

# CORR Insights®: Can Crafted Communication Strategies Allow Musculoskeletal Specialists to Address Health Within the Biopsychosocial Paradigm?

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## Where Are We Now?

“D<sup>o</sup>ctor” is derived from the Latin word “Dochere,” meaning to teach [8]. Orthopaedic surgeons embrace this role when we discuss musculoskeletal pathology and treatment, but in my view, we become uncomfortable when broaching the subject of stress and emotions. Are we training our doctors

properly? Residency training consists of both structured and nonstructured educational curricula. Presently, residents learn communication skills as part of nonstructured training rather than through a formal curriculum. Indeed, residency programs devote little time to the biopsychosocial aspects of musculoskeletal care.

One of the primary attractions for many orthopaedic surgeons to the field of orthopaedic surgery is the opportunity to identify a specific musculoskeletal problem, surgically repair the problem, and have the immediate gratification of an extremely happy individual whose pain has been resolved and function improved. This selection process is graphically evident during the residency interview process. The applicants are looking for surgical skills to be consistent with their professional identity and vision to make a specific musculoskeletal diagnosis and correct the problem. Most applicants are not interested in caring for people with conditions not responsive to the “usual” care; multiple, nonspecific musculoskeletal problems; and other chronic conditions.

Many orthopaedic surgeons are resistant to consider a role for emotions in the musculoskeletal presentation of the people that they are caring for. But there are potential consequences in this resistance. Withholding our clinical concerns and prescribing the “usual” musculoskeletal treatment for the orthopaedic diagnosis without addressing a biopsychosocial comorbidity is a violation of the bioethical principles of autonomy and nonmaleficence, and it may hinder the person’s ability to get well. Even when the musculoskeletal pathology is straightforward, the results of surgery are affected by human emotions [3, 7]. The LEAP study identified the relationship between outcomes following high-grade open tibia fractures and psychosocial support [3]. A large body of evidence overwhelmingly supports the effect of emotions, self-efficacy, and individual personality characteristics on recovery following injury [7]. Pain perception and rehabilitation can be affected by psychological, biological, and social characteristics [4, 9, 12].

The American Academy of Orthopaedic Surgeons (AAOS) performed an image tracking survey in 1998, polling the public and orthopaedic surgeons [1]. Surgeons performed poorly in ratings including listening, spending time, caring, and compassion. John Tongue, the AAOS president from 2012-2013, called us “high tech, low touch” [15]. Physician

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Hospital Consumer Assessment of Healthcare Provider and System scores were negatively impacted by our lack of communication skills; orthopaedic surgeons scored the lowest among twelve surgical subspecialties [10]. More than 20 years later, we still strive to improve our patient communication skills.

Enter the paper by Gonzalez et al. [5] in this month's *Clinical Orthopaedics and Related Research*®, which recognizes the challenges that orthopaedic surgeons face when identifying and attempting to discuss a mind-body connection. Successful doctor-person encounters require the development of a therapeutic relationship. People seek consultation for pain compromising function and hope to have the problem identified and repaired. Interestingly, the vision of the people being cared for is consistent with many of the applicants to orthopaedic residencies. This common vision may contribute to our lack of comfort in raising our concerns. Orthopaedic surgeons are often uncomfortable and inadequately trained in discussing the possibility of a biopsychosocial influence to the person's pain perception and functional compromise. They may also be concerned that these discussions will undermine the development of a successful therapeutic relationship. To avoid the potential for compromising a therapeutic relationship and avoid uncomfortable discussions, orthopaedic surgeons will often default to a biomedical model of the pain perception by introducing the concept of "over-activation" of neurons. The authors stress that abundant literature supports the concept of a mind-body connection (biopsychosocial) to pain perception, and failure to address these issues, when indicated, will compromise the likelihood of improving the person's condition. The authors have undertaken an

innovative study to identify "conversation starters" that allow an orthopaedic surgeon to successfully introduce the concept of a biopsychosocial contribution to the person's symptoms that may contribute to a stronger therapeutic relationship and improve adherence and outcomes.

### Where Do We Need To Go?

We each have our own professional identity, but we all strive to be healers. Despite our individual professional identities, it is critical that physicians recognize that a person's illness experience and recovery can be dramatically affected by emotions and psychological challenges. Everyone we care for is a unique human being and not just another "patient" with a specific musculoskeletal diagnosis that will respond to a textbook treatment plan. We will have greater success as healers when we learn evidence-based strategies to improve our communication skills and the ways in which we address a person's illness narrative [11]. Teaching the necessary tools and skills will assist orthopaedic surgeons in expressing their concerns compassionately and reinforce therapeutic relationships. Simply helping a person see how his or her mood, misunderstandings, concerns for the future, and personal stress may be affecting recovery may successfully guide that person to recovery [6]. Other individuals may require a referral to a primary care physician or a mental health professional to make it more likely they will achieve the best possible recovery.

Gonzalez et al. [5] have introduced a potentially valuable tool in addressing a mind-body connection, but it is important to remember that this is only one tool that can be utilized in an overall strategy to improve our

communication skills. Knowing how to frame the presentation of difficult discussions is crucial but will only be successful in conjunction with empathetic communication. I agree with the authors that the actual effectiveness of these "crafted communications" needs to be further tested in a clinical setting. Tremendous research opportunities exist in the orthopaedic community in understanding the mind-body connection in musculoskeletal pathology and creating effective clinical care pathways that improve recovery.

Every physician-person encounter is a human interaction based on successful communication. Each person we care for, irrespective of their musculoskeletal condition, is an individual who may be experiencing their problem differently than others. Sitting, making eye contact, listening, and acknowledging what the person is reporting helps build a therapeutic relationship. Learning to normalize and validate each person's concerns builds an empathetic atmosphere. Establishing empathy and concern will allow the orthopaedic surgeon to utilize techniques of motivational interviewing [14] and guide the discussion seamlessly into the importance of addressing a mind-body/biopsychosocial connection along with treating any identifiable anatomic pathology.

Work-hour restrictions and increasing ambulatory surgery has affected the learning opportunities for orthopaedic residents and registrars. In the past, residents had the opportunity to meet people the day before surgery and observe a seasoned clinician discuss the planned surgery. Residents spend more time in the operating rooms and less time observing in an office setting. Instead of assuming that residents and registrars will learn communications skills during their residencies, educators need to adapt to the changes and

include communication skills and the mind-body paradigm as part of the residency curriculum.

### How Do We Get There?

Regular videotaped simulation sessions beginning with basic orthopaedic encounters and progressing to a variety of challenging encounters related to human emotions, psychosocial challenges, medical errors, and sharing of bad news can be one successful strategy. A threshold number of surgical cases is required for our residents. A threshold number of observed or videotaped office encounters, with critical feedback during each resident rotation, should also be required.

The AAOS Clinician Patient Communication workshop, established after the AAOS image tracking survey in 1998, was a highly successful, evidence-based program that specifically addressed the importance of addressing both the biomedical model and the biopsychosocial model of caring for people. The program served as an opportunity for practicing orthopaedic surgeons to improve their communication skills and office encounters. Orthopaedic surgery program directors utilized the sessions to develop a foundation of communication skills in their residents and registrars. The program was discontinued a

few years ago due to cost concerns. The program should be restored.

Our words heal and our words harm [2, 13]. Improving our communication skills is equally as important as improving our technical skills. Learning the tools and developing the skills to address the mind-body paradigm will improve orthopaedic outcomes, reduce challenging encounters, and improve our professional satisfaction.

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