Essential Elements of Communication

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KEYWORDS

• Communication • Physician-patient relations • Relationship-centered
• Patient-centered care • Health care • Health communication

KEY POINTS

- Relationship-centered care recognizes that all health care relationships occur in the context of reciprocal influence, include the dimensions of personhood in addition to roles, and involve affect and emotion.
- Relationship-centered care improves outcomes for patients, providers, and institutions.
- Communication skills are essential to relationship-centered and patient-centered care.
- Experts in health care communication reached consensus about which skills are considered essential, and several models incorporate these skills.
- Essential communication skills include active listening without interruption, the use of open-ended questions to explore the patients' concerns and assess understanding, the use of plain language and summary, and the ability to respond to emotion with expressed empathy.

INTRODUCTION

"Questions, connections and common ground are vital tools in assisting your patient to feel like a whole person, and helping them remember you are too."
-Marcus Engel, The Other End of the Stethoscope

The concept of relationship-centered care stems from the patient-centered care movement of recent decades.[1] Patient-centered care prioritizes patient preferences, improves quality of care, and supports morally, ethically sound medical practice.[2] The Pew-Fetzer Task Force helped to define relationship-centered care as patient-centered, with a focus on the meaningful relationship between patient and clinician.[3] **Box 1** lists the core principles of relationship-centered care.[4]

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Box 1
Principles of relationship-centered care

1. Relationships in health care ought to include dimensions of personhood as well as roles
2. Affect and emotion are important components of relationships in health care
3. All health care relationships occur in the context of reciprocal influence
4. Relationship-centered care has a moral foundation

To excel at relationship-centered care, one must build and hone knowledge, skills, and attitudes in 4 areas (**Box 2**).[3] These 4 areas are interdependent. Relationship-centered communication (RCC) is an approach that a provider can use to incorporate the principles of relationship-centered care in their communication with patients.

RCC has positive effects on patients, providers, and the health care system. Patient-centered communication techniques can reduce pain and anxiety, promote weight loss, and reduce systolic blood pressure.[5–11] For hospital-based physicians, RCC elicits clinically relevant information and contributes to patient agreement about treatment plans.[12] RCC increases communication ratings for physicians and does not prolong the encounter.[13] Studies have shown that physicians are happier when RCC is used. Both patient and provider benefits impact the health care system as a whole.

CURRENT EVIDENCE

Essential Elements

How does a provider practice or perform RCC? As with any skill or procedure, understanding the components of RCC is crucial. These components are known as the essential elements of physician-patient communication. In 1999, a group of people from medical schools, residency programs, continuing medical education providers, and prominent medical educational organizations in North America met to identify and specifically articulate ways to facilitate communication teaching, assessment, and evaluation.[14] The group created the Kalamazoo Consensus Statement.[14] The Kalamazoo Consensus Statement delineates a set of essential elements in physician-patient communication. These elements were intended to facilitate the development, implementation, and evaluation of communication-oriented curricula in medical education and inform the development of specific standards in this domain.

The essential elements are best delineated as communication tasks (**Table 1**). The task of building a relationship is fundamental and occurs within and across encounters. The other communication tasks are more sequential. These essential elements can be applied to multiple care settings and patient encounters.

Box 2
Knowledge, skills, and attitudes that pertain to the patient-provider relationship

1. Self-awareness and continuing self-growth
2. Patient's experience of health and illness
3. Developing and maintaining relationships with patients
4. Communicating clearly and effectively

Table 1
Essential elements of communication

Communication Task	Examples of Relevant Knowledge, Skills, and Attitudes
Build a relationship	Greet and show interest in patient as a person Use words that show care and concern throughout interview Use tone, pace, eye contact, and posture that show care and concern
Open the discussion	Allow patient to complete opening statement without interruption Elicit patient's full set of concerns Explain and/or negotiate an agenda for visit
Gather information	Use open-ended and closed-ended questions appropriately Structure, clarify, and summarize information Actively listen using nonverbal (eg, eye contact) and verbal (eg, words of encouragement) techniques
Understand the patient's perspective	Explore contextual factors (eg, family, culture, gender, age, socioeconomic status, spirituality) Explore beliefs, concerns, and expectations about health and illness Acknowledge and respond to patient's ideas, feelings, and values
Share information	Use language patient can understand Check for understanding Encourage questions
Reach agreement on problems and plans	Encourage patient to participate in decisions to the extent he or she desires Check patient's willingness and ability to follow plan Identify and enlist resources and support
Provide closure	Ask whether patient has other issues or concerns Summarize and affirm agreement with plan of action Discuss follow-up (eg, next visit, plan for unexpected outcomes)

Adapted from Kalamazoo Consensus Statement[14] *and Essential Elements Communication Checklist.*[25]

An example of the opening and closing of an encounter using relationship-centered skills in the outpatient setting is given. The following dialogue is annotated to demonstrate the essential elements of communication.

Example: The opening of a new patient encounter with a primary care provider.

Provider: "Hi. Mrs. Smith? I am Dr. Jones-it is great to meet you. Just to make sure I have the right chart; can you confirm your name and date of birth?" [Build a Relationship: Greet]

Patient: "Yes. Margaret Smith, 12/10/1963."

Provider: "Terrific, I have the right chart. I am just going to wash my hands before we start." (as washing hands) "I noticed your shirt says "Grandma knows best." How many grandkids do you have?" [Build a Relationship: Show interest in patient as a person]

Patient: "My daughter has 2 boys, and my son has a new baby girl born a month ago!"

Provider: "Congratulations! People say being a grandparent is even more amazing than being a parent." [Build a Relationship: Use words that show care and concern throughout interview] Patient: "That's for sure. And I am lucky they all live nearby so I get to see them a lot."

Provider: “That is lucky! Is it ok if I take a seat?” [Build a Relationship: Use words that show care and concern throughout interview]

Patient: “Of course.”

Provider: “First, I just want to acknowledge the computer—I will need to do some typing for my records, but I will do my best to keep it to a minimum so that I can focus my attention on you.” [Build a Relationship: Use eye contact that shows care and concern]

Patient: “Great.”

Provider: “How can I help you today?” [Gather information: Use open-ended questions]

Patient: “I have been having a lot of back pain recently. I’ve had it on and off for a couple of years, but it seems like it has been increasing in intensity lately and happening more frequently.” [Open the Discussion: Allow the patient to complete opening statement without interruption]

Provider: “I am sorry to hear that. Before we jump into the story of the back pain I just want to make sure I get a list of all the concerns you were hoping to cover today. What else is on your mind?” [Open the Discussion: Elicit full set of concerns]

Patient: “Well. I do need a refill of my blood pressure meds.”

Provider: “Sure thing. So back pain, blood pressure meds…what else?” [Open the Discussion: Elicit full set of concerns]

Patient: “I have been feeling a little down lately and having trouble sleeping.”

Provider: “Thank you for sharing that. You do seem a little down, and it can be so hard to have trouble sleeping. We will definitely spend some time on that. What else is on your mind?” [Build a Relationship: Use words that show care and concern throughout the interview; Open the Discussion: Elicit full set of concerns]

Patient: “That’s enough!”

Provider: “Alright. So, we have back pain, blood pressure meds, feeling down, and trouble sleeping. I would also like to review what vaccinations and screening tests you are due for if that is alright?” [Open the Discussion: Explain and/or negotiate an agenda for the visit]

Patient: “Of course.”

Provider: “Of the three concerns you mentioned, which is most important to you today?” [Build a Relationship: Negotiate an agenda]

Patient: “Well actually I think feeling down and having trouble sleeping really started with the back pain so maybe we should start there?”

Provider: “Sounds good. Why don’t you tell me the story of the back pain, starting with when it first began and taking me through to now?” [Gather Information: Use open-ended questions]

Patient: “Well, like I said, I have had pain in my lower back for the last couple of years, usually related to overdoing my workout without stretching enough or when I am unusually stressed. I take a couple of Advil and do more stretching, maybe take a day off of exercising and it goes away. For the past couple of weeks, though, it has gotten worse. It started when I was trying to help my daughter move- I was lifting some heavy boxes and felt my lower back spasm. I went home, took some Advil, put a heating pad on it, but it didn’t go away. Since then, I have noticed that the pain now shoots down my left buttock. It is pretty much there all the time now.” [Open the Discussion: Allow the patient to complete opening statement without interruption]

Provider: “That sounds really difficult.” [Build a Relationship: Use words that show care and concern throughout the interview] “How has this impacted your life?” [Understand the Patient’s Perspective: Explore contextual factors]

Patient: "Well, I can't exercise at all. It makes it hard to fall asleep and stay asleep at night so I am exhausted during the day."

Provider: "That sounds really debilitating." [Build a Relationship: Use words that show care and concern throughout the interview] "What do you think might be causing the pain? [Understand the Patient's Perspective: Explore beliefs, concerns, and expectations about health and illness]

Patient: "My husband has a slipped disc in his lower back and has had the same kind of pain in the past, so I am worried I might have that too."

Provider: "Yes, it certainly has a similar pattern. What concerns you the most?"

Patient: "I am worried it won't go away, and that I'll have to get surgery."

Provider: "I think most people in your situation would be concerned about that. I am so glad that you came in today. We will definitely get to the bottom of this and get you feeling better as soon as possible, and hopefully without needing surgery!" [Understand the Patient's Perspective: Acknowledge and respond to the patient's ideas, feelings, and values]

Patient: "Thank you, that would be amazing."

Provider: "Let me just make sure I've got the story right; please correct me if I am wrong. You have had pain in the lower back on and off for years, usually from overdoing it with exercise, sometimes from stress, but it is usually relieved with Advil or stretching or resting. This pain is a little different in that it started when you were lifting boxes helping your daughter move. You had an immediate back spasm followed by a constant pain that now shoots down the back of your left leg and doesn't go away with Advil, stretching, rest, or heat. It prevents you from exercising and makes it hard to get enough sleep, so you are pretty exhausted. Did I get that right?" [Gather information: Structure, clarify, and summarize information]

Patient: "Yes!"

Provider: "And all of this has led you to feel pretty down, is that right? Shall we talk a little more about that?"

Fast forward to the closing of the visit, after gathering the full history and completing the physical examination: Provider: "So your examination is consistent with what we would call a "herniated disc." I know you said that your husband had a "slipped disc" in the past. What do you understand about a "slipped" or "herniated disc?" [Share information: Check for understanding]

Patient: "I know it has something to do with the nerves from the spine in the lower back."

Provider: "That's exactly right. To understand what a herniated disc is and how it causes symptoms, it's helpful to first learn a little about the back and spine. The back is made up of vertebrae that sit on top of one another like a stack of coins. Each bone has a hole in the center. When stacked, the holes in the bones form a hollow "tube" that protects the spinal cord. The spinal cord is like a highway of nerves that connects the brain to the rest of the body. The spinal cord runs through the tube and nerves branch out from the spinal cord and pass in between each vertebrae to connect to parts of the body. Cartilage discs sit in between each of the vertebrae to add cushioning. Sometimes these discs slip out of position and press on the nerves, causing pain. Sometimes the outer shell of the discs breaks open, spilling the jelly material inside which irritates nearby nerves." [Share information: Use language the patient can understand] "What questions do you have about that?" [Share information: Encourage questions]

Patient: "So did the heavy lifting cause the disc to slip?"

Provider: "Possibly, though many times it can just happen out of the blue."

Patient: "So what is the next step?"

Provider: “The good news is that you don’t have any of the warning signs of something more serious going on, so we don’t need to do any imaging unless the pain doesn’t go away. I also think you have been under-using the ibuprofen, so we have room to go up on the amount and frequency of that. Sometimes patients also benefit from either physical therapy or acupuncture or chiropractic adjustment. What are your thoughts on those options?” [Reach Agreement on Problems and Plans: Encourage the patient to participate in decisions to the extent he or she desires]

Patient: “I would be willing to try some physical therapy. I don’t like the thought of acupuncture and my husband didn’t have a great experience with a chiropractor.”

Provider: “Alright. So, let’s try increasing the ibuprofen to 600 mg four times a day with food to protect your stomach. I will also write you a prescription for physical therapy. I would like to see you back in two weeks to check in on the pain control, but obviously I would want to hear back from you sooner if things get worse.” [Provide Closure: Discuss follow-up] “What questions do you have?” [Share information: Encourage questions]

Patient: “Should I continue to avoid exercising?”

Provider: “Yes. I would hold off on exercise for now but am confident we will be able to get you back to your normal routine soon. What other questions do you have?” [Share information: Encourage questions]

Patient: “No more questions for now. I feel relieved to have a plan.”

Provider: “Me too! I know we have covered a lot of information in the last few minutes. Just so I know that I have been clear, would you mind reviewing what you understand about the problem and the plan going forward?” [Share information: Check for understanding]

Patient: “Well, my pain is being caused by a slipped disc, which is when one of the discs that cushions the back bones of the spine slips and compresses the nerves or when one of them breaks open and the inside spills out and irritates the nerve. It may or may not have been caused by the heavy lifting I was doing helping my daughter move.”

Provider: “Perfect! And what’s the plan?”

Patient: “I don’t need any imaging because I don’t have signs of something more worrisome. So, we are going to increase my ibuprofen to…not sure I remember the dose, but I know I have to take it four times a day? With food so my stomach doesn’t get affected. You are also going to send me to physical therapy.”

Provider: “Great! Yes, 600 mg four times a day with food and physical therapy. And we will see each other in 2 weeks.” [Provide Closure: Summarize and affirm agreement with the plan of action] “Does that plan seem feasible?” [Reach Agreement on Problems and Plans: Check the patient’s willingness and ability to follow the plan]

Patient: “Definitely.”

Provider: “And is there anyone you can enlist to help you remember the medication, get to physical therapy, and do more of your physical tasks for you over the next couple of weeks?” [Reach Agreement on Problems and Plans: Identify and enlist resources and supports]

Patient: “My husband has already been a major help, and I could probably enlist my daughter if I need an extra pair of hands.”

Provider: “Perfect. What else can I help you with today?” [Provide Closure: Ask whether the patient has other issues or concerns]

Patient: “That’s It, Thanks Doc.”

MODELS INCORPORATING THE ESSENTIAL ELEMENTS

Conceptual models describe how to approach patient-provider communication in a relationship-centered way. These models bring the essential elements of communication to life.

The Three-Function Model

In 1991, Dr Steven A. Cohen-Cole shared 3 components of the patient interview, which are of critical importance to a successful outcome of the patient-clinician interaction.[15,16] Two of the 3 functions are the traditional core functions of the patient encounter: gather data to understand the patient's problems and educate and motivate the patient to adhere to treatment. The other function of the interview was novel: develop doctor-patient rapport and appropriately respond to patients' emotions.

Rapport is a close, harmonious relationship in which those involved understand each other's feelings or ideas and communicate well. Empathy is the ability to understand and share the feelings of another. Responding appropriately to patients' emotions builds rapport and often requires empathy to be successful. Dr Cohen-Cole identified 5 verbal interventions that serve as a core set of basic skills for this function of developing rapport and appropriately responding to emotions: reflection, legitimation, supportive comments, partnership, and respect (**Fig. 1**).[17]

The principles of the Three-Function Model permeate the Cleveland Clinic REDE to Communicate and Academy of Communication in Healthcare (ACH) Fundamental Skills: RCC models. REDE (Relationship: Establishment, Development and Engagement) is a conceptual framework for teaching and evaluating RCC.[18] The ACH framework similarly identifies 3 groups of skill sets: the encounter beginning, skills that build trust, and delivering diagnoses and treatment plans.[19] These models are available as educational workshops for skills training.

The Structural Model

In 1996, Dr Robert Smith shared the first of now 4 editions of *Patient-Centered Interviewing: An Evidence-Based Method*.[20] This method delineates an 11-step, evidence-based interviewing method to be done sequentially to incorporate patient-centered techniques into the typical provider-patient interview (**Box 3**).

The Structural + Functional Model

The Brown Interview Checklist adopts many of the same principles and attempts to combine both structural and functional approaches by breaking the interview into 2 different sections, namely, the "Flow of the Interview" (akin to the structural model) and "Interpersonal Skills" (akin to the functional model).[15] The flow of the interview includes the opening of the interview, the exploration of problems (or information gathering), and the closing of the interview. Interpersonal skills include facilitation skills and relationship skills, which include all 5 of Cohen-Coles' rapport-building strategies.

The Calgary-Cambridge Guide, introduced by Kurtz and Silverman in 1996, also combines both structural and functional elements of the medical interview.[21] This approach breaks the interview into 6 different domains: initiating the session, gathering information, building a relationship, providing structure, explanation and planning, and closing the visit, inclusive of 12 major steps or items, each composed of multiple microskills.

Finally, the Four Habits model, another evidence-based approach to medical interviewing, combines structural and functional elements.[22] The first and fourth habits, "Invest in the Beginning" and "Invest in the End," are structural in nature. On the other

Fig. 1. Core skills for building rapport with patients.

hand, the second and the third habits, "Elicit the Patient's Perspective" and "Demonstrate Empathy," are functionally oriented.

DISCUSSION

Along with the burgeoning patient experience movement, the last 3 decades have given rise to clarity and consensus around the importance of health care communication and the centrality of communication to both patient- and relationship-centered care. Studies have demonstrated a direct link between good communication and outcomes for patients, providers, and institutions. Several models have arisen from the consensus of experts to teach knowledge, skills, and attitudes related to patient-provider communication. Some of these models provide a structural roadmap for the patient interview, whereas others emphasize how communication skills serve different functions in the encounter.

The biggest barriers to implementing relationship-centered care are the lack of provider training in communication and providers' concerns about time. Although most health professions schools now incorporate communication skills training, there are still several generations of physicians in practice who have never received such

Box 3
Structural model for patient-provider communication

Step 1: Set the stage for the interview
- Welcome the patient
- Use the patient's name
- Introduce self and identify specific role
- Ensure patient readiness and privacy
- Remove barriers to communication
- Ensure comfort and put the patient at ease

Step 2: Elicit chief concern and set agenda
- Indicate time available
- Forecast what you would like to have happen during the interview
- Obtain list of all issues patient wants to discuss; specific symptoms, requests, expectations, understanding
- Summarize and finalize the agenda; negotiate specifics if too many agenda items

Step 3: Begin the interview with nonfocusing skills that help the patient to express herself/himself
Start with open-ended request/question
Use nonfocusing open-ended skills
Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, accoutrements, environment, self

Step 4: Use focusing skills to elicit 3 things: symptom story, personal context, and emotional context
- Further elicit symptom story. Description of symptoms, using focusing open-ended skills
- Elicit personal context. Broader personal/psychosocial context of symptoms, patient beliefs/attributions, again using focusing open-ended skills
- Elicit emotional context. Use emotion-seeking skills: direct, indirect, or impact such as belief, triggers, self-disclosure, resonate with unexpressed feeling
- Respond to feelings/emotions. Use empathy skills to address the feelings and emotions such as naming, understanding, respecting, and supporting (NURS)
- Expand the story. Continue eliciting further personal and emotional context; address feelings and emotions (NURS)

Step 5: Transition to middle of the interview
- Brief summary
- Check accuracy
- Indicate that both content and style of enquiry will change if the patient is ready. Continue with middle of the interview.

Step 6: Complete the chronologic description of HPI/OAP

Step 7: Past medical history

Step 8: Social history

Step 9: Family history

Step 10: Review of systems. Continue with physical examination.

Step 11: End of the interview

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training. Several organizations, including the Institute for Healthcare Communication, Cleveland Clinic Foundation, and the Academy of Communication in Healthcare, developed training models for providers in practice. Studies have shown that explicit use of empathic statements can actually shorten visits, and many believe the time

gained from anticipating patients' concerns and clarifying misunderstandings around plans more than makes up for any time added by patient-centered skills.[23,24]

SUMMARY

RCC is an effective approach to communicating with patients. Consensus exists regarding the essential elements of communication, and it supports approaching the patient encounter as a set of communication tasks. Building rapport is the most important task. Multiple conceptual models exist, and training in these models can improve a provider's RCC skills.

CLINICS CARE POINTS

- Approach patient communication with the goal of establishing and maintaining a professional relationship.
- Reflect on how you communicate with patients. Do you use the core communication skills, which include empathy, use of open-ended questions, reflective listening, and patient engagement?
- Building rapport is the foundational task of RCC, and it occurs throughout the patient encounter. To build rapport, use the 5 skills that Dr Cohen-Cole delineates.
- Recognize that the conceptual models are not scripts, yet some good habits in communication are worth memorizing.

DISCLOSURE

Drs G. Constant-Peter and R.E. Pearlman are members of the Academy of Communication in Healthcare whose mission is to improve communication and relationships in health care. They are occasionally engaged as consultants and trainers to teach relationship-centered communication.

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