The REDE model of healthcare communication: Optimizing relationship as a therapeutic agent

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Abstract
The REDE model is a conceptual framework for teaching relationship-centered healthcare communication. Based on the premise that genuine relationships are a vital therapeutic agent, use of the framework has the potential to positively influence both patient and provider. The REDE model applies effective communication skills to optimize personal connections in three primary phases of Relationship: Establishment, Development and Engagement (REDE). This paper describes the REDE model and its application to a typical provider-patient interaction.

Introduction
Effective communication is the foundation for any relationship in healthcare, and our ability to consistently deliver high-quality care requires that this relationship be strong and meaningful. A significant tradition of work on the therapeutic alliance, patient-centeredness and relationship-centered care has long recognized the healing potential of the healthcare relationship. In our experience teaching relationship-centered communication to thousands of seasoned clinicians, we nonetheless recognized that many providers did not intuitively view forming relationships with patients as their role, nor did they perceive benefits of this mode of communication. In addition, in a world intensely focused on patient experience, providers often feel left out. Subsequently, building upon the previous theoretical and empirical work, we constructed a model that put the concept of relationships in healthcare at the forefront. To further reinforce the concept, we directly correlated phases of the healthcare relationship to phases of the medical interview and communication skills therein. Emphasizing the premise that genuine relationships are a vital therapeutic agent, use of this framework has the potential to positively influence both patient and provider.

The REDE model
The REDE model of healthcare communication is a conceptual framework for teaching and evaluating relationship-centered communication. REDE harnesses the power of relationships by organizing the rich database of empirically validated communication skills into three primary phases of Relationship: Establishment, Development and...
In our experience, several considerations led to the design of REDE, its resonance with advanced clinicians and implications for teaching. First, REDE is informative and also transformative because it challenges users of the model to explore their own assumptions and beliefs about patients and their role as providers. Second, we recognized that seasoned clinicians have performed countless interviews and often developed an unconscious competence in communication. Our teaching of REDE appreciates the skills clinicians already have, intentionally models relationship-centered communication in our facilitation method and encourages reflective competence by providing a common language that allows providers to reflect and refine their own skills. Third, the REDE model characterizes communication skills as tools in a toolbox, to be applied as needed. For the healing power of a relationship to be optimized, the skills must be presented in a manner that is genuine and authentic. If every provider was encouraged to recite the same lines of welcome, patients would perceive them as rote and impersonal. At the same time, we acknowledge that in early stages of learning, most newly introduced behaviors can feel scripted or unnatural until they become automated from repetition and practice. For ease of recall and utility, REDE also includes a mnemonic for each relationship phase that further supports the principles of relationship-centered care, as we have found, not unexpectedly, that learners codify information differently, and some appreciate explicit verbiage. Fourth, the REDE model can be generalized to a variety of settings. Because adult learning theory has shown that anchoring new information in what is already known facilitates learning, \textsuperscript{15} REDE skills can easily be woven into the traditional medical interview (See Figure 2) in both outpatient and inpatient settings and used across settings in a variety of conversations.

**Phase 1: Establish the relationship**
Creating a safe and supportive atmosphere is essential for making a personal connection, fostering trust and collaboration. The emotion bank account is a concept originally proposed by psychologist and author John Gottman, Ph.D. It refers to a mental system for tracking the frequency with which we emotionally connect with other people. \textsuperscript{16} Each time an emotional connection is made, it is equivalent to making a deposit in the emotion account with that person. Building up the emotion account is important to sustain a personal connection. This way, when a withdrawal inevitably occurs, such as when a patient is forced to wait to see a provider, the emotion account does not automatically go into the red.

**Convey value and respect with the welcome.** In doing so, we are essentially building the emotion bank account with our patients and families. Given that people form first impressions very quickly and patients are discussing emotional and value-laden topics, how we set the stage for conversation matters, even if it feels irrelevant to the clinical problem(s) at hand. \textsuperscript{17, 18, 19, 20} The skills outlined in Phase 1 are intended to create a climate conducive to the development of trust by demonstrating that the provider is receptive and interested in the person first, patient second.

**Collaboratively set the agenda.** Many providers fear this practice will sacrifice time necessary for assessing or treating the primary concern. However, research has shown that sharing in agenda setting not only facilitates partnership but also improves visit efficiency, diagnostic accuracy and patient satisfaction. \textsuperscript{21} Sharing in the agenda setting helps minimize our tendency to presume what a patient’s concerns are and in what order of priority.

**Introduce the computer.** The electronic health record is a reality for most healthcare providers. How we introduce and utilize the computer should be explained as a means of enhancing patient care rather than detracting from it.

**Demonstrate empathy.** Empathy is the ability to imagine oneself in another’s place and to understand that person’s thoughts and feelings. In his book, “Empathy and the Practice of Medicine,” Howard M. Spiro, M.D., described empathy as “I and you becomes I am you or I might be you (p. 9).” \textsuperscript{22} Substantial research has examined the importance of empathy. Human beings are hard-wired to be empathic toward one another. \textsuperscript{23} Unfortunately, we also know that, without intervention, empathy declines through medical training, over time in practice and with task pressure. \textsuperscript{24, 25, 26} Our experience is that most providers care about their patients, but not all recognize emotional cues or respond to them. Making verbal statements of empathy has been shown to reduce the length of both an outpatient surgery and primary care visit. \textsuperscript{27} In REDE, every opportunity to convey empathy is encouraged, and the mnemonic SAVE is introduced for outlining different types of empathic statements a provider can use.
## Figure 1: The REDE Model Skills Checklist

| Establishment Phase I | Development Phase II | Engagement Phase III |
|-----------------------|----------------------|----------------------|
| **Convey value & respect with the welcome** | **Engage in reflective listening** | **Share diagnosis & information** |
| • Review chart in advance & comment on their history | • Nonverbally – e.g., direct eye contact, forward lean, nodding | • Orient patient to the education & planning portion of the visit |
| • Knock & inquire before entering room | • Verbally using continuers such as – “mm-hmm”, “I see”, “go on” or reflecting the underlying meaning or emotion of what is said – “What I hear you saying is…” or “Sounds like…” | • Present a clear, concise diagnosis |
| • Greet patient & companions formally with smile & handshake | • Avoid expressing judgment, getting distracted, or redirecting speaker | • Pause if necessary |
| • Introduce self & team; clarify role(s) | • Express appreciation for sharing | • Provide additional education, if desired & helpful to the patient |
| • Position self at patient’s eye level | • Position self at patient’s eye level | • Frame information in the context of the patient’s perspective |
| • Recognize & respond to signs of physical or emotional distress | • Recognize emotional cues & respond “in the moment” | |
| • Attend to patient’s privacy | • Allow space to be with the patient & their emotion without judgment | |
| • Make a brief patient-focused social comment, if appropriate | • Clarify the emotion if needed | |
| • Recognize & respond to signs of physical or emotional distress | • Recognize emotion evoked in you & refrain from trying to fix or reassure | |
| • Introduce the computer, if applicable | • Demonstrate verbally with SAVE – **Support** – “Let’s work together...” – **Acknowledge** – “This has been hard on you.” – **Validate** – “Most people would feel the way you do.” – **Emotion naming** – “You seem sad.” | |
| • Orient patient to computer | **Explore the patient’s perspective using VIEW** | **Collaboratively develop the plan** |
| • Explain benefit to the patient | • Vital activities – – “How does it disrupt your daily activity?” or – “How does it impact your functioning?” | • Describe treatment goals & options including risks, benefits, & alternatives |
| • Include patient whenever possible (e.g., share labs or scans) | • Ideas – – “What do you think is wrong?” | • Elicit patient’s preferences & integrate into a mutually agreeable plan |
| • Maintain eye contact when possible | • Expectations – – “What are you hoping I can do for you today?” | • Check for mutual understanding |
| • Stop typing & attend to patient when emotion arises | • **Worries** – – “What worries you most about it?” | • Confirm patient’s commitment to plan |
| • Collaboratively set the agenda | **Dialogue throughout using ARIA** | • Identify potential treatment barriers & need for additional resources |
| • Orient patient to elicit a list of their concerns | • **Vital activities** – – “What do you think is wrong?” | • Alert patient that the visit is ending |
| • Use an open-ended question to initiate survey | • **Expectations** – – “What are you hoping I can do for you today?” | • Affirm patient’s contributions & collaboration during visit |
| • Ask “What else?” until all concerns are identified | • **Worries** – – “What worries you most about it?” | • Arrange follow-up with patient & consultation with other team members |
| • Summarize list of concerns to check accuracy; ask patient to prioritize | • **Vital activities** – – “What do you think is wrong?” | • Provide handshake & a personal goodbye |
| • Propose agenda incorporating patient & clinician priorities; obtain agreement | **Explain the patient narrative** | |
| | • **Expectations** – – “What are you hoping I can do for you today?” | • Assess using open-ended questions – What the patient knows about diagnosis & treatment |
| | • **Worries** – – “What worries you most about it?” | • How much & what type of education the patient desires/needs |
| | **Describe treatment goals & options** including risks, benefits, & alternatives | • Patient treatment preferences |
| | • Collaboratively develop the plan | • Health literacy |
| | • **Vital activities** – – “What do you think is wrong?” | • Reflect patient meaning & emotion |
| | • **Expectations** – – “What are you hoping I can do for you today?” | • Inform – Tailor information to patient |
| | • **Worries** – – “What worries you most about it?” | • Speak slow & provide small chunks of information at a time |
| | **Describe treatment goals & options** including risks, benefits, & alternatives | • Use understandable language & visual aids |
| | • Collaboratively develop the plan | • Assess patient understanding & emotional reaction to the information provided |

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Phase 2: Develop the relationship

Genuine curiosity and interest are the necessary first steps in relationship building. However, once a safe and supportive environment has been created, the relationship needs to evolve and grow. Getting to know who the patient is as a person and understanding that person’s symptoms in a biopsychosocial context is the next step. Developing the relationship also requires continued deposits into the emotion bank account and, thus, ongoing use of empathy.

Listen reflectively. Shown to enhance the therapeutic nature of a relationship, increase openness and the disclosure of feelings and improve information recall,²⁸, ²⁹, ³⁰ reflective listening is vital for developing the relationship. Yet listening in such a way as to understand and acknowledge what is being said can be a deceptively complex and challenging skill.

Elicit the patient narrative. Obtaining the history of present illness (HPI) can quickly become a series of closed-ended questions that are of most interest to the provider.³¹, ³² However, the goal of this skill is to better understand the patient’s perspective on his or her symptoms. This has been proven more efficient and effective than a provider-centered data gathering approach.³³

Elicit the patient’s perspective. Explanatory models are values, beliefs and experiences that shape a person.³⁴ Being curious to explore and open to learn are key to knowing the person, their illness that is a social response to disease and the disease itself. The REDE model suggests a simple mnemonic VIEW to explore the patient’s perspective.

Phase 3: Engage the relationship

The last step in relationship building aligns with the education and treatment portion of a patient encounter. Relationship engagement enhances health outcomes by improving patient comprehension and recall,³⁵, ³⁶ capacity to give informed consent,³⁷ patient self-efficacy,³⁸, ³⁹, ⁴⁰ treatment adherence and self-management of chronic illness.⁴¹, ⁴², ⁴³

Share diagnosis and information. Telling a patient the medical facts and what he or she needs to know is not sufficient for effective care. We must also be sure the patient understands the information. Framing information in the context of the patient’s perspective and engaging in dialogue that allows the patient to register new information and ask clarifying questions facilitates patient understanding.⁴⁴, ⁴⁵, ⁴⁶, ⁴⁷

Collaboratively develop a plan. Relationship engagement is designed to support patient understanding, decision making and consideration of potential treatment barriers. Treatment adherence and behavior change are more likely when the patient is an integral part of the planning process and agrees with the recommendations.⁴⁸

Provide closure. Ending a visit can easily be taken for granted. However, reviewing the time spent and demonstrating respect and appreciation for the patient provides closure and engenders continued partnership.

Dialogue throughout. Patients are unable to comprehend and accurately recall a considerable amount of information presented during a typical medical visit.⁴⁹, ⁵⁰ Dialogue, as opposed to monologue, keeps the patient involved in the learning process⁵¹ and, more important, reflects the importance of the patient’s role as head of his or her treatment team. In REDE, the sequence for engaging in this dialogue throughout the education and treatment portion of a patient visit is summarized by the mnemonic ARIA.
Summary
Effective communication is necessary to deliver safe, high-quality medical care. At the core of effective communication is the ability to develop meaningful relationships with patients. The REDE model builds on a significant research base including placebo, therapeutic alliance, communication skills and patient-centeredness that recognizes the healing potential of the healthcare relationship for not only patients but also providers. The REDE model helps frame the specific communication strategies that optimize their effect(s) on processes, outcomes of care and the patient-provider relationship itself. The REDE model also encapsulates evidence-based communication practices and our experience with seasoned clinicians, mostly staff physicians, within a large hospital system. It is hoped that such systemwide efforts will result in improved experience of care and self-efficacy for patients, and increased confidence, emotional connectedness and resiliency for providers. Future research will examine the generalizability of the REDE model for different contexts and provider types, as well as its potential to impact patient and provider outcomes.

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