

Get With the PROGRAM: A Guide to Compassionate Communication

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Despite growing interest in the importance of compassionate communication and patient experience, many physicians still feel unprepared when faced with delivering bad medical news. To address this need, few methods have been developed to offer physicians a structure for these conversations, with the goal of making the dialogues less traumatic for patients and families and less stressful for physicians. The PROGRAM method promotes compassionate communication to help physicians make a connection with their patients, which is central to improving health care quality. The objective of this article is to provide a systemic approach to structuring difficult dialogues with patients and their families.

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The goal of communication in the current health care setting is more than providing accurate information. Patients and their families routinely research symptoms and diagnoses online and often present with an impressive working knowledge of their condition. Patients are not looking for a walking, talking search engine; they are looking for sensitivity to their physical, psychosocial, and emotional needs. The “tuned in” physician, who is able to effectively communicate with compassion, is better able to foster relationships with patients he or she encounters.^{1,2}

An essential element for building relationships is empathy.^{3,4} In health care, empathy is defined as “a predominately cognitive (rather than an affective or emotional) attribute that involves an understanding (rather than a feeling) of experiences, concerns, and perspectives of the patient, combined with a capacity to communicate this understanding and an intention to help.”^{3(p74)} Based on this understanding, it is obvious that physicians need to hone their patient-centric communication skills.⁴⁻⁶

Effective compassionate communication involves listening to the patient, expressing empathy, explaining what is happening in terms the patient can understand, allowing time for the patient to absorb the diagnosis, and engaging the patient in treatment decisions.^{1,2} Compassionate communication results in a host of positives. Diagnostic accuracy improves as patients open up and are willing to share complete health information with physicians.⁷⁻⁹ Additionally, adherence increases as patients gain an improved understanding of their conditions and the rationale behind their treatment plans, as well as when treatment plans reflect patients’ social factors, including culture, family dynamics, and socioeconomic status. For example, when formulating a treatment plan, the physician must first ascertain whether a patient has insurance, and, if so, what his or her plan will

cover. If this important element is ignored, the patient may be unable to adhere to the plan, whether he or she wants to or not.⁷⁻⁹

It has also been found that health outcomes improve when positive patient-physician communication techniques aid in meeting patients' psychosocial needs. By eliciting and exploring patients' concerns, physicians facilitate the shared decision-making that patients today expect.^{9,10} Also, according to patient satisfaction survey results that examined the relationship between physician communication and patient satisfaction, patients experience a better quality of life and improved patient experience when physicians communicate compassionately and effectively.^{7,9,11} In fact, malpractice lawsuits decrease when physicians practice compassionate communication.^{8,11}

Although the health care industry recognizes the essential nature of patient-centered compassionate communication, patients still often report that their emotional needs are unmet.¹ This is not a complete surprise considering the brief and inadequate training that most physicians are provided in this skill.⁶ Communication techniques are addressed early in residency, but several studies¹¹⁻¹³ suggest that empathy declines as residency progresses. Additionally, communication training techniques are often archaic and ineffective. Traditional training has included didactic lectures or observations of senior physicians in clinical settings or on video.^{10,12} Recently, interactive and multidisciplinary workshops have been favored, but many physicians still report anxiety and lack of confidence in their abilities to communicate with patients.^{12,14,15}

Communication skills can have a positive effect on how physicians express compassion as they communicate with patients and their families.¹⁶ Some institutions have made this training a priority, including the Cleveland Clinic. In 2010, all 43,000 staff members in the Cleveland Clinic health system were trained in skills such as active listening and building patient rapport, and, as a result, their Hospital Consumer Assessment of Healthcare Providers and Systems

scores increased from the 14th to the 63rd percentile in physical communication and from the 55th to the 92nd percentile in overall patient satisfaction from 2008 to 2012.^{17,18} Rush University had similarly impressive improvements after implementing an onboarding hospitalist training program that included direct observation of the staff members' communication skills and individual feedback from communication specialists. Between 2009 and 2014, Rush's Hospital Consumer Assessment of Healthcare Providers and Systems scores improved by 400%.¹⁹ In the present article, I describe the PROGRAM method of compassionate communication, a technique to help physicians relay tragic news to patients and families and form relationships through effective and compassionate communication. The PROGRAM method helps physicians both break bad news gently and provide necessary support to people undergoing life-changing events.

Delivering Bad News Using PROGRAM

Compassionate communication and relationship building becomes even more essential when delivering bad news to patients and their families.²⁰ Patients often consider their physician to be a major component of their support system, and empathy helps to provide that support.^{7,17} At these times, it is imperative for the physician to understand the patient's perspective. In my experience, physicians who successfully deliver bad news do not simply provide information, but they also keep 3 goals in mind: (1) the patient and family should feel that the physician who delivered the news has genuine empathy and feels compassion for their situation, (2) the patient and family should feel that the physician is genuinely competent and will "carry them" to the next step, and (3) the patient should feel that the physician delivering the bad news will not leave him or her. These 3 goals provide a structure that training in compassionate communication can be based on.

Over the past 2 decades, medical schools and hospitals have embraced the idea of providing training in

compassionate communication.¹⁰ Several protocols have been in use to offer guidance to physicians. However, I would like to propose the PROGRAM method, which I believe is best suited to contemporary patients who expect a relationship with the physician treating them or their loved ones. The PROGRAM method has been used to teach more than 600 residents, senior physicians, and other health care professionals how to successfully discuss tragic news with patients and families in the most effective and compassionate manner—even in the most difficult circumstances.

Plan

When bad news is delivered, it is difficult for patients and their families to retain any further information. If the diagnosis is presented before the evidence, patients may be confused or angry or in a state of disbelief, requiring the physician to deliver the bad news a second time. When approaching patients and families to deliver bad news, physicians should plan how they are going to tell them.⁹ The plan should include a beginning when the physician asks them for their understanding of the situation and get on the same page, a middle when the physician prepares them for the news, and an end when the physician helps them get to the next steps.

Prepare

All procedures have a better chance of success when the correct approach is used.²¹ The physician delivering bad news is about to change someone's life forever, so he or she should avoid distractions, such as personal electronics. To prepare, physicians should give their phones or beepers to the charge nurse or resident and instruct them to call only in extreme emergencies.

Position

Physicians should position themselves for success. They should always sit down but have the patients and family members sit first. (In my practice, I have learned it is more difficult to get others to sit if I sit first.) Ideally, physicians should be close enough to

touch the patient or family members if it seems appropriate. This is a human-to-human interaction. It is important that the physician avoids any barriers, such as desks or tables, between him or her and the patient. Even a physician holding a chart on his or her lap can be an emotional barrier to empathy by sending a message that the conversation should be only clinical. The following dialogue is an example of a well-planned interaction with a patient:

“Mr. Johnson, I am glad your wife is here with you because I wanted to go over your test results with you.” (At this point, the physician should sit down and position himself or herself properly before continuing.) “As you know, you were admitted to the hospital yesterday because you were having some difficulty breathing. I was especially concerned when you told me that you frequently noticed blood in your sputum, so I ordered a CT scan and some blood work. I just finished reviewing the results of the CT scan with the radiologist. We discussed some areas on the CT scan that were very concerning for a type of lung cancer called adenocarcinoma.” (The physician should pause here and sit silently while the patient and family have time to process the information before moving on to the next steps.)

Review

Physicians should make every attempt to get on the same page as the patient or the patient's family. A review of the immediate events that led to the patient's reason for presentation can serve as the starting point for building a relationship with patients and families because it can help avoid confusion about diagnosis, prognosis, or treatment, and it can help avoid distrust of the physician. Most importantly, the review helps lead the patient to the all-important “bracing moment.” The review should start with the physician asking the patient or the family about their understanding of the situation or their reason for presentation. In the case of sudden tragedies, it may be more appropriate to do the review using just a few sentences that explain how the patient became sick enough to result in death or severe impairment. For example, “As you know, Ms Smith, your husband collapsed while doing yardwork.

Table 1.
Nonverbal Messages That Physicians May Send to Their Patients Through Body Language

Body Language	Nonverbal Message
Standing up	"I am in a hurry"
Sitting down	"You have my undivided attention"
Legs crossed, leaning back	"This is routine for me"
Leaning forward, mirroring position	"I am here for you"
Sitting behind a table or using barrier	"I want to protect myself from emotion" "Let's keep this clinical"
No barrier, close enough to touch	"I am here for you and want to make a human interaction"
Arms folded or hands under table	"I am uncomfortable with the situation"
Hands reaching out or together	"We are together" "I will help you"
Reaching out with fingers up	"Calm down, now!"
Reaching out with palm down	"I'm here to hold your hand"

While being transported to the hospital, the paramedics needed to place a tube in his airway because he stopped breathing. When he arrived, he was not breathing and he had no heart rate.”

Observe

There are 3 components of effective communication: verbal (words), paraverbal (tone, pitch, volume) and nonverbal (body language).⁸ Patients and family members may observe and use a physician’s nonverbal clues to determine whether news is going to be good or bad. When a physician’s body language is not consistent with the message he or she is delivering (eg, a physician sitting in a chair with a casual posture when delivering bad news), it often creates anger, disbelief, and distrust (**Table 1**). During a discussion of tragic news, physicians should not appear relaxed or casual. My preferred posture is a position sometimes called *mirroring*, which involves having both feet on the ground, putting both hands together, and leaning forward with my elbows on my knees. Sensitive non-

verbal communication significantly affects patient health outcomes, adherence, and satisfaction.⁸

Gradual

The most important element of the PROGRAM method of delivering bad news is to always deliver the bad news gradually. This is often daunting, as studies have demonstrated that delivering bad news and watching patients and families suffer is extremely difficult for physicians, who would rather avoid painful subjects that distress them.^{7,22} But, this moment is not about the physician. Blindsiding a patient or family by delivering news too abruptly can often interfere with closure for patients and may affect them decades later.

For years, I have watched physicians start the conversation with a “shot over the bow,” (eg, “I have bad news to tell you.”) Despite the best intentions, I find this method does, in fact, blindside them. The result is a mental tailspin that limits how much they comprehend what the physician is telling them from that point on. To prepare patients and families for what they are about to be told, physicians should use verbal clues during the review to lay out the case and indicate where the story is about to go. They should also send subliminal messages with nonverbal clues. Physicians should ask the patient to sit down, position themselves without barriers, and avoid a casual appearance.²

Relationship

Forming a relationship with a patient and family, especially when the physician has not treated the patient for years, is challenging and important. “Relationship words” can help physicians connect to and reassure patients and their family that they are there for the long haul (**Table 2**). An important lesson I have learned over the years is to use *I* instead of *we* whenever possible, as it suggests a 1 on 1 relationship. When physicians say, “We are doing everything we can,” they may believe that referring to the medical team, whose cumulative experience is being used to save the patient, is comforting. However, I have learned from

speaking with families over the years that it implies that the physician is avoiding responsibility. The physician is just one small cog in the vast wheel. Instead, physicians can say, “I am doing everything possible to help your son.” This immediately makes the relationship more personal. Similarly, the words *concerned* or *worried* also add a personal tone. They suggest a deeper investment than *think*, which can imply the physician is not sure of the diagnosis.

Accountability/Answer

Physicians must realize that when they break bad news to their patients, they have just changed their lives forever. Patients and families are often feeling confusion, sadness, and panic, and they are often incapable of thinking rationally. Knowing that they can depend on the physician to lead them to the next step can help them deal with the sudden change in their lives. It is extremely important that they feel that the physician is the expert in the room to give them a sense of stability in a now “upside-down” world. Simply saying to a patient or family, “I will help you get through this,” will solidify the committed patient-physician relationship, reduce their anxiety, and give them the time needed to grieve without worrying about the next step.

Meet Again

After the bad news has been delivered, patients and families need to understand exactly what the next step is going to be. I like to let them know exactly when they will see me again so they know they will not be abandoned. Physicians should be specific (eg, “I will give you a short time to process and will be back in a few minutes” or “I will make an appointment to follow up in 2 weeks”). In the special case of emergency medicine physicians, telling a family something along the lines of “Your mother is being admitted to the intensive care unit, but I will check to see how she is doing when my shift is over,” can give them the comfort of knowing that the patient will be supported through this challenging time.

Table 2.
Possible Patient Interpretations of and Suggestions of Improved Wording for Commonly Used Physician Phrases and

Physician Phrase	Patient Interpretation/ Thoughts	Better Phrasing
“I am one of the hospitalists here.”	This physician is just one of the health care providers in a large hospital. If anything goes wrong, he or she will not feel accountable.	“You can count on me to take control of your care.” “I am the physician in charge of your care today.”
“It looks like you might have a brain tumor.”	The physician is not really sure.	“I am concerned that this lesion is consistent with a brain tumor.”
“I understand.”	How can the physician understand unless he or she has a brain tumor too?	“I can’t imagine how this must be for you.”
“I am sorry to have to give you this news.”	The physician is sorry to be stuck giving me bad news.	“I am sorry.”

Conclusion

Compassionate communication is being recognized as a central component of quality health care. More and more physician education programs, whether residency or beyond, are providing training in this skill. However, evidence suggests these skills wane over time, and physicians may benefit from periodic refresher courses.⁷ Continually promoting compassionate communication skills in physicians may have a positive effect on patient outcomes and quality of life for both patients and their families, and the PROGRAM method could be used to teach future physicians important aspects of these skills.

References

- Amutio-Kareaga A, García-Campayo J, Delgado LC, Hermosilla D, Martínez-Taboada C. Improving communication between physicians and their patients through mindfulness and compassion-based strategies: a narrative review. *J Clin Med*. 2017;6(3):e33. doi:10.3390/jcm6030033
- Cook K. Improving physicians' communication skills. *H&HN Daily*. May 28, 2015. <https://www.hhnmag.com/articles/3451-improving-physicians-communication-skills>. Accessed November 20, 2017.
- Hojat M. *Empathy in Health Professions Education and Patient Care*. New York, NY: Springer International; 2016:74.
- Berg K, Majdan J, Berg D, Veloski J, Mohammadreza H. A comparison of medical students' self-reported empathy with simulated

- patients' assessments of the students' empathy. *Med Teach*. 2011;33(5):388-391. doi:10.3109/0142159X.2010.530319
5. Baile W, Blatner A. Teaching communication skills: using action methods to enhance role-play in problem-based learning. *Simul Healthc*. 2014; 9(10):220-227. doi:10.1097/SIH.0000000000000019
 6. Mercer SW, Reynolds WJ. Empathy and quality of care. *Br J Gen Pract*. 2002;52(suppl):S9-S12.
 7. Ha JF, Anat DS, Longnecker N. Doctor-patient communication: a review. *Ochsner J*. 2010;10(1):38-43.
 8. Ranjan P, Kumari A, Chakrawarty A. How can doctors improve their communication skills? *J Clin Diagn Res*. 2015;9(3):JE1-JE4. doi:10.7860/JCDR/2015/12072.5712
 9. Derksen F, Bensing J, Lagro-Janssen A. Effectiveness of empathy in general practice: a systematic review. *Br J Gen Pract*. 2013;63(606):e76-e84. doi:10.3399/bjgp13X660814
 10. Levinson W, Lesser C, Epstein R. Developing physician communication skills for patient-centered care. *Health Aff (Millwood)*. 2010;29(7):1310-1318. doi:10.1377/hlthaff.2009.0450
 11. King A, Hoppe RB. "Best practice" for patient-centered communication: a narrative review. *J Grad Med Educ*. 2013;5(3):385-393. doi:10.4300/JGME-D-13-00072.1
 12. Al Odayani A, Ratnapalan S. Teaching communication skills. *Can Fam Physician*. 2011;57(10):1216-1218.
 13. Batt-Rawden SA, Chisolm MS, Anton B, Flickinger TE. Teaching empathy to medical students: an updated systematic review. *Acad Med*. 2013;88(8):1171-1177. doi:10.1097/ACM.0b013e318299f3e3
 14. Vaidya V, Greenberg LW, Patel KM, Strauss LH, Pollack MM. Teaching physicians how to break bad news: a 1-day workshop using standardized parents. *Arch Pediatr Adolesc Med*. 1999;153(4):419-422.
 15. Gough JK, Frydenberg AR, Donath SK, Marks MM. Simulated parents: developing paediatric trainees' skills in giving bad news. *J Paediatr Child Health*. 2009;45(3):133-138. doi:10.1111/j.1440-1754.2009.01440.x
 16. Riess H, Kelley JM, Bailey RW, Dunn EJ, Phillips M. Empathy training for resident physicians: a randomized controlled trial of a neuroscience-informed curriculum. *J Gen Intern Med*. 2012;27(10):1280-1286. doi:10.1007/s11606-012-2063-z
 17. Lee T. Capturing the patient voice: better communication makes better physicians. *NEJM Catalyst*. October 12, 2017. <https://catalyst.nejm.org/better-communication-makes-better-physicians/>. Accessed November 20, 2017.
 18. Advisory Board. *Engaging Physicians in Patient Experience: Beyond HCAHPS Scores*. Washington, DC: Advisory Board; 2014. <https://www.advisory.com/-/media/ABI/Research/COB/Studies/2015/Engaging-Physicians-in-Patient-Experience.pdf>. Accessed January 16, 2018.
 19. Duta S, Abbas S. HCAHPS and the metrics of patient experience: a guide for hospitals and hospitalists. *Hospital Med Practice*. 2015;3(6):10.
 20. Heyland DK, Cook DJ, Rocker GM, et al. Defining priorities for improving end-of-life care in Canada. *CMAJ*. 2010;182(16):e747-e75. doi:10.1503/cmaj.100131
 21. Fernando AT III, Arroll B, Consedine NS. Enhancing compassion in general practice: it's not all about the doctor. *Br J Gen Pract*. 2016;66(648):340-341. doi:10.3399/bjgp16X685741

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