The Basics of Evidence-Based Communication – Short Version

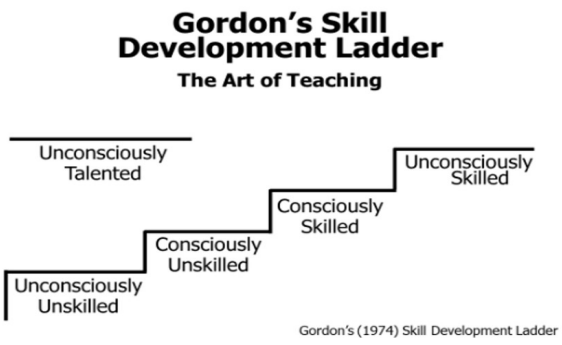
What components are needed for evidence-based communication in healthcare? What is a simple educational framework – including for teaching – in this field?

Step 1: Compassionate Self-Reflection – My Personal Starting Point

I am able to assess

a) where I currently stand on the Gordon's Skills Development Ladder, and where I want to develop
b) what communication behaviors were characteristic of me at the outset—or, in some cases, still are. The reference point is: What was my communication behavior like in young adulthood (between the ages of 16 and 19) as I was leaving my parents' home? What aspects of that are still helpful to me when communicating, and what would I like to modify or expand upon?

Regarding a) the Gordon Skills Ladder



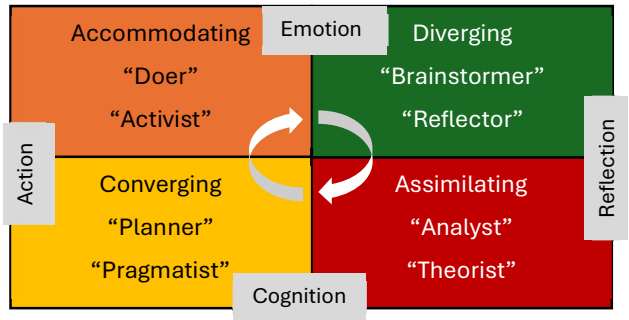
Am I
- unconsciously talented?
- currently, at least from time to time, aware of where I'm still "unskilled"?
- aware of why I'm doing what I'm doing right now?
- a different level?

Where do I want to go (personal & professional development)?

Regarding b): reflection based on the Kolb Experiential Learning Cycle

Based on my upbringing and experiences at home, am I someone who

- tends to react emotionally quickly or express my own emotions?
- tends to think things over for a while before saying anything?
- tends to seek out and rely on facts during a conversation?
- doesn't beat around the bush very much or very willingly?



Was I able back then (and perhaps even today):
- To express my emotions freely?
- Did I listen more than I spoke?
- only spoken when I knew I had good arguments?
- Did I like to take the lead in conversations?
- Did I tend to prefer "less talk, more action"?

How does this benefit me as a communicator or trainer?

The advantage of this reflection is that I become aware of where my strengths lie, but also of areas where I should be more mindful—whether as a conversation partner or an observer: giving the other person enough time and space, acknowledging emotions rather than avoiding them, gently reining in my own flow of speech, etc.—what do I want to pay particular attention to based on my upbringing? This allows me to continually move up the "Gordon Skills Ladder," and every conversation remains engaging.

Step 2: The Methodology, the HOW, the Conversation Process

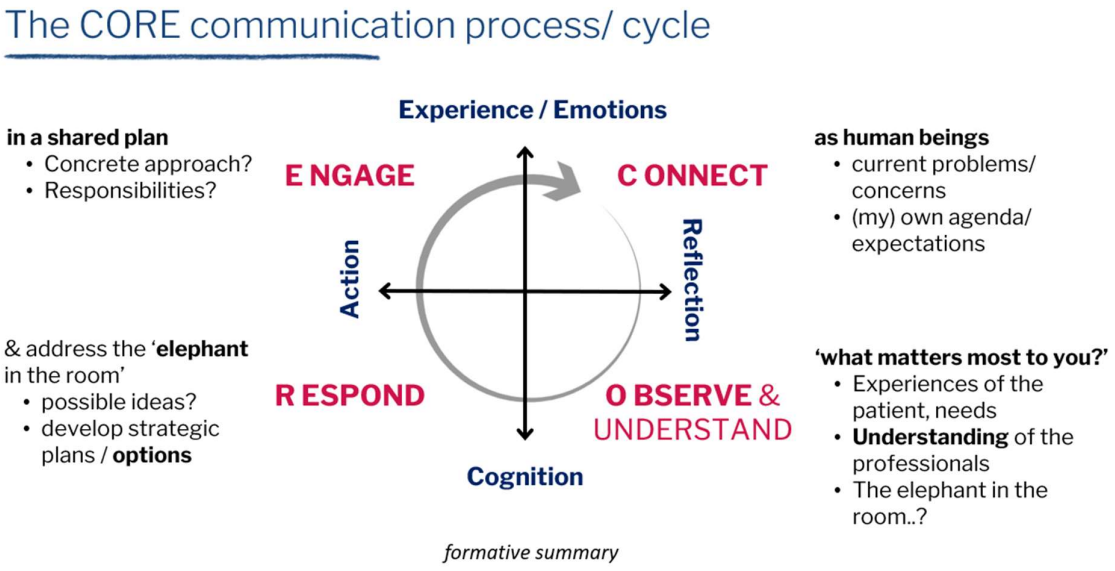
("process skills" according to Silverman)

The CORE Cycle

The basic idea and evidence is that, in principle, a conversation is about

a) connecting as human beings *("connect")*,
b) exploring the other person's perspective (*"observe & understand"*),
c) to jointly develop ideas for solving problems ("respond"), and
d) finally, to agree on concrete next steps ("engage").

We should spend 75% of the conversation time on "connect" and "observe & understand," and only 25% on "respond" and "engage." CORE is based, on the one hand, on David KOLB's "experiential learning cycle" (how to solve problems together, Kolb's Learning Styles & Experiential Learning Cycle), and, on the other hand, on the so-called Glasgow Consensus Statement on effective communication, an international evidence-based recommendation on the essential components of a high-quality conversation ("Reinforcing the humanity in healthcare: The Glasgow Consensus Statement on effective communication in clinical encounters").



A very essential part of the conversation is **"connecting**." As human beings, we meet one another, clarify our roles, expectations, and areas of expertise, as well as our availability in the near future. If there's a "click" here—if the connection "feels right"—we can then go on to discuss even difficult topics with respect and trust. The key trigger for this is our own sincere presence and curiosity in wanting to connect with the other person (see Ronald M. Epstein, M.D., F.A.A.H.P.M., Attending). **"Observe & Understand"** involves, in particular, exploring what the illness is doing to the affected person ("illness")—active listening and the willingness to regard this perspective as at least as relevant as one's own medical classification ("disease"). It is also about finding out whether—and if so, what—the "elephant in the room" is: for example, anxiety ranging up to a sense of existential threat. Or it could be mistrust, or possible denial/rationalization, etc.

What does *"formative summary"* mean?

At the transition from reflection to action – that is, before the action plan is discussed – I should summarize what I, as a professional, have understood or heard. I try to express in my own words what I have understood and how this illness or situation is affecting or has affected the person I am speaking with (understanding "illness"; see Eisenberg 1977, *Disease and Illness. Distinctions between professional and popular ideas of sickness—PubMed), and then I add how I classify the situation medically ("disease"). I begin with phrases such as: *"May I summarize what I've understood so far, and please correct me if I'm wrong? I'll then share my assessment of the situation from my medical perspective."*

How does CORE benefit me as a communicator or trainer?

CORE is an easy-to-remember tool for structuring your own communication in the spirit of partnership and for overcoming the fear that the conversation will get out of hand and become unstructured. CORE helps structure a conversation in such a way that a shared understanding of an issue or situation – in accordance with the "learning cycle" – leads, ideally, to a joint solution with a clear division of tasks and responsibilities. This is the practical application of what's known as "patient-centered communication" or "relationship-centered conversation."

The same applies to me when I'm working as a trainer: CORE is one of the reflection tools (see Step 3) for discussing the experience with learners, incorporating "time-outs" at certain points, and thereby achieving a sense of security and clarity in teaching.

Step 3: BECOME as a reflection tool during and after the conversation

(so-called "perceptual skills" according to Silverman)

Fundamentals of Reflection



During the conversation – whether as a participant or as an observer/facilitator – I reflect on clearly defined components of the conversation that have been shown to be relevant in the evidence—the BECOME components.

The technique is that of "In – and – Up," meaning that, on the one hand, I am engaged in the conversation or actively listening, while on the other hand, I mentally place myself in a sort of drone that rises above us – the communicators – to reflect from above on what is happening right now.

BECOME as a Reflection Tool

See next page

How does BECOME benefit me as a communicator or trainer?

BECOME offers the advantage of a framework for systematic reflection as well as for one's own professional development in communication. It provides tools to systematically identify potential areas of conflict during and after so-called difficult conversations, both in training situations and in real-life scenarios.

Was it – or is it – rather because I currently have far too little time for the conversation, or because the other person reminds me of my hated math teacher ("Basics"), or because I presented myself too much in the role of an expert ("Experience," Transactional Analysis), or because it was difficult to shift my perspective ("Content," too much medicalization/technical jargon), etc.? This isn't about "blaming or shaming," but rather about mutual understanding and personal growth.

The result should increasingly be that mutual understanding becomes tangible and experiential, and that a kind of collaborative working group emerges for developing solutions by drawing on expertise as both a professional and an adult with life experience. The same applies to the training situation: a great deal of trust, a shared structure for reflection, and a "safe space."

BECOME as a Reflection Tool

B asics – Fundamentals *Where do we start?* Self-reflection / Biography of my communication behavior; Self-care / Mindfulness	B	See Step 1 But also: How am I feeling right now? How much time? How much energy do I have for a conversation? What does the person I'm talking to bring out in me?
Experience / Attitude (Experience in the encounter, attitude) *How do we perceive each other?* The Experts' Meeting Relationship-Oriented Communication	E	Am I curious about the person I'm talking to? What role do I have/do I take on? Do I see them as an expert on their own life? So-called "eye level"? Conversation in the Adult "I" according to Transactional Analysis?
C ontent ("the glasses") (Content—the "lenses") *What are we talking about?* Diagnoses / illness; functions; biopsychosocial aspects; effects; personal experience of illness	C	What are we talking about? Medical diagnoses/treatments? Activities of daily living? The subjective experience of illness (how does the illness affect the person we're talking to?)
Out**comes/Goals** *What do we want to achieve together?* So-called "goal-concordant care"; shared assessment, individual goals, shared objectives	O	What do we hope to achieve through conversation, and what through treatment? Finding a path together, shared understanding ("shared mind")? How much "togetherness" is possible?
M Method / Skills (Method / Skills) *How do we proceed together?* Learning cycle according to KOLB and the Glasgow Consensus Statement = CORE Addressing emotions Nonverbal, paraverbal, and verbal skills	M	See Step 2; additionally: Where are we currently in the CORE cycle? Conversation components? Emotions? But also, in particular: my nonverbal/paraverbal cues and those of the other person: voice, pauses, breathing, body tension, etc.
E valuation *How did it go for us?* Did we achieve our goals/expectations?	E	Did we feel heard and understood (including by each other)? Mutual feedback on the quality of the conversation? What's still missing or wasn't discussed? What's next?