

Kidney News

April 2016 | Vol. 8, Number 4

Empathy and Communication are Critical Skills that Can Improve Care

By Eric Seaborg



During her nephrology fellowship, Jane Schell, MD, was surprised at how unprepared she felt to talk with elderly and very ill patients about their poor prognoses and the probably disturbing trajectory of their diseases.

Her personal discomfort led her into

a research project where she discovered that her sense of a lack of preparedness—leading to a hesitancy to engage—was widely shared even among her older, established colleagues. And patients reported that this failure of communication left them feeling uncertain, confused, and not ready for the challenges they faced.

A regular part of nephrology practice is delivering emotional news and guiding patients as they deal with life-and-death topics like dialysis initiation and withdrawal. Yet nephrologists do not receive education in skills—communication and empathy—that should be considered as important as other aspects of their training, according to Schell, who is now a practicing nephrologist and palliative care physician at the University of Pittsburgh.

“Most physicians are not adequately prepared to have these kinds of conversations with seriously ill patients,” said James A. Tulsky, MD, chair of the de-

partment of psychosocial oncology and palliative care at the Dana-Farber Cancer Institute and a pioneer researcher in clinical empathy and communication. “There is very little in any of their training—whether it is medical school residency or fellowship—that focuses on communication skills in these difficult situations.”

Patient outcomes: for better or worse

This training absence spans most specialties, despite strong evidence that physician empathy and communication improve patient care. A Joint Commission on Accreditation of Healthcare Organizations report found that communication failures were a root cause of more than 70 percent of serious adverse health outcomes in hospitals.

And conversely, studies show a clear association of clinical empathy with better patient outcomes. In two studies of

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Research on Crystal-Induced Cell Death Could Pave Way for New Molecular Targets for Treating Kidney Diseases

By Timothy O'Brien

Crystals play a role in the development and progression of a wide range of diverse diseases, from gout to atherosclerosis to kidney disease. New experimental findings suggest that these crystallopathies may involve a “regulated process” of crystal-induced cell death called necroptosis, according to a report in *Nature Communications*.

The study also clarifies the steps in the pathway leading to necroptosis, suggesting promising new therapeutic targets to limit crystal-induced cytotoxicity and tissue injury. Necroptosis is just one of several recently recognized categories of “necroinflammation”—with distinct molecular pathways—potentially relevant to a wide range of kidney diseases.

Led by Prof. Hans-Joachim Anders of Ludwig-Maximilians-Universitat in Munich, the researchers performed a series of experiments to understand the types and mechanisms of cell death in crystal-induced tissue injury. Various crystallopathies share common features, suggesting a similar underlying pathogenesis. Crystal-induced inflammation has been considered the main mechanism by which cell death occurs.

But recent studies have identified new pathways of “regulated necrosis”—in which cell death results from active processes leading to cell necrosis that, in turn,

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Empathy

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diabetes patients, researchers administered the Jefferson Scale of Empathy to physicians and grouped them according to whether they scored high, medium, or low on empathy skill. The researchers studied diabetes because it has clear patient outcomes that can be tracked in electronic health records.

In a study of 29 family physicians and 891 diabetic patients, the patients of physicians with high empathy scores were significantly more likely to have good control of their hemoglobin A1c and LDL cholesterol compared with patients of physicians with low empathy scores. The second study included more than 240 physicians and examined the incidence of hospitalizations among 20,000 diabetic patients. The rate of hospitalizations due to acute metabolic complications in diabetic patients was much lower for patients of high-empathy physicians compared with patients of low-empathy physicians.

Hands-on training

When nephrologists learn the key skill of putting in lines, they learn through a carefully organized process of observing a senior person, then performing the procedure themselves with an attending hovering over their shoulder and giving them feedback, Tulsky said. “If they have trouble doing it, they wouldn’t hesitate to ask one of their more senior supervisors, ‘How should I do this better?’ That doesn’t happen for communication,” he said. “It is unlikely that before they go in to share news with a patient as a fellow that their seniors will talk to them about it beforehand or that [their attending] will observe them and give feedback.”

A successful program

“People think that there is a hard part and a soft part of medicine, and that communication is the soft, fuzzy part. But effective communication is just as hard as knowing how to remove a gall bladder,” said Nirmal Joshi, MD, chief medical officer of Pinnacle Health System in Harrisburg, PA.

Joshi instituted an empathy and communication training program for physicians at Pinnacle Health because of low patient ratings of doctor-patient communication. His team created a one-hour training exercise that began

with the physicians talking for 10 to 15 minutes to a patient-actor trained on a script and the patient’s “family.” The actors then provided feedback on how well the physician performed on specific measures of communication. The physicians next viewed a 20-minute film on best practices to improve doctor-patient communication.

In addition to this training, Joshi made communication improvement an ongoing part of the hospital’s focus by hiring a coach who periodically sits in on patient encounters and gives real-time advice on how physicians can improve. He hired Stacia Melenchek, M.Ed., to be the physician coach because she had a master’s degree in education but little background in healthcare so would bring a consumer’s perspective to the task.

About 350 physicians have been through the training, and over two years patient satisfaction scores increased a remarkable 40 percentile points. “In some disciplines, the scores are now in the 90th percentile, and in other instances they are between the 50th and the 90th percentile,” Joshi said.

Some of the steps emphasized at Pinnacle seem simple: introducing yourself and explaining your role in the context of all the other providers a patient sees in a hospital, and sitting down rather than towering over the bedside.

But Melenchek also coaches clinicians on making an empathic connection by listening carefully to patients and reading their body language and facial expressions. She emphasizes the importance of noticing when a patient is feeling emotional and overwhelmed, and thus will have a hard time processing the information a clinician is eager to impart. Melenchek also stresses giving medical information in plain English. “I educate them to use a fifth to eighth grade reading level,” she said.

The patients are not the only ones who benefit from improved communication, according to Esther Tucci Thoman, manager of physician training at Pinnacle. The physicians have noticed that if they listen carefully and communicate clearly, not only is the patient more likely to adhere better to the plan of care, but it’s less work for them in the long run because they get fewer calls and questions from nursing later on.

Not easy to learn

Some of these tasks seem so simple that physicians are surprised to learn that

they are not actually performing them, according to Kathryn Pollak, PhD, professor in community and family medicine at Duke University, where she also coaches physicians. She records patient-doctor encounters, and when she plays them back, physicians are surprised at the number of times they miss opportunities to respond empathetically.

Particularly in a specialty like nephrology—in which the news is often laden with heavy emotional content and the patient needs to buy into a treatment plan—physicians need to get away from their prescriptive mode of laying large amounts of information on patients and tailor their approach to the individual.

Nephrologists need to remember that “the information that they are giving is highly emotional for patients,” Schell said. “Giving the diagnosis of kidney disease for us seems like an everyday activity. But for a patient, it means that something has changed. They may be dying. They may not know what to expect.”

Schell compared watching for emotion with looking for other kinds of clinical data like vital signs. “We should be watching how our patients respond, whether it is nonverbal and looking away, whether it is showing shock, or whether they say words that are emotion cues, [such as] ‘I can’t believe this.’ When patients are emotional, cognitive data generally doesn’t go through. Not only do they not hear it, but [we] miss an opportunity to attend to our patients’ emotions so that we help them process the emotion.”

Schell and Tulsky recommend a process they call “ask, tell, ask” for entering into conversations about serious illnesses. “You always need to ask a patient their understanding before giving them information,” Tulsky said, because finding out how much or how little they know should affect what information you give them and how you give it. “You then give information in short bite-size chunks. [It is] very important not to use jargon and not to talk too much. Then the final ‘ask’ is to ask about their understanding of what you just explained.”

Tulsky was one of the founders of a project called VitalTalk, which offers multi-day courses and an online course on communication. Its website offers free “talking maps” for addressing a variety of sensitive subjects as well as videos illustrating how to deal with a

Techniques to start improving communication

A map for conversations on goals of care is called REMAP:

- R** = Reframe. “I think we are in a different place now.”
- E** = Expect emotion. “I can see that this is really hard for you.”
- M** = Map out patient’s goals. “What is most important to you right now?”
- A** = Align with those goals. “I hear what you are saying is these things are most important.”
- P** = Plan treatments. “Based on what you are telling me about what is most important to you, these are the treatments I would recommend.”

A map for responding to emotional concerns is NURSE:

- N** = Name the emotion: “You seem worried.”
- U** = Understand: “I see why you are concerned about this.”
- R** = Respect: “You have shown a lot of strength.”
- S** = Support: “We will get through this together.”
- E** = Explore: “Tell me more.”

variety of patient situations (www.vital-talk.org).

Schell participated in the development of VitalTalk, and led the development of NephroTalk, which began as a half-day workshop and has developed into a three-day workshop held annually in Pittsburgh. Open to fellows across the country, it focuses on communication tools for challenging topics with practice opportunities with simulated patients. (For information: <http://renal-fellow.blogspot.com/2015/11/attend-nephrotalk-2016-to-improve-your.html>) Schell is continuing to develop the curriculum under a grant from ASN.

“Communication is just another procedure you need to learn, and it is just as hard,” according to Duke’s Pollak. “When you first start, you are going to make mistakes. You are going to think, ‘Why have I forgotten how to talk?’ Then it just becomes second nature.” ●

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