Cath Lab Digest

A product, news & clinical update for the cardiac catheterization laboratory specialist

PROGRAM SPOTLIGHT

Building a VTE Center of Excellence at HCA Florida Memorial Hospital

An interview with Mohannad Bisharat, MD, FACC, Medical Director of Cardiac Coronary Interventions, Ashchi Heart & Vascular Center.

More than a decade ago, the United States Surgeon General instituted a nationwide "call to action"[1] to solve a serious and growing health problem in the U.S.: deep vein thrombosis and pulmonary embolism (PE). In the years since and with the magnitude of COVID-related thrombotic events, the impact of that call has been less than hoped for and the number of patients who suffer from venous thromboembolism (VTE) continues to increase.[2,3]

In the spring of 2021, the interventional cardiologists at HCA Florida Memorial Hospital decided to amplify their efforts to address VTE at their institution. Dr. Mohannad Bisharat describes how the VTE Center of Excellence program got its start, how patient pathways have changed, and the key elements needed for success.

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In This Issue

PATIENT CARE

Communication Coaching in Cardiology

CLD talks with Kathryn Pollak, PhD

Kathryn Pollak and colleagues recently published a two-arm randomized clinical trial in *JAMA Internal Medicine*[1] evaluating a communication coaching intervention in cardiologists. The trial was performed at outpatient cardiology clinics at an academic medical center and affiliated community clinics from February 2019 to March 2020. Participants included 40 cardiologists, 161 preintervention patients, and 240 postintervention patients. Half the participating cardiologists underwent three 1:1 communication coaching sessions. Two sessions included feedback on their audio-recorded encounters with patients. In the sessions, communication coaches taught 5 skills: (1) sitting down and making eye contact with everyone present, (2) asking open-ended questions, (3) reflective statements, (4) empathic statements, and (5) "What questions do you have?" Blinded coders evaluated recorded audio of physician-patient conversations and patients completed a survey after their visit.

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CASE REPORT

The Use of Renal Artery Stents in Aneurysmal Coronary Artery Disease

Jessica Pickard, BS, MS-IV; Adam Reitz, DO; John Phillips, MD

Abstract

Aneurysmal coronary artery disease (ACAD) is a condition in which the coronary arteries become widened and dilated. It is defined as arterial dilatation with a diameter 1.5 times greater than the adjacent normal coronary vessel.[1] The optimal approach to the management of acute coronary syndrome in the setting of ACAD is somewhat controversial and understudied. While optimal management includes percutaneous intervention and stent placement, the diameter of these vessels poses a challenge to appropriate percutaneous intervention and restoration of blood flow, causing many ACAD patients to receive second-line therapies including balloon angioplasty and mechanical thrombectomy. This case report aims to shed light on the potential utilization of renal artery stents within aneurysmal coronary vessels to provide patients with ACAD first-line intervention in the setting of acute coronary syndrome.

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Communication Coaching in Cardiology

CLD talks with Kathryn Pollak, PhD

Dr. Pollak, can you describe your background and your work in clinical communication techniques?

I am a social psychologist studying how to change behavior. I have been studying clinician-patient communication for 25 years and developing wide-scale interventions to help clinicians change their behavior. Some programs do a good job at changing communication, but could be also focusing on clinician satisfaction, which is why I pivoted to one-on-one communication coaching. This type of coaching not only teaches skills, but it also provides an opportunity to model the skills and also, importantly, to provide empathy to clinicians, who have a very hard job.

Normally we think about communication from physicians as a way to make patients feel better. You are saying it can also be a way to help clinicians feel better?

Absolutely. Communication coaching works in two ways. One is that I can provide empathy to clinicians in their struggles, not just in communication, but just struggles in general, such as with electronic health records and all the things they deal with that contribute to burnout. Second, when clinicians learn more effective communication skills, they are more satisfied because their patients are more satisfied, the patients are more adherent, and the patients are also less likely to sue. There is a lot of research showing that a very high number of malpractice suits come from communication problems, so when clinicians can better communicate, benefits can extend beyond the impact on their patient's health. One study showed that when physicians expressed more empathy, their patients had improved A1C numbers. Communication makes a difference in terms of health outcomes, and happier patients make for happier clinicians as well.

Tell us about your study.[1] Why focus on cardiologists?

Cardiology has been an understudied field in communications. We have done a great deal of communication work in oncology and primary care, even in palliative care and pediatrics, but cardiology was more of an unknown territory. Cardiology communication is challenging in its seriousness and in the complexity of the procedures that clinicians need to explain. Think about what it means to talk about a stent, coronary artery bypass graft surgery, or implanting a pacemaker. These are complex procedures that clinicians need to communicate, and the outcomes of any of these procedures could have life-or-death consequences for patients.

Communication is important. It is important for every clinician. I think it is incredibly important for cardiologists because of the dire situation of many patients, and the complexity of information that the clinicians need to communicate. While I was excited to be looking at cardiology communication, it was not that we felt like there were deficits. It simply was an understudied specialty, and we thought there would be opportunities for improvement, just given how challenging the field is.

Recognizing and responding to emotion is not easy for humans, not just doctors, but doctors have an added layer of needing to gather clinical data, make a diagnosis, and make a treatment plan while still recognizing that the person who is giving you the story might have emotions that are tied in with that data.

The trial included 40 cardiologists, 20 of whom underwent coaching. Tell us about setting up the one-on-one coaching sessions.

I based our approach on prior work that I had finessed with other clinicians (see Table 1 for a brief example). I had already coached primary care physicians, palliative care clinicians, and hospitalists. From that, I had not perfected, but definitely refined, a protocol and the ability to focus on key skills that we know are evidence-based, and lead to better patient satisfaction and better patient adherence. We tried to make it easy for clinicians, who were all cardiologists. I say clinicians just to be inclusive, but all of the participants in this study work as cardiologists.

One of the things that I love about coaching and that I have learned from my prior work is that doctors are not often told what they are doing well. One of the beautiful aspects of communication coaching is that I can spend most of my time telling doctors what they are doing well. In the trial, I had one cardiologist who had been practicing for 30 years. He said, "I'm not really sure you're going to be able to teach me anything. I've been doing this a long time. I really didn't want to be in the intervention arm. I had hoped to be in the control arm," because that meant he had to meet with me for three sessions. After our first feedback session, we came back together for the second session, and he said, "I want to take back what I said. I have learned something and this has been really valuable."

I value having that opportunity to praise clinicians, because what we know about adult learners is that we do the things that we are praised for. When we are told what we are doing well, we are going to be more likely to do that in the future. We don't do as well when we are told, "Don't do this, don't do that." We do much better when we are told, "That was great! Keep doing it." That is most of what I do and the most critical piece of this coaching. I was excited to see it was where I had the greatest effect.

Of all of my communication coaching, the area in which clinicians need the most guidance is in recognizing and responding to emotion. In the control arm, we found that cardiologists were comparable to other clinicians in many specialties. When a patient expressed a negative emotion, cardiologists responded with empathy between 20% and 30% of the time, meaning 70% to 80% of the time, they did not express empathy.

What I was excited about in this study was the result from the intervention arm. When patients expressed a negative emotion, the cardiologists who had undergone communication coaching sessions responded with empathy 50% of the time. We were able to more than double the responses to negative emotion. It is exciting because I think this type of response is one of the hardest skills to teach. Recognizing and responding to emotion is not easy for humans, not just doctors, but doctors have an added layer of needing to gather clinical data, make a diagnosis, and make a treatment plan while still recognizing that the person who is giving you the story might have emotions that are tied in with that data.

Here is an example. In cardiology, it is not uncommon for patients to report passing out with no notice. They could be standing at the checkout at Walmart and pass out with no notice at all. There was one incident where a man was driving a car, ended up in a ditch, and had no idea how he got there. There was another incident where a woman had gone into a public restroom. Her husband waited outside the restroom for 20 minutes, and finally had to go into the women's restroom, only to find

her on the floor. From a cardiologist's standpoint, something went wrong with the patient's heart and they have to figure it out. They have to understand what happened so they can diagnose and treat it, so it doesn't happen again. What is very hard for doctors to do, and often no one has taught them how to do this, is to try to get that clinical information and also recognize that what that patient is describing is terrifying. It is very hard to straddle both of those needs.

That is where I feel like I had the greatest impact, helping clinicians to recognize that of course it is essential to obtain the clinical information, and also, even though this is the third person today who has told you how they passed out, to please remember that for this person, it was a scary event. All you need to say is, "Wow, that sounds really scary," and let the patient get their emotion out, feel heard and understood, and then the encounter goes so much better than when the clinician doesn't recognize that emotion. Then the patient is still scared and needs to have that fear recognized by their doctor.

It can be a skill that doctors haven't learned. I would say humans in general aren't great at it, but doctors have a much harder job, because of what they need to do in a very limited amount of time. Again, they have to do it well because a patient passing out while driving a car, for example, is dangerous. From a cardiologist standpoint, their primary focus is, "I must figure this out because this patient's life is at risk."

There's a benefit to both physicians and patients from communicating empathy even while under significant pressure.

Exactly. This is very true also in oncology or in surgery. I have worked with back surgeons where patients are describing excruciating pain, but when it is the seventh person that day, it is hard to stay fresh. It is hard to remember each patient's experience is unique. They are suffering, you need to recognize that suffering. But it is so hard when it becomes routine. But for the patient, it is never routine, while for the doctor, it can become routine. Trying to remember to be fresh to the patient experience is something that can be taught. Medical school and residency are now doing a much better job of teaching these communication skills, but it has only been in the last 10 or 15 years that these ideas have been incorporated into training.

TABLE 1. Example of coaching feedback.

Clinician communication	Coach feedback
"What do you think is going on?"	That is an excellent example of an open-ended question. You could have said, "Do you think xxx" but instead you chose to ask in an open-ended way and let the patient tell you what she thinks might be the reason. This lets the patient talk and also gives you the chance to learn something about which you might have not known to ask. Great job!
"So you have not been able to do what you normally can do."	Excellent job of reflecting back what you heard the patient say. This shows you are truly listening and not thinking about what you will make for dinner. Keep it up.
"You are right that taking that pill with food is best."	Nice job praising your patient. When you praise him, he will be more likely to do it again in the future. You also told him he was 'right' which empowers him further to be in charge of his own health as he feels knowledgeable.
Caregiver (CG): "I am just worried that I cannot take care of her anymore." **Dr:** "So what did you do when she passed out?" *Later in conversation* **CG:** "If she passes out again, I am just not sure I can help her." **Dr:** "Yeah. So how are other things going?" **CG:** "I am just feeling so scared about her passing out again." **Dr:** "I know you are scared. Tell me more about what is going on." **Patient (Pt):** "I'm worried about what the scans say." **Dr:** "I can see you are worried." **Pt:** "Yeah, I just feel like the cancer is back." **Pt:** "I find myself thinking about this all the time. I just want to get back to my old life." **Dr:** "So what does your normal life look like?"	Here is somewhere you can do something a little differently. The caregiver expressed his concern that he no longer can take care of his wife. See here, he says it again on page 4, and he says it again almost the same way on page 7. If you address his emotion the first time he says it, our research shows that he will not bring it up again. When you don't address it however, he is going to bring it up until you address it. What this does also is it preoccupies his mind, and he might be less likely to process what you are saying until you let him know that you have heard his emotion. Great job both recognizing and responding to the patient emotion! And you did it right away rather than talking about the scan then addressing the emotion. That was a good instinct to ask an open-ended question to find out what her normal life looks like. Next time, address her emotion before you ask your question. You can use a wish statement: "I wish things were different." Or name her emotion: "You seem sad that your life has shifted because of your cancer."

Reprinted with permission from Pollak KI. Teaching effective communication by modeling effective communication: experiences of a communication coach for clinicians. *Patient Educ Couns*. 2020 Feb; 103(2): 423-427. doi:10.1016/j.pec.2019.08.024

You mentioned the reward being that the encounter is going to go better and the patient might do better. Are cardiologists seeing that result?

I don't know from the cardiologist standpoint, unfortunately. Of course, we surveyed patients to get a sense of their experience. In some of my other studies, I did show an increase in patient satisfaction. I also saw an improvement in burnout among clinicians in many of my coaching studies.

The two issues with this current study are that the patients were extremely satisfied, so I couldn't do anything with their experience, which is very common among patients who see specialists dealing with serious illness. The same thing happens in oncology. It is very hard to budge patient trust in a doctor or patient satisfaction, because so much is at stake. You love your oncologist and you love your cardiologist because if you don't, what are you doing there? So patients might be a little more likely to be critical with their primary care physician, but not with cardiology or oncology. Unfortunately, I couldn't find a difference in any of the patient satisfaction scores, which would be meaningful because there were such ceiling effects.

Coaching does have an impact on burnout in clinicians. The clinicians who undergo coaching tend to have improvements in burnout versus those who are in the control arm. The cardiologists in this study were very happy. Generally, cardiologists are not the most unhappy of the doctors, so I didn't have an impact there either because they were just so happy, which is great. I couldn't show the impact I have been able to demonstrate in other studies

We have two channels, basically, as processors. We have an emotional channel and we have a cognitive channel. When our emotional channel is flooded, our cognitive channel is blunted.

focused on other fields of medicine. Still, one of the things we teach in communication is that you may not see the impact right away, but when your patients start to adhere to your recommendations, it may provide that impact.

The other reason it is critical to address the recognition of patient emotion is related to how we take in information. We have two channels, basically, as processors. We have an emotional channel and we have a cognitive channel. When our emotional channel is flooded, our cognitive channel is blunted. For example, we had a cardiac surgeon who was the patient, who four times expressed a negative emotion. They did it subtly the first time, they did it a little less subtly the next time, they did it much more directly the third time, and then the fourth time, they basically said, "I'm scared we're missing something." They didn't say it like that the first three times. But what happens is that while they are experiencing that fear, that emotion, they can't adequately process all of the things their doctor is saying. They can't follow recommendations. They can't make informed decisions because the cognitive part of their brain is shut off and the emotional part of their brain is in overdrive. When doctors make empathic statements, let patients get their emotion out and help them feel heard, the patient's emotional levels go down. Then patients can actually process information, which means they can make an informed decision. They can follow recommendations because they actually understand what the doctor is saying. Clinicians can get frustrated and will say, "I explained this to the patient, why don't they understand?" Well, it is because the patient couldn't hear or take in that information, because they were scared, angry, or worried, or whatever the emotion was that was happening meant they were not able to process any information. It is a critical point. If clinicians learn to address emotion, patients are going to better understand what they are supposed to do for their own health. They are going to better understand their condition and will be more likely to follow the recommendations, and that is a long-term effect. The patients will be doing better, but you might not see it right in that moment. You might see it a little further down the road. I will say, as a caveat, I did not assess that in this study.

If a clinican is reading this interview and wants to implement some of what you are suggesting, what do you recommend?

That is a great question. It is interesting because what we know about learning communication is that it is not easily learned just by reading an article. I wish we could easily do that. Even when I give lectures, it doesn't change behavior. There are a few reasons. One is that doctors tend to be overachievers. That's how they got where they are. They are smart and hardworking, and that is why they are in the field. They look at the skills presented and think, "I already do that, so there's no reason for me to do anything, because I'm already doing all those things that you're talking about." It is only when they have the opportunity to get feedback and to practice, that they actually change their communication.

I wish there were an easy fix, like "go watch this webinar" or "go see this talk." It doesn't tend to work that way. Clinicians need have an opportunity to try the skills, get feedback, and try again. People have questioned the scalability of my coaching protocol, asking, "Do you really need three sessions?" Three sessions is a lot, right? I tried to cut one of the feedback sessions, and I did some focus groups with some of my clinicians from one of my coaching studies. I said, "Do I really need that second session? Because I was trying to make it more scalable." The clinicians said, "Absolutely, because we got feedback from you in the first feedback session, and we wanted to show you that we did it." They need that opportunity to get feedback, and then to practice and get that feedback again. It is a critical piece. Simply listening to a talk just doesn't accomplish the same goals, because doctors don't have that critical element of practice and feedback.

Can you share more about the coaching sessions?

They can be quick. When I coached hospitalists, it was actually quicker, because they are in the hospital so often. This study relied on the cardiologists to audio record their own conversations. Honestly, that was the hardest part about the whole study for both me and the cardiologists, because they would forget because they are busy being cardiologists.

I have resubmitted a grant to train palliative care clinicians using this same coaching model but adding a booster session six months later, because one of the things we don't know from this study are the long-term effects of the three coaching sessions. We want to assess a little further out to make sure that those effects are sustained.

Have you found any workarounds that might help?

I just did a study where I trained hospitalists to coach each other. In the inpatient setting, it is significantly easier because they can go in the room together and give each other feedback right away. Hospitalists are rounding on inpatients, so I would join them, but I also taught the hospitalists to be coaches using a parallel process. I would coach first, they would watch me, then they would coach, and I would watch them and then give them feedback, because they need practice and feedback, just like the people who are being coached. If we could come up with a model where the clinicians are coaching each other, that would be more scalable. Of course, hospitalists are busy, too. But I will say that the doctors who learned to be coaches couldn't believe the benefits in terms of their own communication and their relationships with their colleagues. They also hadn't had the opportunity to see how their colleagues communicate. I will say that one of the hardest things for these clinicians is that nobody has watched them communicate since they were in training. They think, "Holy cow, someone's going to watch me? That's scary." As a coach, I tell them my favorite part is getting to tell them all the things they are doing well — and they are doing a lot of good things. It is also really powerful for them to be able to see each other communicate and provide that feedback.

Any final thoughts?

I want to emphasize my admiration for people who have chosen to go into the cardiology field. Not just cardiology, but medicine in general, including nursing. We did this study mostly pre COVID. I feel an incredible admiration for the dedication that all clinicians have and that they chose this very hard field. I am honored to be able to offer a skill that makes their lives better and to highlight all the wonderful things that they do. ■

References

1. Pollak KI, Olsen MK, Yang H, et al. Effect of a coaching intervention to improve cardiologist communication: a randomized clinical trial. *JAMA Intern Med*. 2023 Jun 1; 183(6): 544-553. doi:10.1001/jamainternmed.2023.0629
2. Pollak KI. Teaching effective communication by modeling effective communication: experiences of a communication coach for clinicians. *Patient Educ Couns*. 2020 Feb; 103(2): 423-427. doi:10.1016/j.pec.2019.08.024

Kathryn I. Pollak, PhD

Professor in Population Health Sciences; Professor in the Department of Family Medicine and Community Health Cancer Prevention and Control, Duke Cancer Institute, Durham, North Carolina; Department of Population Health Sciences, Duke University School of Medicine Durham, North Carolina

Kathryn Pollak, PhD, can be contacted at kathryn.pollak@duke.edu