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CLINICAL RISK COMMUNICATION

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Hello. I am Tim O'Leary and I am the Clinical Risk Communication Officer at the Deployment Health Clinical Center. Today's briefing will cover risk communication in a clinical setting.

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This presentation will cover several definitions of risk communication, a brief overview of the history of this relatively new field, the purposes of risk communication, and how it may be used to improve the provider-patient relationship.

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The National Research Council's Committee on Risk Perception and Communication developed this definition of risk communication. It recognizes that risk communication involves considerably more information than just technical risk. It also involves values, trust, credibility, and caring because, especially in a clinical setting, it focuses on the patient's brightest hopes and darkest fears about the future.

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Again, CHPPM's definition of risk communication begins, not with risk, but with building and maintaining relationships. It is the relationships that make communication about risk possible.

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Finally, Vincent Covello offers this definition. Dr. Covello is a leading authority on risk communication. He stresses that this is a "science-based" approach to communication in that it is backed by empirical research. Still, the definition focuses on situations of high concern, low trust and that are sensitive or controversial. These are generally emotionally charged and the first task of the communicator is to build a relationship of trust and credibility.

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Trust in individuals and organizations is by far the greatest factor in communicating about risk. It is equal to the next two most important factors combined.

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Trust and credibility are difficult to gain and easy to lose in an emotionally charged atmosphere. Once lost, they are almost impossible to regain. Trust and credibility factors are listed here in roughly descending order of importance. It is the connecting human values that are the most important thing in developing trust and credibility. Technical expertise is near or at the bottom. The old saying is true; people do not care how much you know until they know how much you care.

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Gaining trust and credibility is essential for effective communication. Low trust and high concern lead people mentally to amplify mistakes and negative feelings about the communicator. Even in high-concern

situations where trust and credibility are already high, the techniques of risk communication can be useful to maintain that high level of trust.

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Risk communication began in the early 1980s in response to health and environmental concerns such as the discovery of the Love Canal Hazardous Waste Site under a housing development and the release of methylisocyanide gas in Bhopal India, which killed about 2,000 people.

Communities and other groups in the vicinity of industrial sites or hazardous waste sites became alarmed about their health and safety. Government and industry leaders were deeply distrusted and rebuffed when they attempted to open conversations with these groups. These officials eventually realized that the perception of health, safety, and environmental peril and their perceived ties to that peril was so overwhelming that it blocked out most attempts to provide other information. They realized clearly that they needed to take a different approach to communication.

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Research into communicating with communities and other groups about risk revealed that risk was less acceptable to people if:
It was imposed involuntarily instead of voluntarily accepted.
It was manmade or manufactured instead of natural.
It was unfamiliar instead of familiar.
It had dreadful or disastrous consequences, even if the probability of those were very small.
It had an unfair impact on a particular segment of the population.

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It was especially dangerous to children or to future generations.
It was poorly understood.
It could not be reversed.
It could not be seen, felt, smelled or otherwise sensed.
It was created and imposed by an individual or organization that was disliked or distrusted.
It was created and imposed by an individual or organization that did not respond to the public's concern.

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There is no magic way to communicate that will ensure success. Nevertheless, experts in the field of risk communication have devised these guidelines to help overcome the concern and distrust that many feel toward messages from those in authority. These rules for effective risk communication may seem obvious, but they are constantly violated in practice.
These principles were formulated with a focus on a group setting, such as a workplace or public communication environment, but the same principles may be applied to individual situations such as those found in the healthcare practice setting.
Rule 1. In a democracy, people have the right to participate in decisions that affect their lives. The goal of risk communication is not necessarily to diffuse concern or to avoid action. Instead, it is to produce an involved, informed recipient of information that is interested, thoughtful, solution-oriented, and collaborative.
Rule 2. Different goals, audiences, and media require different communication strategies.
Rule 3. People are usually more concerned about trust, credibility, control, voluntariness, fairness, caring and compassion than about technical details. To identify real concerns, a communicator must listen and understand.
Rule 4. Trust and credibility are the most valuable assets. They are difficult to obtain and, once lost, are almost impossible to regain.

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Rule 5. Credible, neutral sources of information can help communicate effectively. Few things hurt credibility more than conflicts and disagreements among information sources.
Rule 6. The media plays a major role in transmitting information and play a critical role in setting agendas and forming mind-sets. In that sense, it is important to know what messages are being delivered by the media to the audiences you wish to reach as well as to participate in formulating messages for delivery through the media on topics of interest to your audiences.
Rule 7. Technical language and jargon are barriers to communication. Distant, abstract, unfeeling language puts most people off. Acknowledging emotions such as anxiety, fear, anger, outrage, and helplessness is far more effective.

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Risk communication began as an attempt to reach communities or relatively large groups of people, and has been used that way for about two decades. Now, however, the DoD/VA Post-Deployment Health Clinical Practice Guideline applies those techniques to small groups and individual patients in a clinical setting. Building trust and credibility is still the heart of risk communication and the general rules definitely still apply. In a clinical setting, the focus is on individual patients instead of communities, organizations, or other large groups, but the principles of communication are the same -- especially the idea that half of communication is listening. It is vital that a provider listens to and understands a patient's concerns rather than just treats a set of symptoms.

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Clinical risk communication must meet the needs of individual patients. One size does not fit all in this endeavor either. At its simplest, where the patient's concern is not a major factor, building trust and rapport may be sufficient. When a patient is concerned and shows disease symptoms, disease-centered education and treatment is appropriate. The next step, where the patient is concerned but does not show any symptoms, additional information and additional investigation may be necessary. Where the patient is concerned and shows symptoms that may not fit a clear-cut diagnosis, education on medically unexplainable physical symptoms (MUPS) and rehabilitation should be added. At this point, the provider may wish to consult with the Deployment Health Clinical Center, either through the web link or through the toll-free line. As a final step, the three-week course of treatment through the Specialized Care Program at DHCC may be appropriate.

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The Clinical Practice Guideline has risk communication principles built into the major decision points. These range from the initial step of the recently deployed through those who are not symptomatic but are concerned, to those who display symptoms, which may be chronic.

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Using risk communication concepts can help to reduce patient distress and physical health concerns and reduce frustration and tension in the provider patient relationship. Most importantly, it can help patients focus on relevant health risks and turn their attention away from risks that may not be relevant.

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Patients come to their providers with many concerns about risk. Usually those concerns revolve around illness and death. In addition, virtually every medical procedure involves some degree of risk to the patient.

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Sometimes, being the bearer of good news can be just as bad or even worse than being the bearer of bad news.

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In this case the patient may not believe the health provider. The patient feels sick and may believe that the provider is not being forthcoming or cooperative, is protecting the interest of the organization, is incompetent, is uncaring, or all of the above.

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In this case, the provider should deliver the good news that the patient's condition seems better than the patient believed. Even so, the patient was correct to seek a medical evaluation.

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Provider-patient situations fall into two categories – those in which a decision must be made about a diagnosis or treatment and, not surprisingly, those that do not

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When the provider and patient must make a decision, the provider should inform the patient about the risks and benefits of all of the procedures so that the patient can make a decision based on all that is known about the patient's condition and how to treat it.

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Where a decision does not have to be made, the provider should discuss the patient's concerns, possible causes of the patient's symptoms, and potential means to alleviate those symptoms.
The provider should again validate the patient's decision to seek treatment.

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In discussing the patient's concerns and possible symptoms, it is always best to keep enough humility to recognize that medicine cannot explain everything. This attitude can serve the provider well in those instances when a cause for unexplained symptoms is finally discovered.

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Risk communication can bring the patient into a willing partnership with the health care provider and make the patient more willing to carry out a prescribed medical program of care. It can also lead to an improved satisfaction with the medical care received and improved confidence in the provider and the health care system because the patient was an active and willing participant in all of it. Finally it can improve the patient's level of functioning in society and life roles as long as he or she continues to follow a medical program designed to promote a healthier lifestyle.

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A handy way of remembering steps in communicating with patients who are very concerned about their health and may not fully trust the provider or medical system is through the acronym, ENVITE. It stands for: Empathy, Non-confrontational, Validate, Inform, Take Action, and Enlist Cooperation.

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Empathy. A provider should emphasize empathy, compassion, and concern for the patient. Technical facts certainly have their place in discussions with patients but should not be the only communication that takes place. Building trust with a patient requires a deeper understanding of the individual. A patient shows up with all of his or her life experiences in addition to a set of symptoms. The patient perhaps carries fears of chronic ill health or even death and, especially in a military setting, may wonder if the provider is primarily focused on the interests of the patient or of the organization. This situation is especially true if the patient has been shuttled between providers and clinics over a long period of time with little improvement in his or her condition.

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Non-confrontational. The provider should listen to the patient with the intention of understanding rather than refuting. The patient should be encouraged to share his or her thoughts on the symptoms, how they might have been produced, and what effect they are having on the patient's life. Even though they may not have a scientific or diagnosable basis, to the extent that they affect the patient and those around the patient the symptoms must be addressed.

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Validate. The provider should acknowledge that the patient was right to seek medical care and should ask about potentially ill-defined or subjective illnesses. The patient already knows that he or she feels ill and this feeling of illness may have already lasted a very long time. A provider that dismisses such illnesses risks having the patient conclude that the physician is incompetent, uncaring, and untrustworthy.

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Inform. A provider should provide as much information to the patient as possible so that he or she can make informed choices about treatment options. The physician should avoid the use of medical jargon or scientific terms that the patient may not understand. The provider should also acknowledge uncertainties in clinical diagnoses. Providers may be tempted to appear knowledgeable and decisive in dealing with symptoms. Even so, acknowledging the uncertainties about the causes of common symptoms will usually increase trust and credibility on the part of the patient because it shows further validation by the physician and shows that the patient's concerns are not being dismissed.

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Take Action. The provider should describe treatment options and schedule an extended follow up visit and discussion lasting 30 minutes or so. It may also be worthwhile for the patient to bring his or her significant other to the follow up visit to provide a greater insight into the dynamics of the patient's life and into possible causes of the patient's symptoms.

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Enlist Cooperation. Providers often seek to identify the source of a patient's problem and then to fix the problem. This mechanical approach, however, does not address the other dimensions of the patient's life that may contribute to his or her current illness. A more holistic, patient-centered approach is necessary to establish goals for treating the patient that both the patient and provider can accept; and then to establish landmarks for measuring progress toward those goals. Such goals may include medical measures such as a reduction in the nature or severity of symptoms but may also include non-medical goals such as an improved ability to function effectively in family or job-related activities.

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Using these risk communication techniques takes more time at the beginning but the results are worth it in terms of the provider-patient relationship. Ultimately, taking more time at the beginning of patient treatment may save time over the course of patient care. By building the patient's trust and enhancing the provider's credibility with the patient, the use of risk communication principles can lessen the tensions and occasional battles of will and conflicts between providers and patients. The result is a smoother course of treatment with the provider and patient in a partnership to improve the patient's health and quality of life.

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Who should develop knowledge of risk communication? Certainly the physician should have these skills. In addition, others who have contact with the patient should be able to communicate in a low trust and high concern situation. These people include nurses, naturally, but should also include the administrative staff such as desk clerks or receptionists who will likely have the first and last contact with the patient and who can in many respects influence the tenor of the patient's care.

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In summary, clinical risk communication can be very useful to communicate with patients in low trust-high concern situations. Building trust and credibility between provider and patient is the very heart of the risk communication process; and this is achieved by valuing the patient's views and beliefs about his or her medical condition.