Physician-patient communication

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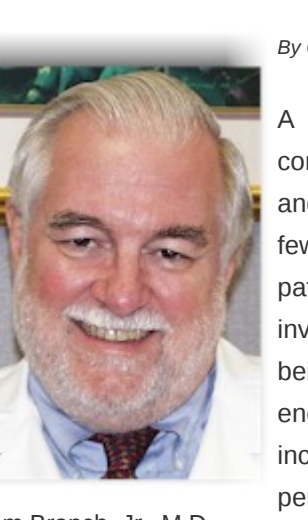

William Branch, Jr., M.D

By Christopher Guadagnino, Ph.D.

A growing body of evidence links effective physician-patient communication to desirable outcomes such as lower patient stress levels and improved adherence to treatment, higher physician satisfaction, and fewer medical malpractice lawsuits. The paternalistic model of physician-patient interaction has years ago yielded to one that encourages active involvement of patients in their care management, and patients are now being offered consumer-directed models of health insurance that encourage them to "shop around" for physicians, while interest is increasing by federal and private health insurers in physician performance measurement, reporting and quality incentives.

These developments are driving what some experts regard as a paradigm shift in medical education: training medical students, residents and physicians in "best practice" communication skills, restoring the value of empathy and rapport-building between physicians and patients – once common in medical practice, but now perhaps crowded out by managed care's toll on physician time and resources.

The Institute of Medicine, in a 2004 report, *Improving Medical Education: Enhancing the Behavioral and Social Science Content of Medical School Curricula*, noted that half of all causes of morbidity and mortality in the U.S. are linked to behavioral and social factors and lamented that the medical profession has yet to successfully incorporate knowledge of psychological and social variables into standard medical practice. "To make measurable improvements in the health of Americans," the report said, "physicians must be equipped with the knowledge and skills from the behavioral and social sciences needed to recognize, understand, and effectively respond to patients as individuals, not just to their symptoms." The report noted that "communication skills, which are emphasized in the behavioral and social sciences, will assist physicians in building therapeutic relationships with their patients and increase the likelihood that patients will follow their advice."

Perhaps less tangible, while certainly more profound, is the humanizing effect on the medical profession when physicians begin to incorporate social and personal aspects of their patients' lives into their care regimes, recognizing these aspects not as time-consuming niceties, but as key ingredients to truly effective care of a human being.

Interpersonal and communication skills have in recent years become a core focus of medical education, with the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) having identified them as core competencies. The National Board of Medical Examiners last year added a Communication and Interpersonal Skills (CIS) Subcomponent to the United States Medical Licensing Examination, whereby performance is assessed by standardized patients – actors trained to role play as patients – who use rating scales based upon national consensus statements on essential communication skills in questioning, information-sharing, and professional manner and rapport.

Pa.'s medical schools have begun to incorporate into their curriculum innovative programs to help students foster empathetic encounters with patients in a variety of situations, such as routine history-taking, handling sensitive information, managing substance abuse, breaking bad news and motivating uncooperative patients. Research-based communication training and skill-building programs for medical school faculty and practicing physicians have been offered at the national level for several years, and are becoming more technologically sophisticated with the growth of electronic media.

Communication "Best Practices"

In 1978 members of the Society of General Internal Medicine formed a Task Force on the Medical Interview, offering to medical school faculty an annual course on how to teach effective communication skills, and in 1983 began publishing a quarterly newsletter, *Medical Encounter,* which continues to disseminate clinical, research and narrative data relevant to improving the physician-patient relationship. The group formed an independent organization in 1993 – the American Academy on Physician and Patient – and has recently changed its name to the American Academy on Communication in Healthcare (AACH) to reach beyond the physician community, according to **William Branch, Jr., M.D.**, the organization's president-elect, and Director of Emory University School of Medicine's Division of General Medicine.

The AACH fulfills its mandate to "disseminate the practice of health care relationships and communication that integrate best medical practices with patients' and clinicians' values, needs and choices" by holding annual teaching and research forums, which Branch says have led to widespread adoption by medical schools of experiential learning techniques pioneered by the AACH.

Several models of "best practices" in physician-patient communication can be gleaned from research, says Branch. A model that focuses on communication functions emphasizes three skill sets: effective information-gathering and diagnosis-forming, building a relationship with the patient, and offering patient education and counseling. Building a relationship requires demonstrating active listening skills, communicating empathy verbally and nonverbally, being supportive and conveying respect – behaviors that Branch says can be learned by being shown, practiced and subject to feedback until they work.

A second model emphasizes a patient-centered attitude, actively attending to the words and nonverbal cues of a patient, rather than imposing the physician's interpretive frames on the patient, which may impede understanding by both.

A third model, the motivational interview, is effective for counseling contexts such as encouraging lifestyle changes, smoking cessation and weight loss, and uses empathy techniques to explore motivations and barriers to changes, as well as to boost patient confidence in their ability to make the changes.

Many studies show that a combination of these approaches has statistically significant impact on patient satisfaction, communicative effectiveness ratings by third parties, as well as outcomes – including number of referrals, number of tests ordered, and number of prescriptions written (all fewer), says Branch. One study, he illustrates, suggested that too many patients were getting medication instead of having their real problems addressed by their physicians, and that when physicians spent more time discussing with patients concerns about their disease, they prescribed fewer drugs.

A meta-analysis of some 30 studies found that four features of physician-patient communication led to decreased patient anxiety and improved symptom resolution: clear information by physicians, mutually agreed-upon goals, active patient role and positive affect/empathy/support from the physician, says **Dennis H. Novack, M.D.**, Professor of Medicine and Associate Dean of Medical Education, Drexel University College of Medicine, and editor emeritus of *Medical Encounter.*

Other studies correlate effective communication with reduced risk of malpractice lawsuits. One such study showed significant differences in communication behaviors by primary care of physicians who had malpractice claims filed against them and those who did not: those with no claims used more statements of orientation (educating patients about what to expect and the flow of a visit), laughed and used humor more, tended to use more facilitation (soliciting patients' opinions, checking understanding and encouraging patients to talk), and spent slightly longer (18.3 vs. 15.0 minutes, on average) in routine visits.

Communication patterns can even affect *physician* satisfaction, says Novack: one study showed highest physician satisfaction in a "consumerist" pattern – characterized primarily by patient questions and physician information-giving, and lowest satisfaction in a "narrowly biomedical" pattern – characterized by closed-ended medical questions and minimal psychosocial discussion.

Effective communication during patient encounters is teachable, says Branch, as studies have shown that experiential learning, combined with reflection, have improved the performance of medical students, residents, family physicians and oncologists – as measured on patient questionnaires or rating scales of communicative effectiveness.

As performance measurement evolves, Branch predicts that physicians' communicative effectiveness may play a larger role in pay-for-performance incentive programs. Managed care plans and large group practices already use patient satisfaction survey data in their physician performance appraisals, but Branch says those data are diluted by including responses to questions that are irrelevant to the physician-patient interaction, although they seem to matter most to patients, e.g., "Was it easy to park? Was the receptionist helpful? Was the waiting time acceptable?"

As physician performance assessment moves beyond primitive outcome measures – e.g., how many eligible patients got mammograms – it will incorporate more sophisticated outcomes – e.g., how many patients are getting enough exercise, or have their blood pressure under control – that are increasingly related to how much a patient trusts and is motivated by their physician, and that are increasingly dependent on effective communication, says Branch.

Until relatively recently, medical training neglected the importance of empathy and rapport-building skills, focusing on *curing* the patient with the right diagnosis and the right medicine, but not *healing* the patient by addressing the context and meaning of their illness, according to **Lindsey Lane, M.D.**, Associate Professor of Pediatrics and Director of Undergraduate Medical Education at Jefferson Medical College. Any physician, primary care or specialist, needs to put the patient's illness into a context: acknowledging the roles of their family, work environment and community, while being positive, supportive and encouraging, she says. "We've become so enamoured with the fascination and excitement of our technological abilities to cure disease. But there's a *person* there, and we're being pulled back into a balance," she adds.

Building rapport is central to effective physician-patient interaction, says Lane. Rapport with a patient is built up by "doing many little things – if you do a preponderance of things well, patients may trust you and forgive you if you make one communicative mistake," she says.

A checklist of communication skills is used in standardized patient assessments of medical students during their licensure examinations, and includes: asking about the patient's expectations, feelings and concerns; asking about support systems and impact of illness; encouraging additional questions or discussion; and making empathetic remarks concerning patient issues and concerns. The checklist also includes medical interviewing skills such as using open-ended questions, transitional statements and facilitating remarks; accurately summarizing information from the patient; avoiding leading or multiple questions, interruptions when the patient is talking, and medical jargon unless immediately defined; and providing closure including statements about what happens next.

Empathy is the backbone of positive physician-patient relationships, according to Mohammadreza Hojat, Ph.D., Research Professor of Psychiatry and Human Behavior, and Director of Jefferson Longitudinal Study, Center for Research in Medical Education and Health Care, Jefferson Medical College. Empathy in a health care context is defined as a cognitive – as contrasted with emotional – attribute that entails understanding the inner experiences and perspective of the patient, along with a capability to communicate this understanding to the patient, he says. While excessive sympathy – an emotional sharing – could hamper a physician's ability to render objective diagnosis and treatment, the "compassionate detachment" of empathy enables him or her to understand the patient's needs from the patient's own perspective, Hojat maintains.

Empathy in medical students is linked to higher ratings of clinical competence in third-year core clinical clerkships, although mean empathy scores of medical students decline during the third year of medical school – the time when most clinical skill-building occurs, according to Hojat's research, which used a newly developed Jefferson Scale of Physician Empathy. Of the 20 Likert-type items on the scale, student's scores declined the most significantly on these:

· It is important to ask patients about what is happening in their lives as it is to ask about their physical complaints.

· Physicians should try to think like their patients in order to render better care.

· Emotion has no place in the treatment of medical illness (a reverse-scored question).

Reasons for a decline in empathy scores require further study, says Hojat, while he notes that other researchers have found medical education may erode empathy by placing a greater emphasis on technological than on humanistic aspects of medicine, and may inculcate elitism among medical students.

Hojat notes that medical schools are now paying more attention to humanistic features of medical care, including empathetic engagement in patient care encounters, and he hopes to pursue the idea of developing national norms against which to compare empathy scores of medical students and of physicians, so that targeted educational remedies may be offered to those who score significantly below the group average. Hojat is also using the Jefferson empathy scale to test the validity of feedback given to medical students by standardized patients by studying the correlation between medical students' empathy scores and standardized patient evaluations of their empathetic skills.

Researchers have identified various components of physician-patient communication – such as empathy, reassurance, patient-centeredness, information-sharing and friendliness – as having a statistically significant positive effects on patients' health status and quality of life, according to **Bruce Ling, M.D., MPH**, Assistant Professor of Medicine and Associate Director for Research, University of Pittsburgh Institute for Doctor-Patient Communication. The Institute was launched in late 2003 to coalesce such research efforts, develop expertise in methodologies and assessment criteria, collect best practice examples and techniques, and house a registry of audiotaped data.

Among the interventions shown to be effective, says Ling, is having physicians adapt biomedical information to the psycho-social experiences of the patient that might affect compliance. For example, instead of saying to a diabetic, "You need to change your diet, take your insulin at this interval and exercise at this interval," a physician would say, "Mr. Jones, what's your day like? How does diet and exercise fit into that? How does your schedule affect your ability to take your insulin?" Patient-centered communication has a higher ratio of social talk and patient talking time than does typical office interaction, Ling notes.

Another effective intervention is "patient activation," whereby a health educator coaches patients before they see their physician in techniques such as setting an informational agenda, asking questions and transacting feedback, says Ling.

Ling's own research includes studying colorectal cancer screening exchanges and the impact of various types of information and styles of provider communication on patients' screening completion rates.

While patient-centered interventions have led to outcomes such as a 10 percent improvement in blood glucose levels among diabetic patients, Ling cautions that there are too many confounding variables and population differences in the studies to glean impact magnitudes. From a moral and ethical perspective, however, communicative improvements are inherently valuable: patients desire them and they forge satisfying and trusting patient-provider relationships, he adds.

Aside from the challenge of learning and practicing these improvements, a physician must learn to incorporate their patient's agenda into the 15-minute "box" allotted for the typical office appointment, says Ling. Electronic messaging capabilities – email, Web-based bulletin boards and the like – are exciting and viable extensions of that "box," he says, and researchers are currently looking at various issues raised by those alternatives, such as monitoring their impact on the frequency of live interaction, ensuring security and privacy of their information, controlling their volume and the time it takes to exchange them, and minimizing misunderstandings that can occur with them. One study, for example, found that physician-patient electronic information exchange led to a decrease in volume of office visits, but no change in volume of telephone calls, notes Ling.

Training Programs

There is a growing number of training opportunities in interpersonal communication for practicing physicians that supplement traditional Continuing Medical Education offerings by specialty societies.

The Institute for Healthcare Communication (formerly the Bayer Institute for Health Care Communication), founded in 1987, has conducted more than 9,000 CME workshops for more than 120,000 clinicians and health care workers, on topics such as difficult clinician-patient relationships, risk management, informed consent, error disclosure, and electronic communication.

The AACH, in addition to its annual faculty development and teaching and research forums, offers CME courses and workshops for physicians at a various institutions, which recently included Geisinger Health System and Lehigh Valley Hospital, says Branch.

AACH and Drexel University College of Medicine have jointly produced a Web-based learning resource, "doc.com," which archives 40 multimedia interactive modules and hundreds of videos showcasing various communication competencies, says Novack. Scenarios cover subjects such as domestic violence, alcoholism diagnosis and counseling, responding to strong emotions, exploring sexual issues, spirituality and religious beliefs, the adolescent interview, medically unexplained symptoms and somatization, and terminating the doctor-patient relationship. Vignettes are accompanied by running commentary of individual communication skills at the moment they are being portrayed, as well as meta-level comments by the participants – such as why the physician made an empathetic comment or probed a particular point, says Novack. The resource also accommodates real-time chats with other users to facilitate discusssion among learners, he adds.

Newly-minted physicians emerge from their education with much stronger training in interpersonal communication skills than their mentors did, as students at every Pa. medical school are now exposed to curriculum in communication skill-building, typically beginning in the first year with lectures and proceeding to work involving history-taking interview vignettes with standardized patients. Much of that curriculum is relatively new and still evolving, as are training opportunities for residents.

In Jefferson's "Medical Practice for the 21st Century" course, first year students watch and critique tapes of each other's history-taking interviews, which include sensitive scenarios such as taking a sexual history and dealing with domestic violence abuse, says Lane, who directs the course. When they enter residency training, new physicians are evaluated four times in structured clinical settings involving real patients, using the relatively new "mini-CEX" approach: a 15 to 20 minute snapshot of a resident-patient interaction in which attending physicians assess seven components of competence: medical interviewing skills, physical examination skills, humanistic qualities, professionalism, clinical judgment, counseling skills, organization/efficiency and overall clinical competence, says Lane.

The very first course in the curriculum of University of Pittsburgh's School of Medicine groups ten students with two faculty mentors and two "simulated patients" who don't present the medical history of a standardized patient, but focus on interpersonal cues by improvising responses to learners' attempts to communicate effectively, says Laurel Milberg, Ph.D., Associate Professor of Family Medicine, and Education Director for the University of Pittsburgh Institute for Doctor-Patient Communication. Scenarios focus on difficult issues and students can "freeze" the action to get coaching from the faculty mentors and simulated patients, she says.

When the "patient" cries or expresses anger, Milberg explains, students are encouraged to resist the urge to recoil from the emotion or try to talk the patient out of expressing it, and instead to "lean into" the emotion by demonstrating understanding of it, for example, by saying something like, "It seems as though you are serious about how you feel."

When delivering bad news to a patient, such as a diagnosis of cancer, students are advised not to give too much information all at once, and instead to start by reviewing with the patient what has happened so far in their clinical situation, "giving a warning shot" to prepare them that bad news is coming, then to be quiet – to allow the patient to absorb what was just said and not bury them in a sea of detail of what is to come, says Milberg.

When questioning a patient about a destructive personal habit, Milberg says, students are coached on how to ask questions in a non-judgmental fashion, e.g., "When in a difficult situation, do you find yourself doing something you know you shouldn't, like drink too much?" or "Tell me how you use tobacco. How do you smoke?"

Milberg notes that, during clerkship clinical rotations in family medicine and in geriatrics, preceptors encourage a humanistic orientation toward patients by requiring residents to relate some personal or contextual piece of information about the patient they just saw that is not biomedically necessary, as a criterion of their presentation about the patient.

Early next year, Pitt is going to begin piloting the Balint training approach throughout residencies in several specialties, says Milberg. Named after a Hungarian psychoanalyst who practiced in England in the 1950s, the method involves case discussion among residents at monthly or biweekly meetings, with a focus on the emotional factors and personality types in a physician-patient relationship and a goal of expanding a physician's repertoire for handling difficult situations.

This academic year, Temple University School of Medicine has made major changes to its curriculum, adopting an interdisciplinary "hybrid organ systems approach" by integrating clinical medicine, basic science and "doctoring" skills to facilitate learning from patients' symptoms, says Gerald Sterling, Ph.D., Temple's Associate Dean of Medical Education. To understand how to treat a patient with high blood pressure, for example, a physician needs sharp physical history-taking skills to learn physiological and other contributing factors, such as diet, exercise and other drugs taken, says Sterling.

Physicians' scientific knowledge is not enough, though, and they need to gain their patients' trust to encourage sharing sometimes intimate details about their lives in order to "solve the clinical mystery," Sterling notes. Temple has expanded its use of standardized patients, increasing their "patient instructor" role by having them give more feedback to students, e.g., "You didn't give me enough time to answer your questions," and having both clinical and basic science faculty present to give feedback on all aspects of the history-taking scenarios, Sterling says. The approach allows faculty to identify and remediate students' communicative difficulties earlier on in their training, he adds.

Professionalism and cultural competency are also incorporated into Temple's Doctoring and Clinical Skills course – which is new this year. Students are shown a series of videotaped vignettes designed to illustrate the kinds of behaviors patients expect in their physicians, says **Ellie Kelepouris, M.D.**, director of the course. In one example, a physician is puzzled that a patient who has cancer is offered chemotherapy but declines it. The patient turns out to be a devout Muslim who, had he been asked, would have revealed that his objection was not to the therapy itself, but to the intravenous delivery of it – as his religion prohibits foreign objects in the body, explains Kelepouris.

In another example, a diabetic Hispanic woman is labeled "non-compliant" because she insists on staying in her apartment rather than to receive diabetes care at a clinic. Social issues are revealed to be the reason: she fears she will lose her apartment if she leaves it. The lesson in both cases, says Kelepouris, is to ask plenty of open-ended questions of your patients, and be mindful of cultural and social issues that may be crucial to their care.

A first-year medical student learns how to respond to ethical dilemmas during his or her interaction with standardized patients. Kelepouris illustrates: the "patient" asks, "I want to kill myself – can you help me do that?" The stock response, which is probably least effective, is for the physician to explain that he or she can't do that, has taken an oath, or will be sued. Students are instead urged to interpret what the patient is asking – perhaps it is that they need help in coping with their disease – by eliciting more information: "I'm here to listen to what you have to say, and to help you. Let's start at the beginning – what is it that makes you say that?" Or, "Tell me what is uppermost in you mind. What is it that makes you want to end your life?"

In breaking bad news, such as a malignant biopsy, students are encouraged to establish a sense of trust with the patient and to tell the truth in a sensitive way. "The next word out of your mouth will change this person's life and their family's life," Kelepouris reminds them. Most important, she says, is for the student to impart that there is hope, that they have the patient's best interests at heart, and that they are going to help the patient.

Standardized patients – drawn from a pool of trained laypersons of different age groups and shared among institutions – are also trained to stonewall students: "Well, if you're not going to help me, I'll find someone else." The statement could be coming from a cancer patient who is in pain, says Kelepouris, and the student is urged to try an empathetic response to get the patient to talk more openly, such as, "I need to understand where I can help you in other ways. Why are you unhappy?"

Temple is looking at how to design a transition curriculum to expand the two-year doctoring course to the third-year clerkship setting on hospital floors, ambulatory centers and physician offices, says Kelepouris, who notes that communication in the hospital setting involves a whole different psychology: patients are sicker, more uncomfortable, and there is even more of a power imbalance between physician and patient.

Standardized patients also model difficult encounters for students in Penn State College of Medicine's second-year medical ethics course, says course director **Michael J. Green, M.D.**, Associate Professor, Department of Humanities, and Department of Internal Medicine. After disclosure of a diagnosis of HIV, for example, the "patient" implores the physician not to tell her spouse about it. In communication exchanges that go poorly, says Green, the student takes a heavy-handed approach and demands that the patient tell her spouse, while a better interaction involves physician and patient negotiating a mutually satisfactory agreement, which perhaps includes how the physician can help facilitate disclosure.

In another scenario, students are asked to obtain informed consent to perform a spinal tap on a "patient" suspected of having central nervous system Lyme Disease, and they must explain to the patient the risks and benefits of the procedure, while never having performed a lumbar puncture. For every procedure, there is a first time that a medical student will perform it, and the scenario challenges students to formulate what to say to the patient. Green says there is a debate as to whether the student should volunteer that they have never done the procedure, and suggests that the student be honest if asked, and should otherwise say something like, "I'm a third-year medical student and I'll be supervised during the procedure. It will be a team approach."

To manage the power imbalance inherent in the physician-patient relationship, students are taught to provide the information that is necessary for patients to make an informed decision, and to serve as a resource to help them make it – offering not just the raw data that "there are 13 different antibiotics you can choose," but also recommendations and reasons, says Green.

In their two-year Primary Care Skills course, students at Philadelphia College of Osteopathic Medicine are evaluated in standardized patient exams, one component of which is professionalism, says **Harry Morris, D.O., MPH**, Chair of PCOM's Department of Medicine. Separated into two categories, PCOM's professionalism evaluation includes relationship quality – establish and maintain rapport, demonstrate empathy, demonstrate confidence, use appropriate body language, and examination quality – elicit information clearly and effectively, actively listen, provide timely feedback and information, conduct thorough and careful physical exam, and holistic relationship rating, says Morris.

PCOM trains its standardized patients to assess whether a student is "patient-focused" or "symptom-focused," by looking for behaviors such as genuine eye contact, relaxed body language, open-ended questions, probing questions, not interrupting, setting a clear agenda, and following through with clarifications and summaries, says Penny Patton, PCOM's standardized patient program administrator.

Demonstrating empathy effectively boils down to deep listening: the idea that the patient's story has credence – not just *what* they say, but *how* they tell it, including the affective and nonverbal cues they offer, according to **Hershey Bell, M.D.**, Clinical Professor of Family Medicine and Associate Dean of Faculty Development and Evaluation, Lake Erie College of Osteopathic Medicine.

To evaluate clinical skills of interns and residents in its graduate training network – including interpersonal communication skills – LECOM uses a Web-based tool called Medical Professional Performance Systems, which includes interactive role play simulations and gives program directors tailored remediation plans based on assessment results, says Bell. The tool also compares an individual's ratings to the mean scores of a cohort of residents.

In what it calls a "360 degree Evaluation," LECOM has interns and residents rated by preceptors, patients, nurses and other health professionals, using the tool's assessment scales. LECOM has applied the evaluation tool to faculty as well, with students rating their teachers' professionalism and collegiality, helping faculty model those skills for their students, while also identifying where to hone their teaching skills, adds Bell.

When the focus in medical education shifted more heavily to interpersonal communication competency training, says Bell, the older generation of faculty – who as students were taught that "these skills will come" – found that they wanted training themselves, and he notes that an emerging product line of educational modules is becoming available to fill the gap at all skill levels.

To help foster professionalism and humanism, the University of Pennsylvania School of Medicine launched a program three years ago that pairs individual medical students with a chronically ill patient for the three-year duration of the student's medical education training, says **Paul N. Lanken, M.D.**, Associate Dean for Professionalism and Humanism, and Professor of Medicine and Medical Ethics. The Longitudinal Experience to Appreciate Patient Perspectives (LEAPP) program is designed to foster an understanding of patients' medical, social, cultural, economic and spiritual contexts by meeting with or calling them at least once a month in their home, doctor's office, outpatient center and hospital, says Lanken. Patients are recruited from Penn's physician practices and represent a spectrum of age and socioeconomic groups, from Medicaid beneficiaries to wealthy suburban residents, he notes.

Students share their experiences with groups in an accompanying doctoring course, designed to illuminate the "bio/psycho/social" aspects of their patient's illness. A patient who has arthritis, for example, may experience pain every time he has use the bathroom in his house because it is upstairs, while another patient might be exhorted by her physician to take walks three times a day – although she lives in an unsafe neighborhood, Lanken illustrates.

The LEAPP program continues to evolve new opportunities for student-patient interaction, Lanken notes, as students can now shadow nurses at Wissahickon Hospice, and one cohort of students will have the LEAPP program incorporated into clerkships in the Departments of Medicine, Anesthesiology and Critical Care, Psychiatry, and Family Medicine.