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Published in:
Health Education in Practice: Journal of Research for Professional Learning

DOI:
10.33966/hepj.7.1.17511

Health Education in Practice: Journal of Research for Professional Learning

Vol. 7 | No. 1 | 2024

Education-in-practice article (single blind peer-review)

Citation: Links, M, McLean, M, Pepper, M, Hrivnak, G & Lai, C 2024, 'ISBAR+ a new communication tool to advocate for patients', *Health Education in Practice: Journal of Research for Professional Learning*, vol. 7, no. 1 https://doi.org/10.33966/hepj.7.1.17511

ISBAR+ a new communication tool to advocate for patients

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Abstract

Introduction

Recognising the importance of social determinants of health is a key part of the curriculum for health practitioners. The ability to advocate on behalf of patients is a competency that demonstrates enacting this understanding in practice. Communication frameworks are used to structure difficult conversations in multiple settings, notably handover. There is no commonly accepted communication framework to structure a patient advocacy conversation.

Approach

We assembled a team with skills in patient advocacy, healthcare communication, community advocacy, education and business negotiation to identify the knowledge, skills and attitudes required and to develop a framework suitable for this purpose. We chose to adapt the ISBAR framework as an existing communication framework commonly used for handover.

Outcomes

ISBAR+ is a framework that is based on a person-centred approach and 'integrated negotiation'. 'Intention and Inquiry' involves a compassionate understanding of the patient's position. 'Situation' is a succinct framing of the problem. 'Background' is the information required for the decision-maker to make a person-centred decision. The next step is 'alignment' of the priorities of the patient, practitioner and decision-maker. 'Response' is the proposed solution, and '+' ('plus') is the actions taken for implementation.

Conclusions

ISBAR+ provides a framework for conversations advocating on behalf of patients that draws from the literature around advocacy inside and outside health. A communication framework allows the development and evaluation of interventions to teach and promote this critical function to promote person-centred care.

Keywords: advocacy, social determinants of health, communication, framework.

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INTRODUCTION

Advocacy is recognised as a key role of the health practitioner to achieve improvements for self, peers or patients (Hubinette et al. 2022). Patient advocacy can be applied to a clinical problem (clinical advocacy), problems indirectly related to an individual patient (paraclinical) or the 'system' (supraclinical) (Hubinette et al. 2014). Advocacy on behalf of patients acknowledges a power imbalance between patients and the health system, with a professional responsibility to use this power in the patients' interests (Links et al. 2018). Advocacy complements but does not replace empowering patients to speak for themselves.

The health advocate role also recognises that optimal care for an individual patient requires addressing issues such as recognising the patient's wishes and concerns, assisting the patient in navigating the health system and addressing the impact of a range of determinants of health (Earnest et al. 2010; Hubinette et al. 2022). These activities result in more appropriate evaluation and treatment, as well as the development of effective person-centred therapeutic care alliances.

Shared decision-making is considered a central element of person-centred care, but in reality, senior clinicians, healthcare teams, administrators and other decision-makers act as resource 'decision-makers'. Advocacy is required because decision-makers control access to care by prescribing treatment, making referrals and deciding about admission to and discharge from services. A key advocacy activity is when a practitioner advocates for a patient to the decision-maker to achieve the patient's goals and priorities. Students and non-clinical staff also have a potential advocacy role. Little guidance exists to help practitioners undertake these critical conversations effectively. This article describes the development of a tool to guide these conversations.

Advocating for patients requires good communication skills among healthcare team members to ensure the advocates message is acted upon. Such action-oriented conversations benefit from a framework. Two examples of effective frameworks in clinical situations are SPIKES (Setting, Perception, Invitation, Knowledge, Empathy and Summary) for breaking bad news (Baile et al. 2000) and ISBAR (Identify, Situation, Background, Assessment and Recommendation) for handovers, such as transitions of care in the Emergency Room or between teams (Burgess et al. 2020). These tools can be provided, promoted and disseminated to improve the efficiency and efficacy of these critical conversations.

The ISBAR framework provides useful lessons around the development (Burgess et al. 2020), implementation (Australian Commission on Safety and Quality in Health Care n.d.), evaluation (Marshall et al. 2009) and adaptation (Brewster & Waxman 2018) of such a framework. One of the main lessons is the advantage of familiarity and iteratively building upon a previously useful framework.

In addition to the importance of having structure in advocacy conversations, a review of healthcare communication frameworks has highlighted the need for continuity between preparation, performance and follow-up. A common purpose and understanding between the participants help create an educational and therapeutic alliance (MJ Links et al. 2020).

Healthcare communication frameworks have been criticised as reductionist and prescriptive 'scripts', inhibiting creative conversations (Salmon & Young 2011). They are better viewed as a 'scaffold'. While novice learners generally cling to a scaffold, experts know when to jump free, much like jazz musicians who improvise around a theme (Haidet 2007). Another criticism of reducing healthcare communication to a list of steps is that doing this neglects the importance of intention and values. It makes a difference to the patient if the same content is addressed with a priority given to compassion or efficiency (M Links et al. 2020). Making the intention explicit is thus an important aspect of implementing a communication framework. This paper outlines the process of adapting a tried and tested communication framework to patient advocacy conversations. Providing a tool to structure these important conversations is one step towards promoting health advocacy and moving towards more person-centred care.

APPROACH

A team of experts in healthcare communication and advocacy was assembled to review and develop an appropriate tool. Iterative discussions resulted in the identification of community advocacy, education and business negotiation as additional relevant fields of expertise, leading to the recruitment of relevant experts. The lead author drafted the first version of the tool, and the assembled team provided iterative feedback to optimise its development.

Literature from the fields of health, general advocacy and education, and the integrative negotiation literature were used to identify key attitudes, knowledge, skills and structures required for an effective advocacy conversation (Amnesty International, n.d.; Earnest et al. 2010; Fisher et al. 2012; Hubinette et al. 2022; Ury 2007; World Health Organization 2006; Ziv et al. 2022). A tool that fitted the required purpose was selected from the existing communication literature. Finally, the selected tool was adapted for patient advocacy.

The knowledge required includes understanding the problem, the perspectives of the patient and decision-maker and how power is deployed within the system. The key skills required are an ability to take multiple perspectives, creativity in generating solutions, an ability to communicate succinctly and project management skills of planning, implementation and follow-through (Amnesty International n.d.; Earnest et al. 2010; Fisher et al. 2012; World Health Organization 2006).

The key attitudes identified were compassion and a willingness to empower others, which result in an attitude of person-centred care. These were combined with a mindset of systems thinking and improvement, which resulted in a focus on quality and safety. Quality and safety were defined by the quintuple aim of a quality healthcare system: patient experience, quality and safety, value (efficient use of resources), supporting the health workforce and equity (Nundy et al. 2022). The knowledge, skills and attitudes underlying the tool are shown in Table 1.

Table 1. Knowledge, skills and attitudes underlying a patient advocacy conversation

Knowledge	
Issues from both perspectives	Identifying both patient and decision-maker interests and concerns
Power dynamic	Understanding the power dynamic and its impact
Skills	
Perspective flexibility	An ability to take multiple perspectives
Creativity	Creativity in generating solutions that align the goals of patient and decision-maker
Communication	Communicating clearly and succinctly
Project management	Planning, implementation and follow-through
Attitudes	
Compassion	Acting out of a wish to relieve the patient's suffering
Empowerment	Facilitating the patient's ability to speak and act on their own behalf
Person-centeredness	Prioritising the patient's wishes and concerns
Systems thinking	Understanding how the system works and utilising this for effective change
Improvement mindset	A belief that outcomes can be improved along with a drive to make it happen
Focus on Quality and Safety	Quintuple aim of a quality healthcare system

The structure selected was based on the ISBAR mnemonic, which has been widely used as a communication teaching tool for clinical handover (Burgess et al. 2020). It aims to reach a common understanding of a patient's problems and is succinct, action-oriented and endorsed by the World Health Organisation. We suggest that this shared purpose allows the structural components to be repurposed for an advocacy conversation. An advocacy conversation requires both reaching a common understanding plus an extra step of enacting change (+), thereby creating ISBAR+. The identified elements of an advocacy conversation were then inserted into the ISBAR+ framework and reviewed by a group of experts in healthcare advocacy, community advocacy, healthcare communication and business negotiation to ensure that all important elements were included.

OUTCOMES

The acronym ISBAR+ now stands for Intention/Inquiry, Situation, Background, Alignment, Response, while the plus (+) stands for further actions.

INTENTION AND INQUIRY

Advocacy starts with an *intention* of compassion and empowerment, a curiosity about the other person and the knowledge and skills to achieve meaningful change. A process of *inquiry* then leads from empathy to compassionate action.

Inquiry starts with seeking to understand the patient's perspective, that is, their interests, concerns and goals. During this process, exploring 'Why?' can often help the practitioner to uncover the patient's underlying interests.

Understanding the perspective of the decision-maker (who controls access to care) can come from previous conversations, while understanding how the system works (systems thinking) comes from previous experience or advice from the team. Understanding the interests of all parties is essential to creating a solution that provides mutual gain. These steps precede the advocacy conversation.

SITUATION

The advocacy conversation starts with a succinct framing of the problem—the decision to be made—and points to a solution. Summarising this situation at the beginning of the advocacy conversation allows the listener to focus their attention on what is important to the decision-making process.

BACKGROUND

The *background* consists of the information brought to the conversation that will help the decision-maker to make an informed decision. This information includes facts, options and relevant opinions (e.g., of other team members and the family). The practitioner or student must integrate it with their understanding of the patient's interests and situation.

ALIGNMENT

This key step in the conversation aligns the shared priorities of the patient, practitioner and decision-maker. This alignment involves identifying shared and conflicting interests of all parties to ensure a mutually beneficial outcome. An understanding of the decision-maker's perspective is critical to be able to frame and reframe the situation and shared interests of the parties involved to achieve alignment.

One strategy that can help in this regard is to demonstrate the alignment of the patient's interests with a better-quality health system (the quintuple aim) (Nundy et al. 2022). This approach can often be effective in fostering alignment of the stakeholders' interests because of the legitimacy of these aims. An example would be demonstrating that the proposed action not only improves patient satisfaction but also relates to patient safety, resource utilisation, staff wellbeing or health equity. Having a proposal that meets shared interests creates the potential for a 'win–win' agreement.

RESPONSE

The *response* is the proposed solution to the identified problem. If the preceding steps have been effective, this will ideally result in a mutually acceptable outcome. If, however, one does not achieve the desired advocacy outcome, the practitioner will need a measured response. An initial step is to seek clarification. By asking 'why' and using active listening, the practitioner may be able to gain valuable insights regarding the decision-maker's interests or constraints that were not apparent earlier in the process. Paraphrasing, asking for corrections and acknowledging the decision-maker's point can help the practitioner demonstrate their genuine interest in reaching a mutually agreeable outcome. Doing these things can lead to alternative ways to reframe the situation or generate new proposals or perhaps a compromise. An extended discussion dealing with more difficult negotiation situations is given in Ury (2007).

Even with reframing the situation or revision of the proposals, the decision-maker may still have concerns about the potential success of the options. It is helpful to have anticipated this possibility and have a plan. In such a situation, it can be tempting to escalate (e.g., seek the intervention of a superior) or otherwise use a power imbalance to force an agreement. A more measured, person-centred approach, however, could be to highlight both the 'costs' of no agreement (poor health outcomes or patient dissatisfaction) and the benefits of mutual agreement (quality care). This approach might help lead to a mutually beneficial person-centred outcome. Thus, regardless of the initial response, the practitioner is continuously working to achieve agreement as well as strengthen the relationship with the decision-maker. This hopefully sets the scene for future successful advocacy.

PLUS (+)

Achieving agreement may seem like the end, but it is only the beginning. The efforts thus far can help reach an acceptable solution, which must then be implemented. During this step, unforeseen barriers may emerge. Without continued advocacy, the solution may not be fully implemented, and the interests of the patient remain unmet. Thus, advocacy ends with successful implementation, not just successful negotiation.

Finally, this step provides an opportunity for reflection. The practitioner needs to reflect on each advocacy opportunity to examine what worked and what did not work and learn to be more effective in the future. The implementation step can provide useful feedback. The implementation of an agreement often goes much more smoothly when both the advocate and the decision-maker spend sufficient time fully exploring the other's interests. Satisficing—doing just enough to reach agreement—may provide an acceptable outcome, but greater effort in understanding during the negotiation phase can avoid challenges or misunderstandings during implementation.

The features of the framework are summarised in Table 2, and an example is provided in Appendix 1.

Table 2. A summary of the ISBAR+ framework

Intention and Inquiry	Intention: Curiosity, compassion and empowerment Inquiry: Stakeholder perspectives, barriers, enablers, solutions
Situation	Brief statement: The problem
Background	Information required for a decision: Facts, alternatives and opinions
Alignment	Aligned values, goals and priorities of decision seeker, decision-maker and team to act as 'levers'
Response	Desired outcomes and your response to the result Your response to the decision
Plus (+)	Follow-up communication and actions

ISSUES FOR APPLICATION AND EVALUATION

The ISBAR+ framework is suitable for use as a teaching tool to promote discussion of advocacy conversations while promoting the values of person-centredness and the quintuple aim. It links principles from the disciplines of healthcare advocacy, community advocacy, education, integrated negotiation and healthcare communication.

The utility of ISBAR+ as a tool depends upon its feasibility and acceptability as a structure for these conversations. The tool's impact depends upon its ability to achieve desired outcomes and relies heavily on practical training and further learning around integrative or interest-based negotiation skills to offer a clear, practical approach towards the goal of effective patient advocacy.

Lessons learnt from the implementation of the ISBAR framework for clinical handovers may also inform the implementation of ISBAR + as a framework for patient advocacy and may help maximise uptake. These strategies include the identification of communication as a safety and quality issue, endorsement by relevant national and international organisations, the development of implementation support resources and 'toolkits' and the use of multiple communication channels (journal publications, websites, video sharing platforms, posters, lanyard cards) (Marshall et al. 2009). Faculty development and training are key.

The ISBAR+ tool can be further developed as a self-assessment tool to evaluate what components of the conversation were utilised and the efficacy of each component. Further research could build upon the

framework to identify other aspects of effective advocacy conversations. Additional work is needed to consider the training and additional conversations required for effective implementation and system change.

SUMMARY AND CONCLUSIONS

ISBAR+ is a framework for structuring advocacy conversations. It utilises an existing tried and tested communication framework adapted for advocacy. Although the purpose of this toolbox is focused on patient-level advocacy, a similar approach could be utilised to enable practitioners to advocate for themselves, their peers and their communities.

Approaching such conversations with curiosity, compassion and a goal of empowering patients is key. ISBAR+ provides a useful scaffold to enable these conversations and a common language for learning and practice.

Acknowledgements

We wish to acknowledge the First Nations people on whose land this work was done, particularly the Kombumerri people of the Gold Coast, and advocate for recognition that this always was and always will be Aboriginal land.

Conflict of Interest

Nil

Funding

Nil

References

Amnesty International n.d., Influencing decision-makers—a guide to effective advocacy, viewed 25 March 2022, https:/www.amnesty.org.au/wp-content/uploads/2016/07/AMN2171_AdvocacyGuideMR-1.pdf.
Australian Commission on Safety and Quality in Health Care n.d.,

ISBAR—A handover 'how to', viewed 25 March 2022, https://www.safetyandquality.gov.au/publications-and-resources/resource-library/isbar-handover-how.

Baile, WF, Buckman, R, Lenzi, R, Glober, G, Beale, EA & Kudelka, AP 2000, 'SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer', Oncologist, vol. 5, pp. 302–11.

Brewster, DJ & Waxman, BP 2018, 'Adding kindness at handover to improve our collegiality: the K-ISBAR tool', Medical Journal of Australia, vol. 209, pp. 482–3, <https://doi.org/10.5694/mja18.00755>.

Burgess, A, van Diggele, C, Roberts, C & Mellis, C 2020, 'Teaching clinical handover with ISBAR', BMC Medical Education, vol. 20, p. 459, https://doi.org/10.1186/s12909-020-02285-0.

Earnest, M, Wong, S & Federico, S 2010, 'Perspective: physician advocacy: what is it and how do we do it?', Academic Medicine, vol. 85, no. 1, pp. 63–7, https://doi.org/10.1097/ACM.0b013e3181c40d40.

Fisher, R, Ury, W & Patton, B 2012, Getting to YES: negotiating an agreement without giving in, 3rd edn, Random House Business Books, London.

Haidet, P 2007, 'Jazz and the "art" of medicine: improvisation in the medical encounter', The Annals of Family Medicine, vol. 5, pp. 164–9, https://doi.org/10.1370/afm.624.

Hubinette, MM, Ajjawi, R & Dharamsi, S 2014, 'Family physician preceptors' conceptualisations of health advocacy: implications for medical education', Academic Medicine, vol. 89, pp. 1502–9, https://doi.org/10.1097/ACM.0000000000000479.

Hubinette, MM, LaDonna, KA, Scott, I, van der Goes, T & Kahlke, R 2022, 'When I say… health advocacy', Medical Education, vol. 56, pp. 362–4, https://doi.org/10.1111/medu.14728.

Links, M, Ayling, T, Doran, J, Braganza, S, Martin, P, Clayton, J & Hiremagalur, B 2020, 'A compassionate pause', Patient Education and Counseling, vol. 104, no. 2, pp. 432–https://doi.org/10.1016/j.pec.2020.08.012.

Links, MJ, Watterson, L, Martin, P, O'Regan, S & Molloy, E 2020, 'Finding common ground: meta-synthesis of communication frameworks found in patient communication, supervision and simulation literature', BMC Medical Education, vol. 20, p. 45, https://doi.org/10.1186/s12909-019-1922-2.

Links, MJ, Wilkinson, T & Campbell, C 2018, 'Discourses of professionalism: metaphors, theory and practice', Medical Teacher, vol. 41, no. 1, pp. 91–8, https://doi.org/10.1080/0142159X.2018.1442565.

Marshall, S, Harrison, J & Flanagan, B 2009, 'The teaching of a structured tool improves the clarity and content of interprofessional clinical communication', BMJ Quality & Safety, vol. 18, pp. 137–40, https://doi.org/10.1136/qshc.2007.025247.

Nundy, S, Cooper, LA & Mate, KS 2022, 'The quintuple aim for health care improvement: a new imperative to advance health equity', JAMA, vol. 327, pp. 521–2, https://doi.org/10.1001/jama.2021.25181.

Salmon, P & Young, B 2011, 'Creativity in clinical communication: from communication skills to skilled communication', Medical Education, vol. 45, pp. 217–26, https://doi.org/10.1111/j.1365-2923.2010.03801.x.

Ury, W 2007, Getting past no: Negotiating in difficult situations, rev. edn, Bantam Books, New York.

World Health Organization 2006, Stop the global epidemic of chronic disease: a practical guide to successful advocacy, viewed 15 October 2023, https://iris.who.int/handle/10665/43513.

Ziv, T, Wamsley, M, Lai, CJ, Griffiths, EP, Maxey, A, Kryzhanovskaya, I & Teherani, A 2022, 'A is for advocacy: how introducing student advocacy assessment impacts longitudinal integrated clerkship students and clinical supervisors', Medical Teacher, vol. 44, pp. 149–57, https://doi.org/10.1080/0142159X.2021.1967903.

APPENDIX 1

An example of a scenario with a junior doctor using the ISBAR+ framework to advocate for delaying a patient's discharge.

Scenario
You are a junior doctor on a medical team, and the consultant is the decision-maker with decision-making authority for admissions and discharges. You have been on intake this week, and the ward is full. There is an imperative to discharge patients, and you are looking forward to being less busy. On the ward round, the consultant decides that Mrs X is able to go home following completion of intravenous antibiotics for pyelonephritis and resolution of her symptoms. You are charged with discharging her. On reviewing her chart and talking to her about how she is feeling, she discloses that she is concerned about going home as her caregiver (daughter) has been diagnosed with COVID-19 and is undergoing seven days of isolation. She wants to stay in hospital. You are using the ISBAR+ framework to advocate for her staying in hospital.
Intention and Inquiry
Identifying that your *intention* is to prioritise Mrs X's needs and respond compassionately is an important first step. *Inquiring* about her concerns, what options are available for her and the barriers to being able to care for herself are important issues.
After these inquiries, you determine that Mrs X is at risk of a fall if not supervised at home by her daughter. As there are no other supports, the preferred option is to grant her wish to stay in hospital.
You now communicate with the consultant
Situation
'Hi, Doctor Y, this is Matthew, your intern. I would like to update you on the discharge plans for Mrs X. There is a problem with her discharge in that she currently has no support at home, and I am thinking it is best that she stays in hospital.'
Background
'As you know, she lives with her daughter, is quite frail, mobilises with a walker and was classified as a falls risk in hospital. The problem is that her daughter has been diagnosed with COVID-19 and is not able to care for her. I have spoken to the social worker, and there are no supports available while the daughter is infective.

Alignment
'The nurse in charge and I think that she is not safe for discharge and will likely require readmission.'
Requested response
'I thought we should delay discharge and get a more thorough allied health assessment and see if we can figure out an alternative plan.'
Response back
The consultant agrees with your plan 'Thanks; she will be very grateful that you have addressed her concerns." *The consultant does not agree with your plan and insists on discharging her* This is a difficult situation. The possibilities include: *(1) Clarification:* Saying to the consultant: 'Just so I understand; can you explain why you think she will be okay at home?" In this situation, you might also *register your concern:* 'I am worried she will be back in hospital.' *(2) Compromise:* Saying to the consultant: 'Okay, I understand your perspective. I would like to first speak to her daughter to explain and see if she is alright with this plan, given your thoughts. Would you be able to join this conversation to discuss together?' *(3) Escalation:* Enlist support and communicate your concerns to someone else who is in a position to revisit the issue and advocate more effectively, such as the nurse manager or discharge planner.
Plus (+)
There are actions required following this conversation that include communicating with the patient and the family as well as the team about any amended plan. It would be appropriate to thank the patient for raising their concern and encourage them to do so in future.