Talking with Your Doctor
A Workshop for Patient Groups

Facilitator's Manual

Division of Health Care Communication
informed and shared decision making
www.chd.ubc.ca/DHCC/

Talking with Your Doctor
A Workshop for Patient Groups
Facilitator's Manual

Division of Health Care Communication
College of Health Disciplines
University of British Columbia
#400-2194 Health Sciences Mall
Vancouver, BC Canada V6T 1Z3
Tel 604-822-8002
Fax 604-822-2495
Email isdm.dhcc@ubc.ca
Web http://www.chd.ubc.ca/DHCC

2004, 2007, 2012

TALKING WITH YOUR DOCTOR Manual.docx wg 2012-11-12

Table of Contents

Section

1

1. INTRODUCTION

Welcome to the Talking with your Doctor facilitator's manual! This manual is a resource for community facilitators prepared by the Informed Shared Decision Making (ISDM) project based in the Division of Health Care Communication, College of Health Disciplines at the University of British Columbia. The goal of this project is to improve the communication between health care providers and their clients. Thank-you for becoming part of our team!

Project History

The Informed Shared Decision Making project started in 1996 in the Division of Health Care Communication, College of Health Disciplines at the University of British Columbia. The goal of the project was to investigate and improve communication between healthcare professionals and their clients. Different threads of the project have included developing and conducting workshops for doctors, making changes to the medical school curriculum, and facilitating a program called "Talk to your Doc" that centers around a workshop for high school students by medical students. One aspect of the ISDM project focuses on helping health care clients improve their communication skills, allowing them to make the most out of their visits to the doctor. To achieve this goal a workshop called "Talking with your Doctor" has been developed to target clients who see their doctor on a regular basis. This manual is designed to encourage organizations, community groups and support groups to offer this workshop to their members. We are confident that the workshop can be duplicated by these groups as a adjunct to their present work.

Purpose and Intent

We all have some difficulty communicating with our physicians, but there are things that we can do to make this communication more effective and get the most out of our doctor’s appointments. Informed Shared Decision Making, or ISDM, is a way of thinking about your relationship with your doctor. The ISDM principle encourages doctors and patients alike to recognize their relationship as a partnership, where the responsibility for decision-making is shared equally. The patient should feel confident not only to share concerns and questions with their doctor, but also feel prepared to help direct course of their own care. Evidence shows that patients who take a more active role in their healthcare:

- are more satisfied with the care they receive
- pursue treatment more actively
- get better faster

The goal of this workshop is to help patients become active participants in their care. An active patient asks questions, voices concerns and has opinions about their care which they share with their doctor.

Section

2

2. DOCTOR-PATIENT COMMUNICATION

Over the past few years doctors have begun to understand the need for greater patient involvement in decision-making. Unfortunately the ideal of informed shared decision making can sometimes be difficult to achieve. The following competencies were developed by the informed shared decision making project to help doctors involve patients in decision making and communicate effectively:

- Develop a partnership.
- Establish or review preferences for information. How would the patient like to receive information?
- Establish or review preferences for role in decision making. How would the patient like to make decisions? How much involvement would they like to have in the decisions about their care?
- Ascertain and respond to ideas concerns and expectations. What values does the patient have and how can the doctor accommodate them?
- Identify choices. What are different treatment options?
- Present evidence. What is the current evidence about the risks, effectiveness, etc. of different treatment options?
- Make or negotiate a decision in partnership and resolve conflict.
- Agree on an action plan and complete arrangements for follow-up. What are you (as a team) going to do?

The patient has an equal responsibility to ensure that they communicate effectively and take an active role in their doctor appointments. The following are some of the patient's responsibilities in the doctor-patient relationship:

- Articulate health problems carefully and systematically.
- Ask questions and listen carefully to understand and share relevant information.

- Discuss your ideas and concerns, even if you feel awkward about them.
- Be honest about your emotions, give feedback.
- Work through disagreements
- Agree on an action plan.
- Ask for a brief summary of findings, diagnoses and recommendations.

What is Informed Shared Decision-Making?

Informed shared-decision making is a model of decision-making in the medical encounter that has been increasing advocated as the preferred model for patient and doctor alike. The key characteristics of informed shared decision-making are:

1) ***It takes two (or more) to tango*** … meaning that at least two participants (patient and doctor) are involved. In many patient-doctor interactions there are other people involved as well. For example, many patients bring someone else to their appointments, and they also play a role in decision-making. This person could be:

an information recorder and/or interpreter
a coach – who prompts the patient to ask certain questions
an advisor – gives advice on which course of action the patient should select.
a negotiator – serves as an advocate for the patient
a caretaker – professional or often a spouse.

Often family members take up these roles.

It is also common these days that the treatment decision-making process will involve several doctors. A breast cancer patient, for example, may have a family doctor, surgeon, radiation oncologist, and medical oncologist who are all involved in her care. Often the patient is one of the few communication links between all these different doctors.

2) Both parties share information with each other.

The doctor has information that she must share with patients. She must lay out for the patient different treatment alternatives and their attendant risks. Without such information there might be nothing for the patient to evaluate or talk about. But equally, if not more important is the information the patient shares with their doctor. The patient must communicate clearly

3) Both parties take steps to build a consensus about the preferred treatment.

Through careful discussion and good communication doctor and patient should be able to come to a consensus about the preferred treatment.

4) An agreement is reached on the treatment to implement.
Doctor and patient must negotiate a decision that works for both parties. When both the doctor and the patient have been involved in decision-making the treatment is easier to implement.

Shared decision-making is seen as a way to decrease the inequalities in power and information between doctors and patients by increasing the patients' information, sense of autonomy and/or control over treatment decisions that affect their health and well-being.
Informed Consent

Informed consent is both an ethical and legal right of any patient. It implies at least a minimum of decision-making involvement of the patient because the patient must consent to treatment prior to any intervention. Legally a doctor cannot implement a treatment without first obtaining consent from the patient

Informed Choice

The principle of informed choice states that there shall be full disclosure of treatment alternatives before a patient consents to the proposed course of action. There are many different decision-making contexts and shared decision-making functions more effectively in some contexts than others. For example, a doctor may take a dominant role in emergency treatment decisions whereas for long-term and chronic illnesses doctor and patient can work closely together to develop an optimum treatment solution.

Doctor Knows Best

Older workshop participants will be familiar with the paternalistic model of medical decision-making where the patient takes a rather passive role and the doctor makes the majority of decisions about treatment. In this model the doctor is seen as the expert and the patient as passive and dependent. The patient is expected to follow the "doctor's orders". In our workshops with seniors many made comments about how when they grew up the philosophy was "doctor knows best" and it may take some people a while to change their behaviour from a passive role in the doctor-patient encounter to an active role. You may want to point out to workshop participants that they are the "experts" on their own body. They know what feels normal and healthy for them and what does not. They often know better than their doctor which medications they are taking and their previous medical history. Ultimately the patient knows best how improvements in their health status will affect their personal well-being and about their own personal treatment preferences. Patients may eventually come to see their doctors as a resource for information and will combine that information with their treatment preferences so that they can make their treatment decisions on their own. Some patients may remain uncomfortable with being solely responsible for making treatment decisions and will want their doctor to remain involved. An informed patient may prefer to make the decision herself, to share the decision-making process or to delegate this responsibility to the physician.

Barriers

There are several common barriers that can prevent patients from taking a more active role communicating with their doctors. For example, some patients have concerns about appearing ignorant, foolish, or taking too much of the doctor's time and so they don't ask their doctor any questions. It is important that patients do not let these barriers prevent them from getting information and participating in important decisions about their health. It is the facilitators responsibility to reassure workshop participants that they need not let these barriers stand in their way. Some common barriers are:

Anxiety/intimidation:

> *"Well, you're already in an inferior position … with you sitting down below and they're standing up, looking down at you. You know, that's well, intimidating."* -- Patient

We all agree that doctors can sometimes be intimidating and it often takes a lot of hard work and persistence to learn a new way of relating to your doctor. Workshop participants will need lots of support and reinforcement in order to change their established pattern of communication with their doctor.

Futility – Some patient feel that they are unable to make a difference in the relationship with their doctor. They may feel that communication is solely the doctor's responsibility. In fact, there is plenty of evidence to shows that the patient also the power to improve communication with their doctor.

Time:

> *"You're always feeling that you shouldn't bother them too much. In fact, they have a sign on their door 'only one problem per visit.'"*
> - Patient

Doctor’s appointments seem to be getting shorter and shorter these days and many patients worry that they take up too much of the doctor’s time. Often workshop participants overestimate how long it takes to ask questions and get the answers. In fact, evidence show that doctors appointments for patients that were trained in communication skills were no longer than the appointments for those who weren’t trained in communication skills. Having good communication with your doctor often makes your appointment run more efficiently. A good exercise to do with workshop participants who bring up the issue of time is to ask them how long they thought a segment of the video was. Often they are surprised by your answer.

Rapport/reluctance to bother the doctor – Many patients feel that their relationship with their doctor is already quite good and are reluctant to disturb that relationship by asking questions. They fear that appearing too assertive may jeopardise rapport. You can reassure workshop participants by letting them know that doctors want to hear their questions. Doctors often (erroneously) assume that patients do not want additional information. It is the patient’s responsibility to communicate their need for additional information to their doctor. This helps the doctor to help you.

Language – Language barriers can be significant for some patients. However, it is not just patients who don’t speak English that have this problem. Many patients are intimidated by the medical jargon and don’t ask questions because they don’t want to appear uneducated. Others feel that the doctor doesn’t explain things because they are assuming the patient wouldn’t understand.

Memory – Some patient simply forget to talk about something they wanted to talk about. The solution is simple - write it down!

The P.A.C.E. Framework

The “Talking With Your Doctor” workshop is structured around an easy to remember framework called PACE.

PACE stands for:

P	Presenting detailed information about how you are feeling.
A	Asking questions if desired information is not provided.
C	Checking your understanding of information that is given to you.
E	Expressing any concerns about the recommended treatment.

The PACE framework was developed by Dr. Donald Cegala as an easy way for patients to ensure they are taking their share of the responsibility for good communication in the doctor-patient relationship. Dr. Cegala evaluated the effectiveness of the PACE strategies and found that they helped patients become better communicators. A copy of the PACE booklet is given to every participant in the “Talking With Your Doctor” workshop. The booklet can be reviewed at home and/or taken to doctors’ appointments for review in the waiting room. The booklet allows patients to think about their condition, their reasons for booking an appointment and the objectives they want to achieve in the appointment before they actually go to the appointment. Facilitators may want to suggest to the workshop participants that they share the information with their spouse and friends. They may even want to discuss the PACE booklet with their doctor in order to open up the lines of communication.

Presenting Information

The information the patient gives to the doctor about their symptoms, lifestyle, values and family history provide the basis from which doctors must make their diagnosis and recommend treatment options.

Asking Questions

Patients typically don’t ask their doctors very many questions, even though virtually all patients claim they want as much information as possible. Patients can ask questions, not only to solicit information from their doctor but also to get their doctor to do something for them. For example, a patient may ask “What are the side effects of this medication?” or they may ask “Could you refer me to a specialist?”
Three questions that have been shown to promote shared decision making about medical treatment are:
“What are my options and what will happen if I do nothing?”
“What are the benefits and harms?”
“How likely are these?”

Checking Information

It is important that patients verify the information their doctors give them. They can do this by asking for clarification (e.g. Did you mean I should take only half a tablet a day?), by requests for repetition of information (e.g. Please tell me the name of that test again), or by summarizing what the doctor has said.

Expressing Concerns

Sometimes patients may have concerns or fears about a particular treatment. It is important that patients be honest with their doctor about any concerns they have. With any condition there are usually many different treatment options. By expressing your concerns you can work with your doctor to find the treatment that best meets your needs.

Patients that have been trained to use the PACE communication skills are better at remembering the treatment information and generally comply with the treatment because they felt involved in the decision-making about their care.

References:

Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). *Social Science and Medicine* 1997; 44: 681-692.

Towle, A., Godolphin, W. Framework for teaching and learning informed shared decision making. *British Medical Journal* 1999; 319: 766-69.

Towle A, Godolphin W, Manklow J, Wiesinger H. 2003. Patient perceptions that limit a community-based intervention to promote participation. *Patient Education and Counseling* 2003; 50: 1-3.

Godolphin W. The role of risk communication in shared decision-making. First let's get to choices. *British Medical Journal* 2003; 327: 692-693.

McGee DS, Cegala D. Patient communication skills training for improved communication in the primary care medical consultation. *Journal of Applied Communication Research* 1998; 26: 412-430.

Cegala DJ, McClure L, Marinelli TM, Post DM. The effect of communication skills training on patients' participation during medical interviews. *Patient Education and Counseling* 2000; 41: 209-222.

Cegala DJ. A study of doctor's and patient's communication during a primary care consultation: Implications for communication training. *Journal of Health Communication* 1997; 2: 169-194

Shepherd HL et al. Three questions that patients can ask to improve the quality of information physicians give about treatment option: A cross-over trial. *Patient Education and Counseling* 2011; 84: 379-385.

Section

3

3. FACILITATION

Being a facilitator can be both difficult and rewarding. It is our hope that this section will provide you with some tools to make this role as gratifying as possible. Remember that the advice given here is not written in stone. Each facilitator will develop their own particular style that works for them.

Roles and Responsibilities of the Facilitator

Your role as a facilitator is to:
- Schedule and set-up for the workshop
- Welcome participants and introduce the workshop
- Introduce the PACE framework
- Facilitate the group discussion between the video clips
- Maintain a good working relationship between participants
- Review and wrap-up of the workshop

HELP participants try out new approaches to the physician-patient relationship.
CREATE an atmosphere of teamwork and problem solving.
FOCUS and refocus groups on the PACE framework.
USE the video and booklet as a resource.
EXPLORE other ways to put PACE into practice (e.g., different ways to build a partnership). There is no single correct way to communicate with your doctor.
A good facilitator **LISTENS** and **STEERS.**

At different points in the workshop the facilitator will make possible constructive discussion on what it is like to give and receive information, to articulate wants and needs, and to be assertive. A good facilitator does not do all the talking. Their role is to listen and steer, and keep the discussion focused.

The following are qualities that make a good workshop facilitator:

- various experiences being a group participant
- understanding of group dynamics and conflict resolution
- flexible attitude
- accepting of diverse perspectives
- enthusiasm for the project
- a willingness to help people with their communication

Facilitating a workshop is not just something you do for others but an opportunity to develop new skills and promote your own personal development. Workshop facilitators will get plenty of opportunity to develop their own competencies with the PACE framework. Communication is very much a “learn by doing” process and the more you get practice with the PACE skills you are more likely you will make use of them with your doctor.

We hope that those using this manual will be creative and adapt this workshop to the needs of their own organizations.

Facilitation Skills

One of your primary responsibilities as a workshop facilitator is to lead and guide the group in a discussion. The following are some things to think about when facilitating a group discussion:

- Be a good listener – Concentrate on what participants say, not on what you want them to say.
- Ask them to elaborate, clarify, expand, and explain. Ask for examples.
- Ask participants to support their opinions. Get at the reasons “WHY?”
- Use open-ended questions. Stay away from questions that can be answered “yes” or “no”.
- Rephrase your own questions. If participants struggle with your first question simply rephrase it and try again.
- Pause, give participants enough time to gather their thoughts and form a response. 5-10 seconds is a good pause. This will seem awkward at first and may require practice.
- Paraphrase or summarize what participants say. This shows you are listening and checks your understanding of what participants are trying to communicate.
- Be accepting rather than judgmental or evaluative.
- Encourage and recognize students’ contributions and watch body language for non-verbal cues that a quiet person has something to say.

- Test consensus. Does everyone agree?
- Play devil's advocate.
- Provide a summary or conclusion.
- Create an expectation of participation. Create a relaxed, comfortable atmosphere. Arrange seats so everyone can see each other. Make yourself part of the group; don't sit behind a desk or away from the participants. This may be hard in large groups.
- Be patient. Sometimes it takes a while for people to open up.
- Help participants get to know each other if they don't know each other already.
- Avoid always looking directly at the person speaking or they will talk to you rather than to the whole group.
- Control excessive talkers. Avoid any urge to call on them first, solicit responses from those who haven't participated yet. If all else fails you may want to consider approaching an excessive talker during a break and asking for their cooperation in allowing others to participate.
- Be sensitive to everyone's feelings. Do not let people verbally attack one another or yourself.
- Challenge the participants but do not threaten them. Try not to question one participant for too long.
- Show enthusiasm. Believe in what you are doing!

Ground Rules

Depending on the size and composition of your group you may want to consider laying "ground rules" that can serve as guidelines for how group members should behave with each other and the facilitator. Here is a sample set of ground rules. You may want to discuss the ground rules with the group and have them pick out those they feel are most important or you may want to post the ground rules on the wall and refer to them as necessary.

- When someone has the floor do not interrupt, allow them to finish speaking.
- Be respectful of others opinions.
- Acknowledge other ideas.
- Ask questions to clarify important points.
- Return from breaks on time.
- Give everyone the chance to participate – do not dominate the discussion.
- Stay on topic.
- Do not have side conversations when others are speaking.
- Use positive language

- Do not “doctor bash.”

You and your group may be able to think of other important ground rules.

Elements of a Workshop

The following represent some of the elements of a successful WORKSHOP. Although not all these elements are present in every workshop each contributes an important part to the effectiveness of the workshop goals. Please feel free to omit or shift the emphasis of one or more of these elements to suit your own style and objectives with a particular group.

PRE-ASSESSMENT
Facilitators must do a pre-assessment of their audience in order to target the workshop to their needs. The pre-assessment is meant to identify participants’ pre-existing knowledge, identify special needs of this particular group as well as to choose appropriate scenarios for discussion.

BRIDGE or HOOK
The bridge or hook is intended to get the audience’s attention. It provides them with a reason to be interested in the subject and motivates them to pay attention to the information they are being presented.

LEARNING OBJECTIVE
The learning objective(s) provides the participants with a goal, something they should be able to do by the end of the workshop. It also helps to focus the discussion. Some facilitators are very explicit about the workshop objectives while others let the objectives stem from the content of the workshop.

DISCUSSION START
This is a catalyst for starting your discussion.

MAINTAINING THE DISCUSSION
What are the tools for keeping the discussion moving should things starts to slow down?

TROUBLE SHOOTING

DISCUSSION END or CLOSING REMARKS
This is a closing summary of what happened during the course of the workshop. It provides closure and may also provide additional food for thought for the participants.

Pre-assessment

The acronym A.U.D.I.E.N.C.E. can be useful for performing a pre-assessment of your workshop participants.

A nalysis – Who are they? How many of them are there? Will you break them into groups? What size of groups is appropriate?

U nderstanding – What is their knowledge of the subject? How will I best prepare them for discussion? Are they comfortable participating in a discussion?

D emographics – What are their ages and genders? What are their cultural, academic, and educational backgrounds?

I nterest – Why are they there? Is this workshop of short term or long term interest to them? Do they have a specific problem with their doctor or are they there to improve their communication skills more generally?

E nvironment – Where will the workshop be held? How will I set up the room? Is there audio visual equipment available? Will everyone be able to see and hear the video?

N eeds – What are their needs? What are my needs as the facilitator?

C ustomized – How can I prepare a discussion that is specific to this set of learners? Which video is most appropriate for the group? Are their communication difficulties that are specific to them? For example, stroke patients often have problems with aphasia, a decrease in the ability to use language to express thoughts and feelings. This can create special communication challenges for stroke patients.

E xpectations – What are they here to learn? What do they expect from me, the workshop, themselves and each other?

Bridge or Hook

The bridge or hook is what gets the attention of your audience and encourages them to remain engaged with the workshop. Here are some ways to hook your audience:

- Use the workshop outline or objectives.
- Use a quote or an anecdote.
- Put a new twist in the familiar; take a common saying and change it. For example, you could use the saying “doctor knows best.”
- Start with a personal stories and communicating with your own doctor.
- Use an ice breaker
- Use the ISDM posters
- Show an object or image. Maybe you have a good cartoon about communicating with your doctor.
- Other ideas??

The bridge or hook should be kept short and not take up too much time. It can be very explicit or more subtle. It can be as formal as a planned activity or it can be as informal as a welcome.

Learning Objectives

Learning objectives can be useful for both the workshop facilitator and the workshop participants. The facilitator can use the learning objectives to tailor their materials and focus the discussion. Participants have a better idea of what will be covered in the workshop and what they will get out of it. They can also help if you want to evaluate the success of your workshop –you can just ask, did we meet the objectives?

Here are some learning objectives for this workshop. By the end of the workshop participants should:

- Feel more confident communicating with their doctor.
- Be able to recognize and distinguish between good and bad doctor-patient communication.
- Know several specific techniques for improving communication with their doctor (the P.A.C.E. framework).
- Understand the benefits of taking a more active role in improving doctor-patient communication.

Discussion Start

In this workshop the video serves as a catalyst for starting a discussion about doctor-patient communication. Each video is divided into four segments. In each segment one or more specific communication skills are demonstrated. Your job as a facilitator is to encourage participants to participate in the discussion of each segment. Often simply asking the audience “what happened?” is enough to get the discussion started. Other times you may need or want to try something different. Here are some suggestions of other things you could try. Some work better with certain video segments than others.

- Strongly worded statement. Use a provocative or even inflammatory statement to provoke discussion and challenge assumptions. For example, you could say “all doctors are bad communicators” and see how the audience reacts. You must be certain that the audience isn’t going to think this is actually your opinion.
- Turn to your neighbour. Have participants turn to their neighbour and discuss what communication skills they see demonstrated in the segment or have them discuss what they would do if faced with a similar problem.
- Tales from the trenches. Ask the audience if they have ever been in a similar situation and, if so, what they did.
- Put yourself in the patient’s place. Ask the audience if they could do what the patient in the video is doing? If not, what else could they do to solve the conflict?

Maintaining Discussion

Once your discussion is underway you are usually home free but occasionally everybody will stop talking at once and you must step in to remedy the situation. The best way to do this is to ask a question. There are many different types of questions you might ask. Here are some for you to consider:

- Questions that ask for more evidence
- Questions that ask for clarification
- Open questions
- Linking or extension questions
- Hypothetical questions
- Cause-and-effect questions
- Summary an synthesis questions

Trouble Shooting

There are four common problems that tend to be specific to this workshop. It is likely that at least one of them will come up in any given workshop. They are:

Irrelevant Remarks

It is not uncommon to hear some irrelevant or unproductive comments during the course of a workshop. Sometimes they can throw you off a little, but if you are prepared you can find ways to put the discussion back on track. Here are a few that we've had over the years:
"That doctor's skirt is too short" (referring to the doctor in the video).
"If I was that doctor I'd just walk out of the office if a patient spoke to me like that."

Doctor Bashing:

Sometimes the discussion can revert to doctor bashing. Although sometimes patients need an opportunity to blow off steam it is important not to let doctor bashing take over the thrust of the workshop. In addition, it can sometimes be hard to get workshop participants to focus on what they can do to improve the communication with *this* doctor. Often people will say "I'd just find a new doctor." While sometimes this can be an appropriate solution it does not help patients to take more responsibility for developing their conflict resolution and communication skills.

Powerlessness:

Many patients feel a sense of powerlessness when it comes to improving communication with their doctor. They may feel that they have no control over the relationship with their doctor or they may think it is solely the doctor's responsibility. The Facilitator needs to work at helping the workshop participants believe that they have the power to make a change.

Moving Beyond "I have a great relationship with my doctor":

In any given workshop there will always be a few people who insist they already have a great relationship with their doctor. Often when these people are probed with questions about their communication with their doctor it becomes apparent that there is still a lot of improvement that could occur.

End

You want to finish the workshop by giving participants a sense of accomplishment and closure. This can be as simple as a few closing remarks, or depending on time constraints, could be more of an organized activity.

Have participants write briefly about how their thinking about doctor-patient communication has changed as a result of the video/discussion.
Return to your objectives and see if you met them.
Draw some conclusions.

Section

4

4. THE WORKSHOP

Workshops run smoothly when the logistics are taken care of beforehand. Make sure you know how many participants will be at the workshop. You may want to adjust certain aspects of the workshop depending on the number of participants. For example, role playing generally works better in smaller groups. Some groups may appreciate having a break in the middle of the workshop to stretch and socialize. Below is a generic workshop outline that you can modify to suit your own needs and style.

Facilitators may want to consider charging a fee to give the workshop. Often, charging a fee will make people value the information you are presenting. However, too high a fee may prevent those with limited financial resources from participating. Some facilitators may ask for small honoraria in exchange for giving the workshop.

Workshop Outline

Talking With Your Doctor Workshop

Where: ___________________________________
Date: _____________________________________
Facilitator: ________________________________
Assistance:________________________________

Materials:

Posters of ISDM and PACE
Cegala PACE booklets (one for each participant)
Feedback/evaluation forms
Box or tray to collect them in
Paper & pencils
Clip boards
Name tags & fat pens
Flip chart & masking tape
Check timing
Check refreshments
Check number of participants

Introduction: (15 min)

Introduction of project:
UBC Division of Health Care Communication
Informed Shared Decision-Making Project
Grant support by Vancouver Foundation.

Introduction of selves:
Hook or bridge: Example: “What do you expect when you go to see your doctor?” (Presenter & Facilitator demonstrate, one good e.g., “I’m Marion and when I go to see my doctor I expect that we will always begin with an update on my family - he always wants to know what the kids are doing.”; one bad e.g., “I’m Sheila and I expect that I will be in the waiting room for at least half an hour past my appointment time and my doctor will seem really rushed and tired”)

Check if participants know each other: turn to a neighbour and introduce selves. Participants share with whole group: e.g., “I’m Joe Bloggs and my doctor likes to talk about hockey.”

Refer to ISDM poster - rationale. Role of patient in the changing the world of medicine

Refer to PACE poster - (generic) skills for patients have been shown to work. Use as framework for this workshop. Purpose of the workshop is to demonstrate skills and discuss how you might put them into practice in your own interviews with doctors or other health professionals.

Outline of the workshop:

- show a scenario of doctor, client and caregiver in 4 parts;
- stop for discussion of what happened and how it might be different after each part;
- work together to try out new ways of communicating;
- receive a booklet that will help you to remember and practice;
- feedback & evaluation;
- tea and biscuits (depending on the time of the workshop).

<u>Part 1</u> (2 min video clip)   10 min

Explain what to watch for before playing the video - communications skills, e.g., “P” of PACE Presenting/Planning.

Discussion - focus on skills they saw demonstrated. What’s the starting point (reason for visit)? Patient gives detailed information about what has happened and has records.
“So far, so good . . . let’s see what happens next.”

<u>Part 2</u> (2 min)   15 min

Discussion - What is the underlying conflict that arises? What is important to the characters?

What could you do if you were NOT like this patient (i.e. persistent)? - e.g., write down beforehand what you want so you’re clear about needs.

Write down dialogue for the doctor and patient. Give out paper and pencils. Ask participants to work in pairs. Allow a few minutes. The facilitator should circulate and check on the pairs to see how they are doing. Prompt them with questions, give them ideas for conflict resolution, and remind them of the PACE framework. Ask people to read out scripts developed by the pairs and use their comments to relate to PACE items, etc. This would also be the point where participants could try role playing.
“So those are your ideas, now let’s see what happened.”

Part 3 (2 min)   10 min

“What is the resolution? Where do you go from here?”
Focus on what patient did - Expressing concerns, asking questions (what are the possibilities for partnership and sharing?). The discussion may tend to focus on what the doctor *should* have done and may degenerate into *doctor bashing*. Always bring them back to think what the patient might do.

Part 4 (2 min)   10 min

Outcomes were good for both – a working plan to build on for the future.
Techniques to resolve conflict – both needs are met.
Note the “C” of PACE – checking of understanding and plan.

Discussion - difficulties of putting it into practice   10 min

Many patients have problems in changing the relationship with their doctor. It will take time and practice. Refocus on PACE as specific skills.
How might you go about putting the skills into practice?
Problems you might anticipate?

Closure - 15 min

Get some feedback from participants – pass out evaluation forms
Ask for written dialogues proposed for Part 3 (anonymous)
Close session with handout of PACE booklet – ***in exchange for completed evaluation forms*** – which has further ideas to take home and read.

Thank you to ...

End

Section

5

5. THE VIDEOS

A series of scenarios have been developed to illustrate common communication problems in the doctor-patient encounter. Some of these have been made into videos. In the videos patients use the PACE framework to resolve communication problems. All steps of PACE are demonstrated. The videos are short (about 5 minutes) and have pauses for discussion after each scene. It is important to tell the participants that they will discuss the video.

As a facilitator you may find that it is difficult to get the participants to focus on what the patient might do rather than what they wish the doctor would do. Try to re-focus the discussion back on techniques the patient can use. As patients we need to focus on our capacity to be active rather than on what we wish from our doctor. Workshop participants may find some of the scenarios difficult but it is important to stress that the situation is not hopeless and that there are many ways that *they* can affect a change.

There is a point in each scenario where conflict arises. Stop the video at this point and have participants brainstorm ideas for what the patient might do to resolve the conflict. You may ask participants to work in pairs before opening the discussion to all. Some facilitators have participants try to create a script for the rest of the encounter. This would also be a good point to try some role playing exercises. Some groups may want to role play some scenarios and rehearse different communication strategies while other groups may be more reluctant to do so. Role playing often works best in smaller groups.

If your group is going to try role playing let the role players know that they can take a timeout and ask for help from the group if they encounter a difficulty. It is also a good idea to have participants take turns playing the doctor and patient. Role playing can help participants understand the other side and treat communication as a process that involves two viewpoints coming together.

Video 1: Scenario for SENIORS

Characters:

Peter Johnson – Asthmatic for many years.
Dr Joan Olsen – Peter's family doctor.
Dr Fisher – Joan's locum while she was on holiday.

Overview:

Joan has been Peter's family doctor for many years. She has just returned from holidays to discover that Peter has scheduled an appointment a few week earlier than she would normally she him. Peter has asthma and about three week earlier one of his good friends died of a heart attack. Peter was responsible for making many of the funeral arrangement and was under considerable stress. During this period Peter had several severe asthma attacks and went to visit Dr Fisher, Joan's locum while she was on holiday.

Peter was very pleased with what Dr Fisher had to tell him about his asthma attacks and he relays this to Dr Joan in their appointment. Dr Fisher had suggested to Peter that he take a yoga class and work on some breathing exercises to help improve his asthma. Dr Joan is doubtful that this would have any effect on his asthma and is concerned that he should get some tests done and perhaps be referred to a specialist. Peter is excited about finding a yoga class and hopes that Joan will help him find one that is suitable.

The Scenario:

Stage 1: Beginning and Set-Up
(**P**resenting the information)

Peter apologizes to Joan for having to bring up some bad news when she is just back from a vacation. He relays to her that his close friend passed away and gives detailed information about the type of stress he was under during this period and how his asthma attacks seemed to be getting worse. He describes in detail when the attacks happened, what the attacks were like and how they differed from his normal attacks.

He tells her that the severity of these attacks prompted him to go see her locum Dr Fisher. "What a bright young man!"

Stage 2: Getting Information
(**A**sking, **E**xpressing)

Peter expresses to Joan what it was he liked about Dr Fisher and his advice. He elaborates for Joan telling her that Dr Fisher thought the attacks were stress attacks and that relaxation and breathing exercises may help.

Stage 3: Impasse
(**E**xpressing Concerns)

Peter has expressed his desire to do the yoga but Joan feels she must warn him the he has 'had asthma for a long time and it's just not going to go away – it just won't!'

Stage 4: Resolution
(**C**hecking Information, **E**xpressing Concerns)

Peter responds to Joan by working towards a compromise. He agrees to take the tests that Joan recommends but is persistent with her about his desire to enroll in a yoga class. "You know Joan, it would really be important to me, and helpful if you could support me in getting into some sort of yoga .. meditation .. breathing exercise class. Would you help me find one?" Joan agrees to help.

Transcript of Peter & Dr Joan:

Stage 1:

Dr Joan: Hi Peter.

Peter: Hi Joan. How nice to see you.

Dr Joan: Same here.

Peter: How was your holiday?

Dr Joan: Oh it was wonderful.

Peter: Glad to hear.

Dr Joan: You know, on the beach, sunny. It was really relaxing. Wasn't long enough but …

Peter: Oh good for you. Well, I'm sorry to have to come in with some bad news when you're feeling so rested.

Dr Joan: I noticed you're in here a couple of weeks early. What brings you in?

Peter: Well, you know I've talked about my really good friend John Abbott, [**Dr Joan:** Yes] well, about three weeks ago he had a massive heart attack and he suddenly died.

Dr Joan: Oh, how awful for you.

Peter: Oh Joan, I'm just devastated with that. [**Dr Joan:** I can imagine] He was a widower like myself, he had no family nearby, so I ended making all the funeral and even giving the eulogy.

Dr Joan: That's hard.

Peter: It is. You know it think I'm still in shock.

Dr Joan: I believe that.

Peter: But you know the worst is still to come. About a day after the funeral I had an asthma attack from hell.

Dr Joan: What happened? Tell me about it.

Peter: You know when I usually have an attack I get short of breath and I perspire. But this time it was really different and much, much worse. I got icy cold, my heart started to race, I got lightheaded. But worst of all I started to shake uncontrollably. My arms and hands, I couldn't stop them. I had to get down on my knees and push my arms against the coffee table to stop them so I could get the puffer out of my pocket and into my mouth.

Dr Joan: Now you've been taking your medication [**Peter:** Yes] like I prescribed.

Peter: Yah, yah. But you know I thought that was it – that this would have been a fluke – it couldn't happen again. Wouldn't you know, about two or three days later it happened again.

Dr Joan: That's really close.

Peter: Just as bad. And I really got just so scared and just exhausted and that's when I decided to see your locum, Dr Fisher. What a bright young man!

PAUSE: Discussion

QUESTIONS:

NOTES

Stage 2:

Peter: ... that's when I decided to see Dr Fisher your locum, Dr Fisher. What a bright young man! I'm so impressed what with what he had to say about my attacks.

Dr Joan: So you liked him did you?

Peter: Oh, I really did Joan. You know, he reassured me first of all that what I had done to cope with those attacks was to the right thing … taking the puffer and the Tylenol.

Dr Joan: Well, he's written something on the chart here but it just looks like a lot of chicken scratch to me.

Peter: I'm sorry. Well maybe I better elaborate for you because I really want to tell you what he had to say. After he reassured me what he did was he explained what those attacks were. They weren't just regular asthma attacks, they were stress attacks.

Dr Joan: Well, you know Peter you've been under a lot of stress before and you've never had any attacks.

Peter: I know but I think John's death was much worse than I've ever had to cope with.

Dr Joan: Well, we might just have to reassess your medication, and possibly do some blood tests, and maybe refer you on to the physiotherapist.

Peter: Well, I'm certainly willing to do that. But what he explained was that the stress that I was dealing with probably caused some bad habits in my body, for example, my throat probably got more constricted….

Dr Joan: Peter, we've been dealing with your asthma very well for a number of years now.

Peter: I know but you know even my bladder went into spasm. And he said that was probably due to the stress.

Dr Joan: Well, we should probably refer you on to a urologist and get that checked out as well.

Peter: Well, you know I had a third bad attack a couple of days ago and that's why I decided to see you early. I knew you were coming back.

Dr Joan: Was that one different?

Peter: It was just as bad as the first two. And I'm really … I'm really excited about what Dr Fisher had to say about those attacks and how to deal with . . .

Dr Joan: What exactly did he have to say?

Peter: Well he recommended that I get into a yoga class and learn to do the exercises. [**Dr Joan:** Hmm, interesting], relaxation and meditation exercises. And I'd like your help finding a class for me. Would you be willing to do that?

PAUSE: Discussion

QUESTIONS:

NOTES:

Stage 3:

Peter: You know Joan, I'm really excited by what Dr Fisher suggested I do, to get into the yoga class and get the breathing and meditation exercises and I'd really like your help finding such a class. Would you be willing?

Dr Joan: Peter I really don't know anything about this type of therapy. However, if you want to pursue the yoga and the breathing exercises by all means go right ahead. However,
I need to warn you, you've had asthma for a long time and it's just not going to go away – it just won't!

PAUSE: Discussion

QUESTIONS:

NOTES:

Stage 4:

Dr Joan: ... you've had asthma for a long time and it's just not going to go away – it just won't!

Peter: Well Joan, I understand that and I'm certainly willing to go ahead with the tests and the referrals that you're suggesting. But I'd really like to get clear in my mind exactly what you like me to do at this point.

Dr Joan: Well, I'd like to order some more blood tests, a complete blood work-up, a chest x-ray and a referral to an urologist.

Peter: Okay, that makes sense to me [**Dr Joan:** Oh good] I'll certainly go ahead with that. But you know Joan, it would really be important to me, and helpful if you could support me in getting into some sort of yoga .. meditation .. breathing exercise class. Would you help me find one?

Dr Joan: Well Peter, what I could do is contact Dr Fisher and we could share the information and then have a plan.

Peter: Oh, that would really be great. Thank-you Joan.

END: Discussion

QUESTIONS:

NOTES:

Video 2: Scenario for STROKE SURVIVORS

Characters:

Bill Thomas – had a stroke 8 months ago
Lillian Thomas – Bill's wife and caregiver
Dr Andy Stewart – Bill's Family Practitioner

Overview:

Lillian and Bill are visiting Bill's Family Practitioner, Dr Andy Stewart, for a routine check-up. Eight months ago, Bill had a stroke, and shortly thereafter starting taking Captopril, an ACE Inhibitor to help control Bill's blood pressure (BP), which was at 170/110 in the days after the stroke.

At Bill's 6-month check-up 2 months ago with the cardiologist, Dr Phillips, everyone agreed that Bill had made great strides in his recovery and was doing very well, but both Bill and Lillian expressed some concern about Bill's BP, which by that point had decreased and stabilized at 140/90. Although Dr Phillips thought the BP level was within the recommended guidelines, he wanted to decrease the level further and prescribed a diuretic, hydrochlorothiazide ("water pill"). Bill has been taking the medication as directed.

Since the new medication, Lillian has noticed that Bill has stopped improving and seems to be regressing. Both seem to think that this is just the final affects the stroke. Bill is very concerned with his BP level, and will resist any changes that may increase his BP and, in his opinion, the risk of another stroke.

The Scenario:

Stage 1: Beginning and Set-Up
(**P**resenting the information)

Lillian and Bill quickly review the records they've been keeping which they would like to explore during today's check-up with Dr Stewart. Lillian wonders if the dizzy spells are relevant.

In the days after stroke his BP was 170/110 and Dr Stewart prescribed Captopril. A month ago they had a visit with the cardiologist, Dr. Phillips. Bill's BP was 140/90, but they were still anxious about this and he prescribed a diuretic.

The nurse just took Bill`s BP a few minutes ago and it's 120/80 – very good level.

Dr. Stewart enters and reviews Bill's history and Lillian's BP journal. Lillian and Bill recount what's happened in the last month, noting the excellent BP and also mentioning the dizzy spells. In her journal entries she has also noted that Bill has no energy and takes several naps each day, he's reluctant to go for their daily walks, he has become fuzzy-headed and forgetful at times as well as the minor dizzy spells.

Stage 2: Getting Information
(**A**sking questions)

Lillian asks about Dr. Stewart`s concern about the dizzy spells and offers her theory that they are just something that goes with the stroke. But she questions the idea of that his current symptoms are side effects of the water pill. And she expresses great concern that at the idea of stopping the medication since it was prescribed by Dr. Phillips and the BP is quite low.

(Checking the Information)

Stage 3: Impasse
(**E**xpressing concerns - **A**sking)

Bill speaks up and says he doesn't want his BP to increase, he's happy with where it is. Dr Stewart minimizes Bill's concerns and says if Bill's BP increases a bit, it's no problem, he's still well within the current guidelines. Dr Stewart cautions the couple, however, that Bill's current symptoms may not be side effects of the medication but could in fact be the end result of the stroke. Lillian asks what will happen if they do stop the water pill and what will happen if they don`t.
Lillian asks if they could do an experiment.

Stage 4: Resolution
(**C**hecking Information, **E**xpressing Concerns)

Dr Stewart suggests a compromise: 1)Stop taking the water pill for just 2 weeks and see if the symptoms go away; Lillian checks in with Bill, and he's now satisfied (to Lillian: "Write that down."). Lillian runs over what they're supposed to do one last time, and they agree to make another appointment for 2 weeks hence.

Transcript of Bill & Lill and Dr Stewart:

Stage 1:

Lill: Okay, hon', Dr Stewart is going see us in a couple of minutes. I'm going to show him the records we've been keeping for your blood pressure. Do you think we should mention the dizziness?

Bill: (shakes his head) O-kay.

Dr Stewart (enters): Hi, Lill. Hi, Bill. How are you doing?

Bill: Fine.

Dr Stewart: So, what can I do for you today? You're looking good, Bill.

Bill: Thanks.

Lill: Well, Dr Phillips said we should come in to see you to make sure the meds are working. I've been monitoring Bill's blood pressure every day *(she hands the BP journal to Dr Stewart)* and it's gone down a lot. So I think things are going pretty well. I mean, Bill has had a couple of bouts of dizziness on our walks, but nothing too serious, and that's probably just the way it's going be now. You can see where I marked it down there in the journal.

Dr Stewart: Great. What medication are you talking about? You're still taking the Captopril, aren't you?

Bill: Yes.

Lill: Dr Phillips thought a water pill would help bring down Bill's blood pressure more when we saw him last month, and that's why we're here, just to check in and make sure everything's ok.

Dr Stewart (looking through the journal): Well, you've done a great job keeping track of the blood pressure…

PAUSE: Discussion around the importance of preparing for the doctor's appointment.

QUESTIONS:
What PACE skills did Bill and Lill demonstrate?

NOTES:

Stage 2:

Dr Stewart: ... well, you’ve done a great job keeping track of the blood pressure, but I’m a little concerned about these other symptoms you’ve noted here. It looks like you’ve been having a few dizzy episodes, Bill, and here’s something about fuzzy-headedness, and being tired. It looks like these problems have been happening quite a bit. Is that true?

Bill: Yes.

Dr Stewart: Have you found these symptoms interfering with your day-to-day life?

Lill: I think it’s just something we have to get used to.

Dr Stewart: Well, I’m not sure that’s true, Lill. Do these symptoms seem to have gotten worse over the last month?

Lill: Well, um, Bill, what do you think?

Bill: Hmm, may-be.

Lill: Yes, it’s possible that they’ve increased over the last month. Why?

Dr Stewart: The symptoms you’ve noted down here can be side effects of combining a diuretic – your water pill – with the other drug I prescribed right after you had your stroke, Bill. You started feeling these symptoms more acutely after starting the water pill, and I think these are just side effects.

Lill: You mean Bill’s dizziness and being tired all the time could just be side effects?

Dr Stewart: Absolutely. This water pill is completely unnecessary, and I think you should stop taking it as soon as possible.

Lill: But Dr Phillips said…! (She slices one hand edgewise into the palm of the other.)

PAUSE: Discussion around confronting your FP, and other possible things Lill could have said or should say next.

QUESTIONS:
What is the conflict that has occurred? Why did it occur?
Who is involved in the conflict but not present?
What PACE strategies could Lill use? What would you do if you had this conflict? Have any of you had a similar conflict with you doctor before?

NOTES:

Stage 3:

Lill: ... but Dr Phillips said Bill had to take the water pill to decrease his blood pressure, and it's been doing a great job.

Dr Stewart (surprised): I thought you'd want to stop taking the water pill. Dr Phillips is a great doctor, but he's just concerned about your blood pressure and your heart; I'm concerned with the whole picture of Bill's health. If you're having these types of side effects, that doesn't do much for Bill's quality of life, does it?

Lill: What would happen if Bill stopped taking the water pill? Would it be dangerous?

Dr Stewart: Not at all, Bill's blood pressure would go up a bit, but it'd still be well within recommended guidelines. We'd have to keep a close watch on it, of course.

Bill: No.

Lill: What, Bill?

Bill: Don't want it up. Scared ... No stroke!

Lill: You can see what we think of the idea. Bill's blood pressure is at a really good level. Why would we want it to go up and risk him having another stroke?

Dr Stewart: I think Dr Phillips asked you to make sure you came in for a check up for exactly this reason – if you're experiencing these side effects, we need to know. You don't have to be experiencing these symptoms.

Lill: Are you sure that these are side effects?

Dr Stewart: Well, no. They could be just the end result of a stroke, but the fact that they've increased since you've begun the water pill suggests they are very likely related.

Lill: But you're not sure.

Dr Stewart: No, I can't be sure until Bill stops taking it and we see if the symptoms decrease.

Lill: What will happen if Bill keeps taking the water pill?

Dr Stewart: He'll keep experiencing these symptoms and we won't know if he can get any better or not.

Lill: Well, I was wondering if maybe we could reduce the dose.

Dr Stewart: That's a great idea, I was just going to suggest that.

PAUSE: Discussion about coming to a compromise and working with the doctor to resolve conflicts. How would workshop participants have responded in Lill's place? What comes next?

QUESTIONS:
How did the conflict get solved? Who solved it?
Could you have proposed a compromise like Lill did? If not, what else could you have done? What could you do if the doctor isn't receptive to your suggestion?
What do you think happens next?
NOTES:

Stage 4

Dr Stewart: ... that's a great idea, I was just going to suggest that. Does that work OK for you, Bill?

Bill: Ok.

Dr Stewart: Now I need both of you to do some work over the next couple of weeks. Bill, you need to keep track of how you’re feeling, and if anything doesn’t seem right, let Lill know so she can keep track, ok?

Bill (to Lill): Write that down.

Dr Stewart: And Lill, you’ve got to keep on doing such a great job monitoring Bill’s blood pressure. Make an appointment out front for 2 weeks from now, and we’ll see how things go. Does that sound fine?

Lill: Ok, we’ll do that. Just a couple of questions: How much should we cut the dose back?

Dr Stewart: How much of the diuretic is Bill taking?

Lill: One 10 mg pill each morning.

Dr Stewart: Do you have much left?

Lill: Yes, enough for another month.

Dr Stewart: If you cut each pill in half as you take them, so you’re taking about 5 mg per day; that should do it. It doesn’t have to be exactly in half, as long as it’s close.

Lill: Are there any other side effects we should watch for?

Dr Stewart: Dizziness, light-headedness, forgetfulness, poor coordination – like dropping a coffee cup or the TV remote control. Record anything that seems out of the ordinary and we’ll go over your journal next time you come in.

Lill: What if Bill’s blood pressure starts to go up?

Dr Stewart: It might go up a little bit, and that’s OK in the short term. If it starts to go up quite a bit, either call my office and I’ll se you right away, or if necessary get to emergency. But don’t worry, I think this is a good idea and there shouldn’t be any problems.

Lill: Ok, so Bill, we’re going to cut back the dose of the water pill to half and see if your dizzy episodes go away, and then we’re coming back in 2 weeks to tell Dr Stewart if anything has changed. Does that sound ok with you?

Bill: O-k.

Dr Stewart: Thanks for coming in, and I’ll see you both again in 2 weeks. Good luck.

Bill and Lill: Thanks.

END: Discussion and review of the communication strategies in the PACE framework.

QUESTIONS:
What PACE strategies did Lill use here?
With who, besides the doctor, did Lill do *checking*?
How did Lill get a longer appointment with the doctor? What are other ways you could get more time with your doctor?
What other questions could she have asked?
Who here goes to the doctor alone? Who goes with a spouse or friend? Why?
Doctors sometimes need to be reminded to think about their communication skills. Most doctors will welcome gentle reminders in the form of *asking questions* or *checking information*.
Could you do what Lill and Bill did? Why or why not? What are your barriers?
NOTES:

Video 3: Scenario for MENTAL HEALTH CLIENTS

Characters:

Sandy Lewis – has schizophrenia, female, age 25-45, heavier set.
Sandy was hospitalized involuntarily several years ago after 2 psychotic episodes. At this time she was diagnosed with schizophrenia. Currently, her psychotic episodes have stabilized with medication and she is beginning to recover from the trauma of being hospitalized against her will. She is now coming to terms with her diagnosis and beginning to regain her autonomy.

Dr Wayne McDonald – psychiatrist, male, age 35-45, has been Sandy's psychiatrist for the past 2 years.

Overview:

Sandy's last visit to Dr McDonald was 3 weeks ago, at which time he increased her medication because she had been experiencing a slight increase in psychotic symptoms. Today she is visiting Dr McDonald **for a routine visit.** She is concerned about her ability to perform at an upcoming concert where she has a solo vocal performance. The following side effects from her medication are interfering with her singing: grogginess, dry mouth and weight gain. Her rehearsals/practices are increasing in preparation for the upcoming concert and she is finding it difficult to maintain her busy rehearsal schedule. She feels that she is unable to perform at her best while on the higher dose of medication. She believes that the only way to make it through this performance is to reduce her medication.

The Scenario:

Stage 1: Beginning and Set-Up
(**P**resenting the information, **E**xpressing concerns)
Sandy describes the side effects and her concern about being able to perform at her upcoming concert. Sandy feels that reducing the dose is the only solution to this problem. The doctor is hesitant to reduce the dose, but does not offer other choices and Sandy doesn't ask. She describes the effects of the meds on her life.

Stage 2: Impasse
(**E**xpressing Concerns)

Sandy persists and they negotiate to reduce the dose from 15 mg to 10 mg. The doctor writes a new prescription. The doctor gets up to leave and says he'd like to see Sandy for their regularly scheduled appointment next month. Sandy requests another appointment next week to monitor the change in dose. The doctor agrees.

[This first negotiation is meant to be less successful than the final negotiation. Sandy is not asking enough questions and the doctor is rushed and isn't taking the initiative to provide Sandy with the necessary information.]

Stage 3: Resolution
(**P**resenting Information, **A**sking Questions, **E**xpressing Concerns)

Sandy returns to the doctor the next week. The doctor had forgotten that she was coming in earlier than usual. Sandy reminds him of the reason for the appointment (to monitor the reduction in dose). She brings with her a detailed journal of her symptoms since the decrease in dose. The doctor looks at the journal and notices that Sandy isn't sleeping well, she is experiencing increased anxiety, and the side effects continue to interfere with her performance. The doctor expresses concern that Sandy isn't sleeping well and her anxiety is returning and thus he wants to return to the previous dose. Sandy reiterates how important her performances are (e.g. to her confidence and self-esteem) and asks if there are any other options besides returning to the previous dose of medication. Could she take the extra 5 mg only if she felt it was necessary?

Stage 4: Options
(**C**hecking Information, **A**sking Questions)

The doctor says he could write her a prescription for 2.5 mg to be taken twice daily as needed. Sandy agrees. It sounds like a good option to her because it gives her some control over the medication. Sandy asks if there is anything else she could do to reduce her symptoms without medication. Doctor asks her to think about cognitive behavioural therapy in a group. He also gives her information on lifestyle choices (i.e., caffeine, nicotine, rest, scheduling of medication), and diet (i.e., low blood sugar can increase twitches and fatigue) and how they may be impacting her health. She writes these things down in her journal. Sandy says she will think about the cognitive behavioural training. They agree to the 2.5 mg extra tablets to be taken as needed and the doctor writes her the prescription. They agree that continuing to document the changes she experiences in her journal is a good idea. Sandy double-checks the new medication schedule with the doctor and they schedule another appointment to review the effects of the changes. The doctor wishes her good luck with her upcoming performance.

Transcript for Sandy and Dr McDonald:

Stage 1:

Dr McDonald: Sandy, ah, it’s good to see you again. It’s been, what, three weeks since we saw each other last?

Sandy: Ah, yes.

Dr McDonald: So at our last visit we increased your dose of Zyprexa to 15 mg, um, how’s that going?

Sandy: Well, I’ve been experiencing some side effects since we raised the dose.

Dr McDonald: Okay, what kind of side effects?

Sandy: Well, I’ve had pretty low energy, feeling kind of groggy, and my mouth is pretty dry all the time, and I’ve been, well, gaining some weight.

Dr McDonald: Okay well, I wouldn’t worry about those too much. Those are pretty common side effects that have been reported with this medication so I wouldn’t be too terribly worried about that.

Sandy: Well the thing is I’m singing in this concert in three weeks and its making it kind of difficult to practice and get ready for it.

Dr McDonald: Where are you doing the concert?

Sandy: I’m singing with this jazz group down at Jack’s place, downtown, so…

Dr McDonald: Well um, at this point I ready don’t want to reduce the dose of your medication. I mean you remember how you were before we increased the dose and we don’t want any of those symptoms to come back, so I think we should probably stick with the medication as it is.

PAUSE: Discussion

QUESTIONS:

NOTES:

Stage 2:

Dr McDonald: … so I think we should probably stick with the medication as it is.

Sandy: Well, the thing is this concert is really important to me. It's the first time I've been out there singing for a long time. I even bought myself a special outfit to wear, and with the weight gain, I'm not sure I'm going to be able to fit into it. And with the dry mouth and just feeling low energy all the time I don't know if I'm going to be able to keep up with the rehearsal schedule I, I really feel like we need to reduce the medication back to where it was, so that I can do this.

Dr McDonald: Well, alright, I'll write a new prescription for you. We'll give this a shot but when we meet again in three weeks I want to go back to the previous dosage, alright, if we see any of the old symptoms come back.

Sandy: I was actually wondering if we could schedule an appointment for next week instead so that we could check in on things with the dose going back to the way it was.

Dr McDonald: Okay, that should be fine.

PAUSE: Discussion

QUESTIONS:

NOTES

Stage 3: [A week later]

Dr McDonald: Hi, Sandy, I didn't expect to see you for another couple of weeks.

Sandy: Um, last week when we changed the dosage of my medication we had scheduled another appointment just to check in on things.

Dr McDonald: Ah, I forgot to write that down. Sorry. So, how's that been going?

Sandy: Well, actually, I've been writing everything down in my journal and I brought it in for you to look at.

Dr McDonald: (takes journal) So, you're having trouble sleeping and your anxiety is coming back …

Sandy: Yep.

Dr McDonald: … are we having any more problems with the voices, again?

Sandy: No, no, I'm not there yet. I'm not back there.

Dr McDonald: Well, I'm thinking that we're seeing symptoms coming back again so I think we should be going back to the 15 mg dose.

Sandy: Well, the thing is, you know, like I explained last week, this concert which is coming up in a couple of weeks, its really important to me to be able to perform at my best. I mean this is the first time I've been out there singing for such a long time. It's really making me feel good about myself and I'm feeling really confident about what I'm doing and if we go back to the previous dosage then I'm going to have all those side effects again - I won't have the energy and my mouth will be dry, which is really bad for signing. I was hoping maybe there was something else we could do, like, would it be possible for me to just take the extra dose of the medication when I felt it was necessary, like when I felt really anxious or something.

Dr McDonald: That's actually a good idea. Um, how about this, I'll write a prescription for a reduced dose, you'll keep the prescription that you've got right now, and continue taking the 10 mg, but I'll write a prescription for a dose of 2.5 mg, that you can take twice a day, as needed. So, it's just if you feel like you need to take another dose.

Sandy: Yah, well taking it when I need it will make me feel like I'm more in control of what's going on.

PAUSE: Discussion

QUESTIONS:

NOTES:

Stage 4:

Sandy: ... ah, well taking it when I need it will make me feel like I'm more in control of what's going on. I was actually wondering is there anything else I can do to reduce my symptoms other than using medication.

Dr McDonald: Well, have you thought about taking any, eh, group sessions for … here, why don't you read this. It is a cognitive behavioural therapy group that meets here at the hospital and you can read that and ask me any questions about that...

Sandy: So we can talk about this in our next session then?

Dr McDonald: Right, yah.

Sandy: Let me write this down then. Is there anything else that I could do?

Dr McDonald: Well, a couple of other things, you should be looking at your diet, if your blood sugar drops then that can have a tendency of leading to fatigue, twitching, problems like that.

Sandy: Okay.

Dr McDonald: I would recommend that you try and get some more exercise; just regular exercise can definitely help hold back the weight gain problem. Um, you should look at certain aspects of your diet, reducing caffeine and nicotine would be somewhat helpful I would say. And also the scheduling of your medication, you want to maintain a regular schedule, because if you mix it up too much that can offset the usefulness.

Sandy: Okay. Let me just write down again … so I'm taking my 10 mg like I was before, right? And then I have 2 doses of 2.5 mg that I am to take if I'm feeling like I need it.

Dr McDonald: Right.

Sandy: Okay, I just want to have that down.

Dr McDonald: Okay, so our next visit, when would you like to meet again?

Sandy: Would been able to schedule an appointment for next week? The concert is in two weeks and that would give me a chance to check in with you again.

Dr McDonald: Sure, and I'll be sure to write it down this time.

Sandy: Okay.

END: Discussion and Wrap-Up

QUESTIONS:

NOTES:

Section

6

6. FOLLOW-UP

The goal of the follow-up session is to provide an opportunity for clients to discuss their communication challenges. It is a chance for clients to reflect on how they put the PACE communication skills into action and discuss any challenges they have putting the PACE skills into practice. The follow-up workshop should give clients the opportunity to practice the skills in a supportive environment. The follow-up workshop can also be a venue for clients to discuss with their peers specific communication problems and to work with others to find solutions.

The model for the follow-up is centred on the PACE booklet. The booklet can serve as a trigger for discussion much like the video.

Discussion Questions

1) What do you remember from the workshop?
2) When you saw your doctor, what happened?
3) Was there anything in the booklet that helped?
4) What worked and what didn't work?
5) Was there anything in the booklet you found very difficult to do with your doctor?
6) What would you like to try next?
7) Share with us one thing you did to prepare for your last appointment with your doctor?
8) Share with us one thing you've done to present information to your doctor?
9) Share with us one thing you've done to check with your doctor?
10) Tell us an example of one concern you've shared with your doctor?
11) Tell us one example of a question you've asked your doctor?

12) What words would you use to ask your doctor X …?

Exercises

The following exercises are modelled on the PACE booklet.

Exercise 1: Preparing for your next doctor's appointment.

Turn to page 2 in the PACE booklet. On a piece of paper list one or two concerns you would like to discuss with your doctor at your next visit. Has anybody listed a new condition/concern or a change in the way they are feeling since their last visit? How are you going to describe that change to your doctor? What are the words you would use? What are some specifics the doctor may want to know?

Exercise 2: Your expectations and desires (pages 4-5 of booklet)

Write down one example of something that was really satisfying about your last doctor's appointment and one thing that disappointed you about that appointment? What do you expect from your next doctors appointment? List 3 goals for that appointment? Write down any thoughts you have about what the doctor might do for you at your next appointment? (for example: Prescribe a medication, order a test, give you information about alternative therapies, recommend a specialist, etc.)

Exercise 3: Medications (page 4 and 7 of the booklet)

Tell me one thing you could do to make sure you doctor knows what medication you are taking? (List, bringing their medications to their doctor's appointment, informing doctor of any changes, etc.). Who here has a list of all the medications they are taking and the dose? Does that list include vitamins and /or herbs? Who brings their medications to their doctor's appointment? Do you feel you have enough information about the medication you are taking? On a piece of paper list one or two things you would like to know about the medication you are taking. How would you ask your doctor about these things? What are the words you would use?

Exercise 4: Diagnosis and Prognosis (page 5)

Think back to the time when you first got your diagnosis. List three things you would have wanted to know about your condition. How did you get information about your condition when you were first diagnosed? Have all your questions and concerns been addressed? How could you get more information about your condition from your doctor?

Exercise 5: Tests or Procedures (page 6)

Think back to the last time you had a test or procedure done. Did you feel involved in decision-making about the test or procedure? Write down one piece of information your doctor gave you about the procedure/test and one piece of information you would have liked to have had but did not receive. How could you have asked for that information? What words would you use?

Exercise 6: Alternative therapies and other treatments

Does your doctor give you choices about the types of therapies available for treating your condition? Write down one question you would ask your doctor if you wanted to know about other choices for treatment? (Be as specific as possible). Are you clear on ways, other than medication, that you could improve your condition (for example: diet, exercise, physical therapy)? Tell us one example of how you would ask for information on the risks associated with your current treatment versus risks for any alternative treatments.

Exercise 7: Checking Information (pages 8-9).

Turn to page 8 of the booklet. At the bottom of the page (and top of the following page) there are listed three techniques for checking your understanding of information. Turn to a neighbour and take turns telling each other a story about a visit to your doctor. If you are the “listener” try to use the techniques for “checking” what your partner is telling you. After 3 minutes switch roles with your partner. The content of your story is not as important in this exercise as the skills your partner is using for “checking information.”

Exercise 8: Expressing Concerns (pages 9-10).

Let’s brainstorm some concerns patients may want to express with their doctor. We are aiming for one concern per person in the group. Tell me one reason why you think it is important to express your concerns with your doctor. Write down one example of a concern you’ve shared with you doctor. How did you talk to him/her about your concern? What words did you use? Are there any concerns you would like to bring up at your next appointment? How will you explain your concern to your doctor?

Exercise 9: Medical Records (page 11).

What kind of information do your medical records contain? Can you give us some examples? Your medical records contain important information about your medical history, the medications you are taking, and more. This information belongs to you. Write down one thing you can do to ensure you and your doctor/doctors have access to the most up-to-date information in your medical record. Is there anything that you would like to ask your doctor about the information in your medical records?

Role Playing

Role playing can be incorporated into any of these exercises, especially when participants try to actually say the words they would use to ask their doctor certain questions. Role playing gives participants a chance to practice the PACE skills. Remind them to also practice ‘checking.’ It might be helpful to use someone’s story for any role playing exercises, that way the person playing the doctor has some content they can work with.

Section

7

7. RESOURCES

Contact

Informed Shared Decision Making Project

Please contact us if you need additional P.A.C.E. booklets or if we can do anything to support you as a community facilitator.

Informed Shared Decision Making Project
Division of Health Care Communication
College of Health Disciplines
#400 - 2194 Health Sciences Mall
Vancouver, B.C. V6T 1Z3
Tel: 604-822-8002
Fax: 604-822-2495
E-mail: isdm.dhcc@ubc.ca
Website: www.chd.ubc.ca/DHCC/

Books

Hawkins, Mary F. 2000. Health Talk: How to Communicate with your Doctor. Toronto: Macmillan Canada.

Roter, Debra L. and Judith A. Hall. 1992. Doctors Talking with Patients / Patients Talking with Doctors. Westport, Connecticut: Auburn House.

Meldrum, Helen and Mary L. Hardy. 2001. Provider-Patient Partnerships. Boston: Butterworth and Heinemann.

Canadian Health Agencies

Health Canada Web Site:
www.gc-sc.gc.ca

Public Health Agency of Canada:
www.publichealth.gc.ca

Canadian Institute for Health Information (CIHI)
Vancouver: (604) 801-5385
www.cihi.ca

Canadian Medical Association (CMA)
(613) 731-9331 or 1-800-267-9703
www.cma.ca

College of Physicians and Surgeons of British Columbia
(604) 733-7758 or 1-800-461-3008
www.cpsbc.bc.ca

ISDM Poster

ISDM

Informed
Shared
Decision
Making

= **Partnership**

PACE Poster

Communication Skills

Presenting Information

Asking Questions

Checking Understanding

Expressing Concerns

From DJ Cegala: *Communicating with your doctor* 2000

Notice

“TALKING WITH YOUR DOCTOR” WORKSHOP

DATE: __________
TIME: __________
PLACE: __________

After your Doctor’s appointment do you think of questions you wish you’d asked?

Does it seem like there’s never enough time to talk about everything you’d like to talk about?

Is it difficult to get the information that you’d really like to have?

Would you like to be more involved in making decisions about your health care?

~~~~~~~~~~~~~~~~~~~~~~~~

If you answered yes to any of these questions, this workshop’s for you!

“**Talking with Your Doctor**” is a workshop that explores the kind of problems people experience when they ‘talk to their doc.’ It presents tips and a chance to work out, and try out some of the things that will help you to have a more effective relationship with your doctor. Important techniques to learn about are:

- **Presenting** detailed information about how you are feeling
- **Asking** questions if the information you want is not provided
- **Checking** your understanding of information given to you
- **Expressing** your concerns about the recommended treatment

The workshop will include:

- Introduction and overview – Who are we? What is Informed Shared Decision Making?
- Demonstration Video
- Discussion
- Wrap up – How can you try? How can we help?
- Take away – A booklet, *Communicating With Your Doctor,* by Donald J. Cegala that has ideas that have been proven to work
~~~~~~~~~~~~~~~~~~~~~~~~

Booklet

The booklet by Dr Don Cegala, Professor of Communication and Family Medicine, The Ohio State University. Original title: “Communicating With Your Doctor” © 2001

Talking With Your Doctor …

and other Healthcare Professionals

By
Donald J. Cegala
Modified, with permission, for a project of the Patient Voices Network and UBC Division of Health Care Communication

Notes