are conversation guides that provide clinicians with the tools to navigate a difficult conversation from the beginning to the end. They describe the order in which skills must be applied to be effective. One of our most-used roadmaps goes by the acronym REMAP

(**R**eframe; **E**xpect emotion; **M**ap out goals; **A**lign with the patient; **P**lan treatments) and is used to approach a conversation about the goals of late-stage care (Chapter 8). Each of these steps requires specific skills, and by putting them together in the suggested order, clinicians are far more likely to be successful matching their treatments to patients' goals.

Finally, ***capacities*** are the internal psychological dispositions that clinicians bring to each encounter. They include attributes, known in the ethics literature as virtues, such as curiosity, self-awareness, compassion, and equanimity. Capacities heighten the connections we form with patients and grant us the ability to continue to improve. Words and roadmaps used without the presence of such capacities can fall flat and, at their worst, result in communication that feels inauthentic.

Capacities also include how we manage our own emotional reactions to having tough conversations. These reactions (often called countertransference in the psychological literature) interfere with our ability to build connections or talk about difficult topics. Our sadness in talking to someone who reminds us of family may lead us to avoid talking about a difficult topic. A cultural tendency to avoid conflicts or a desire to be liked may result in our hedging, even if we know how to give clear information. A hint that these factors are at play is when you notice that your skills in low-stress conversations seem to disappear when emotions run high. If you seem to continually get stuck in the same place (even when you know what to do), check your own emotional temperature.

Truly mastering communication requires cultivating these capacities, and we also acknowledge that they are the hardest elements to teach. They may require deep personal reflective work so, as important as they are to good communication, we see them as beyond the scope of this book. This book will focus primarily on learning skills and cognitive roadmaps. We will point to key capacities where we believe they are central to the success of a particular type of conversation, yet leave it to learners to develop these attributes in other ways (and we have offered one reference at the end of this chapter to get you started on that journey). We've also found that something special happens when

clinicians, even in the absence of well-tuned capacities, improve their communication skills. Patients respond! Even clunky expressions of empathy are usually well received. In the process, patients reveal more and draw their clinicians into a deeper and more authentic relationship which, in turn, hones their own capacities such as empathy and tolerance. In other words, good communication begets more good communication.

## What Will Better Communication Do for You?

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

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

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

Even more enthusiastically, one oncology fellow sent us this email a week after completing a VitalTalk communication skills course:

> When I saw a patient today that was distressed, I was able to name the emotion, use empathic statements, and use praise statements. I never once used the word chemotherapy, death, dying, prognosis, or

> treatment. The patient was able to get out what they needed and the conversation segued smoothly into moving forward from here and what we need to do to get there. As a matter of fact, he thought I was the best physician he had ever seen, and ***I didn't even talk to him about his cancer***. I couldn't believe it. ***It was freakin' amazing!*** It was like a switch went off in my head, an epiphany, that if I just talk to patients in a way that provides alignment, I will be able to ultimately provide better care!

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

## What's Our Philosophy?

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

In these situations, communication is not about delivering an information pill and seeing how much the patient can swallow; it is about sending messages to the patient, receiving messages in return, and seeking to coordinate these in a way that leaves a patient informed and feeling heard and understood. This back-and-forth model of communication has some important implications. First, respecting the complete process of communication will lead to better outcomes. The preparatory steps we outline in the roadmaps may seem obvious to you – but for a patient who has never been in your clinic before, they can make a big difference. Second, communication is a two-way process. You must attend to what the patient is telling you. If you are too busy sending messages (e.g., giving information) to read the replies (e.g., hear the patient's emotional reaction), the conversation will no longer sync. It would be like talking to the patient while you are listening to their heart – you will likely miss the subtle murmur.

## Our Basic Principles

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

1. Start with the patient's agenda. (Of course, you bring your own agenda; and first you must find out where the patient is coming from.)
2. Track both the emotional and the cognitive data you get from the patient. (Don't look past the emotion.)
3. Stay with the patient and move the conversation forward one step at a time. (Don't let yourself get ahead of the patient.)
4. Articulate empathy explicitly. (You are creating a safe conversational space.)
5. Talk about what you **can** do before you talk about what you **can't** do. (You need to show you are working for the patient.)
6. Start with big-picture goals before talking about specific medical interventions. (Ensure that you and the patient are aligned about what is most important ***before*** offering details about possible interventions.)

7. Spend at least a moment giving the patient your complete, undivided attention. (When patients tell you something big, put down your pen, stop typing on your computer, and show them you are listening.)
8. Ask your patients what they are taking away from the conversation. (This helps you evaluate how you are doing in the moment and what you can do to improve in the future.)

## A Word about Emotion

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

What does all this have to do with communication? In medical settings, we often hear clinicians frustrated, irritated, or overwhelmed with the emotion patients show, or we notice them trying to ignore emotion altogether. They dismiss emotion as human frailty and assume it has less value than cognition. In fact, emotion plays an important role: it

determines how we decide what is valuable. And when you are talking to a patient with a life-threatening illness, figuring out what is truly valuable is often the most important underlying communication task. Besides, if this emotion is never acknowledged, the conversation will not move forward in a productive way. Responding to emotion is about much more than being nice; it's about being effective. We consider emotion data to be as important as cognitive data and will emphasize recognizing and responding to emotions.

Patients are not the only ones with emotions. Clinicians also respond in ways that can powerfully impact the conversation. The medical news causing the patient distress may also make you sad, as you contemplate losing a patient about whom you care deeply. Or, a patient's behavior may trigger you to feel annoyed or even angry. And, even more complicated, sometimes patients or their situations remind us of tender moments in our own lives. These emotions can create a veil through which we observe the clinical encounter. They may offer greater insight and empathy that enhances our therapeutic effect. Or, if not acknowledged and contained, they may interfere in our role as healers as we use the clinical encounter as a place to inappropriately process our own feelings. Our ability to use our own emotional data in the service of patients is a complex topic that falls under the realm of capacities discussed earlier and about which we encourage further study and, perhaps, personal work.

## How to Use This Book

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

## Maximizing Your Learning

Athletes don't learn to put a ball in a basket or ski down a steep slope by reading a book. And musicians don't improve their tone and dexterity by watching a lecture. Skills, unlike medical facts, must be learned through observation, practice, and feedback. During VitalTalk courses, we demonstrate what good communication looks like so learners know what to emulate. We then teach using observed role-play – because the research shows that feedback is critical to putting new communication skills into practice. When learning on your own, consider ways that you can simulate this idea of practice with feedback. What follows are several ideas for you to enhance the skills we would teach at a course.

*Record yourself.* Listening to your own voice or watching yourself on a video is a humbling experience. (Do I really sound like *that*?) But it's worth the hassle (and the pain). Telehealth visits make doing this particularly easy. Don't forget to have your patient sign permission and make it clear that you are doing this to become a better clinician. Even cynical patients will be impressed that you are trying to improve. Listen for what you say and what you sound like when you're saying it. Better yet, have someone you trust watch or listen to the video or audio. Ask them to comment specifically on something you are working on.

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

*Practice one new skill at a time.* Communication is a complex psychomotor skill, and until you've mastered one thing, it's hard to focus on something else. You wouldn't try to learn to use your new mobile phone while driving a new car, would you? Pick **one** skill. And, the first

time, pick something that doesn't feel too hard. Remember that the best learning happens in situations that offer a bit of a challenge yet aren't overwhelming.

*Debrief yourself.* After a difficult conversation, find a couple of blank sheets of paper and, for a few minutes, in private, write down everything you can remember about what happened. Include snippets of what you said and what the patient said, as well as reactions, emotions, body language, and the effect of the conversation on you personally. Don't censor anything, just get it all down on paper. We try to put our pen on the paper and just keep writing for two or three pages. If other thoughts intrude, just write them down, then get back to the conversation. Later, see if a lesson or an insight emerges.

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

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

*Pay attention to praise*. Working with life-threatening illness has a long learning curve, but it has its rewards. When you get positive feedback,

pay attention. Don't brush off a compliment ("It was nothing," "It's my job"). Breathe deeply, take it in, record what it was that you did successfully, enjoy the moment, and say "Thank you."

You're ready to begin.

## Further Reading

Gottlieb, L., *Maybe You Should Talk to Someone*. Houghton Mifflin Harcourt, Boston, 2019.