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Commentary

The Challenge of Patient-Provider Communication in Ambulatory Care

Al Perry M.P.A., M.H.A., FACHE
Director, VA Central California Health Care System

The 20-45 minute ambulatory care patient-provider encounter has critical value and potential benefits perhaps not fully realized in the VA today. Beyond primary care, these crucial encounters also occur thousands of times a day in VHA Specialty Clinics. For that reason, I invite the VA research community to describe or develop evidence-based best practices for patient-provider encounters. Such research will be particularly important as we transform to the medical home model.

My interest in such research is based on four factors. First, the daily mission that drives us at VA Central California, a Level 2 facility accomplishing 300,000 annual visits, is achieving "clinical excellence in a clean and safe environment." I firmly believe a positive patient experience, while secondary to an accurate diagnosis and effective treatment, is an extremely important aspect of clinical excellence. Our goal for every patient is to improve well being and achieve the best health outcomes. The patient-provider encounter is critical to this fundamental goal.

Second, as the single most important determinant of outpatient satisfaction, "the physician (or provider) is *the* focus of the patient experience."[1] Of secondary importance are efficiency of support staff and length of time in the waiting room.

Third, VHA is committed to Secretary Shinseki's Transformation 21 core principle of "People Centric" care. Overlaying that is the current major investment in the primary-care "medical home" model, which promises far reaching change in the delivery of VA ambulatory care. In this program "home" means health care that is friendly, supportive, and fully coordinated around each patient's needs. Some have described this model as a fundamental transition from provider-centeredness (emphasis on provider expertise and patient passivity) to patient-centeredness (information sharing, shared decision-making, and emotional support).[2]

Finally, since 1996, VHA has aggressively surveyed, widely reported on, and made outpatient satisfaction a core "mission critical" measure among the Executive Career Field (ECF) Performance Measures. Today the overall "passing" standard on how patients rate their care is a score of "9" or "10" on a scale of "0" to "10." Informally this is known to directors as the "WOW!" rating. Embedded in the SHEP survey are several important questions that cover, for example, whether or not providers: explained things in a way that was easy to understand; listened carefully to you; showed respect for what you had to say; spent enough time with you; and talked about the pros and cons of treatment options. Outpatient Veterans are also asked to score their provider or specialist on the rating scale of "0"—representing worst possible to "10"—representing best possible.

Ideally much can be achieved in the ambulatory care patient-provider encounter: positive rapport building; emotional sup-

Director's Letter

The complexity of health care delivery has increased substantially during the past two decades, the result of better understanding of disease pathophysiology, the dramatic growth in diagnostic evaluations and treatments, increased prevalence of chronic disease co-morbidity, lengthening lifespan, and the transformation of health care delivery from inpatient to outpatient environments. Complexity of health care delivery has increased further because of the unrelenting growth in health care costs and the subsequent need for greater efficiency of care (e.g., evaluate more patients in a given time). Reduced patient-provider communication is an unfortunate by-product of medical progress.

Computerization provides one hopeful approach to increasing the amount of time available for communication. Computerization facilitates the aggregation of clinically meaningful data, the transformation of data into information, and the effective presentation of information to providers at the point-of-care. To date, only a barely measurable fraction of the computer's potential impact on health care and time availability has been realized. The hospital and clinic patient centered medical home, in which a multidisciplinary team coordinates care to support the patient, promises not only to improve quality and efficiency of care, but also facilitate communication. Nevertheless, meaningful communication will inevitably continue to be squeezed by the limits of time.

Because emotional issues are so prominent among Veteran and civilian populations, and their impact on physical health and quality of life so high, developing improved approaches to effective communication are more essential then ever. Developing simple methods to measure communication, developing and testing models of communication, developing new approaches to educating providers in the art of communication, identifying changeable factors that have a high impact on communication and approaches to implementing positive change, and understanding the impact of more effective communication on patient outcomes are all imperative research issues.

Seth Eisen, M.D., M. Sc.
Director, HSR&D

high emotion; required computer use by the provider in the exam room; accomplishing an ever-increasing number of clinical reminders; patients ranging widely in age from an 18-year-old Operation Iraqi Freedom Veteran to a 92-year-old World War II Veteran; availability of telehealth (and its limitations); and, in some cases, provider fatigue and burnout. And then there are the numerous patient-provider "connection" and approach choices, such as: handshake or not, white coat or not, to touch or not, standing or sitting, how best to engage a patient with the computer, how to prepare for visit then execute the optimal visit entry, interview and exam, and visit exit.

My challenge to VA researchers is to determine what evidence-based practices VA leaders can draw from ambulatory care patient-provider encounter research. What have proven to be best practices at leaders like The Mayo Clinic, or Geisinger Health? How do we achieve both the desired clinical outcome and a positive patient experience? Timing answers to these questions with the implementation of the "medical home" primary-care model throughout VHA will be of great value to center directors, and, hopefully, will also help VA achieve the best health care possible.

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port; shared decision-making; building trust and confidence in the provider; an open dialogue; high likelihood of adherence with instructions and therapy; and, of course, arriving at the right diagnosis and treatment. For patients, the encounter should provide the answer to their most basic concerns;

"What, if anything, is wrong with me, and what are we going to do about it?"

The challenges in ambulatory care are considerable: limited space; time pressure; potential language barriers; patient anxiety;

Response to Commentary

Good Communication Is Not Magic

James Tulsky, M.D., Center for Health Services Research in Primary Care
Durham VA Medical Center

The role of communication between physicians and patients is sometimes regarded as merely the soft side of medicine. Perhaps more damaging is that even when communication skills are valued, many view them as innate and unquantifiable, thus precluding efforts at improvement. I am grateful to this issue's commentary author Mr. Al Perry for raising awareness of the importance of physician-patient communication to achieve clinical practice success, and for suggesting that this communication is amenable to quality improvement efforts.

Good communication increases patient recall of information, adherence to therapy, satisfaction and, ultimately, clinical outcomes such as diabetic glucose control and functional status.[1] Communication success and failure appear to generate more gratitude and complaints than any other aspect of the work performed by health care professionals and, among non-VA primary care providers, poor communication has been associated with malpractice claims.[2] Most importantly, substantial evidence confirms that the individual components of good communication can be identified and that physicians can be taught to improve those skills.[3]

These data all suggest there is no conflict between achieving the "desired clinical outcome and a positive patient experience." In fact, they are one and the same. To truly achieve the desired clinical outcome one must strive to include a positive patient experience. Good communication is not about just being nice. It is about finding ways to interact with patients that enhance their interests.

What does good communication look like? It starts with patients that feel empowered to ask questions and make their needs known. It continues with physicians that use reflective listening skills to elicit and clarify patients' concerns, and that respond to empathic opportunities (i.e., emotional cues) with unambiguous empathic language. It includes the ability to negotiate and arrive at a shared agenda that reflects both patient and physician priorities. Finally, it requires the giving of information in a way that is understood and retained by patients and their loved ones.

Changing the Communication Culture

Transforming the VA into an institution where patients can expect such an encounter on every visit is not something that will be accomplished through a single CME course or innovative clinical practice. Rather, this is a culture change that will depend upon multiple, empirically-based efforts directed toward patients, physicians, and the system.

First, physicians must learn better skills. Many doctors have received little formal communication training or none at all. The key to successful training is practicing communication skills with observation and feedback. Intensive courses are the gold standard and, although these may seem time consuming and expensive, they can be cost-effective given the potential improvements in quality and cost savings from unneeded tests, referrals, and treatments. On the horizon are computer-based communication skills training programs that use physicians' own recorded conversations for feedback, as well as avatars, and thus achieve the same results without the requirement for a multi-day course.

However, efforts to improve physician-patient communication that concentrate only on physician skills will never fully address the problem; interventions must focus on patients as well. Patients' barriers to disclosure of concerns do not relate solely to physician behavior. A number of proven interventions exist that promote patients' abilities to seek information, ask questions, make their needs known and, in general, achieve a greater sense of control. These include prompt sheets to complete prior to visits, the ability to review their recorded encounters with their doctor, and coaching to help patients formulate questions and overcome barriers to asking. Computerized approaches to such tools are also in development and, with added sophistication, have the potential to be effective and relatively simple to introduce into the clinical setting.

A third cutting-edge tool that can be explored is the introduction of direct observation of clinical encounters for the purposes of quality improvement. The VA is currently very good at providing feedback to physicians about their patients' physiological parameters, such as blood pressure control or hemoglobin A1c. Technology exists to audio-record clinical encounters and code them for the use of ideal communication skills. Although more complicated than simply extracting an A1c from Computerized Patient Record System (CPRS), the value of the feedback could be significant.

Finally, true culture change toward enhanced physician-patient communication will require the alignment of incentives to reward good communication. For example, physicians are currently rewarded for completing multiple clinical reminders during each patient visit. Although worthy individual components, addressing the sum of them in a given visit, particularly if it involves detailed on-screen instructions, may not result in an overall patient-centered experience. We should look at how many of these reminders can be moved out of the physician-patient encounter itself (e.g., patient self-report using tablet PCs), so that the time spent together can focus on patients' concerns.

The recognition by VA leaders—such as Mr. Perry—that good communication is central to excellent health care is a critical first step toward changing the culture. Communication research has advanced to the point where proven interventions are available that could enhance patients' overall experiences. Both physicians and patients will benefit if we can find ways to integrate these innovations into the health care system.

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Research Highlight

Exam Room Computing and the Physician-Patient Relationship

Richard M. Frankel, Ph.D., The Richard L. Roudebush VA HSR&D Center of Excellence on Implementing Evidence-Based Practice, Indianapolis, Indiana

Mr. Dan Deacon,* the medical director of a large VA facility, recently received a letter of complaint from Patrick Pawlson, 72, a Veteran who receives his care at one of the facility's outpatient clinics. Mr. Pawlson complained that his physician, Dr. Eric Salter, "…was more interested in the computer screen he was typing on than me and my medical problems… To be honest, it made me feel unimportant and uncared for." Dr. Salter is a general internist who has worked for the VA for three years. Soon after he started working at the facility it went "paperless" and new computer workstations for the Computerized Patient Record System (CPRS) were installed in all the clinic's outpatient exam rooms to facilitate the transition. Dr. Salter is familiar with the use of computers to document clinical interactions in an electronic medical record, but he was new to using computers in the exam room with the patient present. Mr. Deacon's job is to give Dr. Salter some constructive feedback to help him better integrate his use of CPRS while seeing patients.

Patient-Centeredness and the Electronic Medical Record

In one of its most widely cited and influential reports, the Institute of Medicine (IOM) asserted in 2001 that patient-centered care was one of six domains of quality in medical care, the others being safety, effectiveness, timeliness, efficiency, and equity. The report went on to state that the absence of patient-centeredness is associated with outcomes such as: lower patient satisfaction, poorer adherence to medical recommendations, poorer blood pressure control, higher glycosolated hemoglobin A1c, and greater propensity to sue for medical malpractice in the face of an adverse event.

A lack of patient-centeredness is clearly the focus of Mr. Pawlson's letter of complaint and should raise awareness of the entire health care team. At the same time, it is important to note that Dr. Salter has had no formal training in how to use CPRS with patients in the exam room. Recognizing that a gap in knowledge and skills may account for the complaint, Mr. Deacon decides first to give Dr. Salter a copy of the IOM report. He also suggests that Dr. Salter consider using a "communication coach" to help guide him in how to better integrate the computer into his daily practice, citing a study that showed communication coaches were effective in improving patient satisfaction in a health care organization similar to VA.[1]

Computer Placement

One of the most interesting and challenging aspects of implementing CPRS into clinical workflow is the physical placement of the computer screen.[2] There are currently no national guidelines for optimal placement and there is a great deal of variation in the geography of exam rooms. Our research team is currently working on an HSR&D Investigator Initiated Research (IIR) (08-300) to study the overall effects of CPRS use, including placement, on physician-patient interactions. Unfortunately, the computer screen in Dr. Salter's office is in a corner of the exam room forcing him to turn his back on his patients when using CPRS. Mr. Deacon suggests that Dr. Salter

explain what he is doing in CPRS and apologize for having to turn away to use CPRS. Dr. Salter states that he will look into rearranging the exam room to optimize CPRS use.

Non-verbal Behavior

One powerful way to communicate caring and concern is through non-verbal behavior. Body orientation, eye contact, gestures, and touch are all elements of non-verbal behavior that can affect the course, direction, and satisfaction with care.[3] Reframing Mr. Pawlson's complaint in terms of non-verbal behavior, Mr. Deacon explains to Dr. Salter that too much time using CPRS will be seen by patients as a preference for the technology over the person. He recommends that Dr. Salter make it a habit of making eye contact every 30 seconds or so to reassure the patient that he is listening and personally attending to all concerns.

Typing Skills

Many older physicians grew up in an era where typing was not a required subject and where dictation substituted for having to type. While younger physicians may be proficient typists, it is not usually with an audience present. Many physicians report poor typing skills and embarrassment at having to type in front of patients. Mr. Deacon asks Dr. Salter if this a problem for him, learns that it is, and offers to pay for a self-paced typing tutorial that will improve speed and accuracy.

Partnership

Much technology in the exam room is *physician*-centered. The blood pressure cuff, otoscope, and stethoscope all give the physician information that may or may not be shared with the patient. One of the precepts of patient-centeredness is that care is based on partnerships, and partnerships, in turn, are related to sharing information. The same holds for CPRS. As an educational tool, CPRS can be a rich source of information and guidance. Mr. Deacon reminds Dr. Salter that the word "doctor" comes from the old French "docteur," meaning teacher, and describes how CPRS can be used to partner with, and educate patients.

Research Highlight

The Importance of Clinician-Patient Communication Behaviors

Howard S. Gordon, M.D., Jesse Brown VAMC and the VA HSR&D Center for Management of Complex Chronic Care, Chicago, Illinois

Clinician-patient communication is the primary process by which medical decision-making occurs, and the communicative features of the consultation (e.g., information exchange, shared decision-making) can influence outcomes. Poor communication is associated with worse patient satisfaction, less trust, more complaints and malpractice claims, and worse health outcomes.

Specific communication behaviors of clinicians and patients can be targeted to improve communication. These include patients' active communicative behaviors such as asking questions, being assertive, and communicating concerns. They also include clinicians' patient-centered behaviors such as being supportive, giving information, and building a relationship.

Role of Empathy

Empathy is a powerful method to provide support, yet it is infrequently used by clinicians. When clinicians' focus is largely biomedical, cognitive tasks of determining diagnoses and treatment recommendations occupy their attention. As a result, clinicians find that it is challenging to respond to patients' emotional needs.

The VA HSRD Center for Management of Complex Chronic Care evaluated clinicians' empathic responses given to Veterans undergoing work-up or treatment decision-making for lung cancer. As part of this work, we characterized the types of "clues" or "empathic opportunities" that patients might raise in a medical encounter.[1] We classified the empathic opportunities in patients' statements as relating to the bad news/impact of lung cancer, difficulty with diagnosis or treatment, and health system barriers, among others. Our hope is that such a typology will be useful for clinicians in raising awareness of patients' emotional

needs and as an educational framework to help clinicians learn to respond empathically.

We also noted that empathy was infrequent and given late in the medical encounter, representing an all too common pattern where clinicians provided too little empathy and provided it too late in the encounter. Earlier provision of empathy and provision of these empathic responses periodically throughout the encounter ("interval empathy") are likely to allow clinicians to build understanding and validate patients' concerns, and progressively build trust and rapport with patients.

Fortunately, clinicians can be taught to express empathy, a behavior that can be brief and does not prolong encounters. Our classification of empathic opportunities may be useful in educational modules for teaching clinicians to express empathy.

Why should we consider interventions to improve patients' communication? It would seem much more efficient to just focus efforts to improve communication on clinicians (because there are fewer physicians and each physician has numerous patients). One challenge is that clinicians have developed routines of communication that can be difficult to change. Though interventions to change clinician behavior often are lengthy, interventions to improve patients' communication do not need to be as intensive and can often be administered in the waiting room immediately prior to the visit.

In preparation for the development of an intervention for Veterans, we conducted several focus group interviews to evaluate patients' perspectives on using active communicative behaviors with their physicians. Veterans perceived that they had little influence on the course of their own medical encounter. Veterans felt that clinicians' styles that were paternalistic, pushy,

lecturing, and jargon filled discouraged their participation in the encounter. Also, patients admitted that they withheld information and avoided asking questions because of guilt, embarrassment, or fear of the clinician devaluing the importance of their questions or concerns.[2] These results are useful for educational efforts to increase awareness of the problems that patients perceive when communicating with physicians.

Looking Forward

Efforts to improve clinician-patient communication should recognize that communication is a two-way street. Patients who ask questions are more likely to influence their clinician to provide answers, and clinicians who are supportive are more likely to encourage patients to be active participants in the interaction (e.g., ask questions). These two-way dynamics between patient and clinician mean that improvement in communication of patient, clinician, or both, can improve overall communication.

It is important to make efforts to improve communication in medical encounters because patients who have difficulty communicating with their clinician are less involved in the visit, receive less information from their clinician, and are less satisfied with care. Effective communication by both patients and clinicians can produce better patient self-management, adherence to treatment recommendations, and patient follow-up, thereby lessening the impact of disease on functional status.

Interventions to improve communication are often not even attempted in clinical practice. Efforts to refine and develop interventions that can be implemented are an important goal of future research.

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Research Highlight

Safe and Effective Communication to Prevent Diagnostic Errors

Hardeep Singh, M.D., M.P.H., VA HSR&D Houston Center for Quality of Care and Utilization Studies, Houston, Texas

Diagnostic errors (i.e., diagnoses that are delayed, wrong, or missed) are increasingly recognized as a patient safety concern in ambulatory care. Although multiple factors influence the diagnostic process, communication is a central theme. From the initial patient-provider encounter to confirmation of a diagnosis through diagnostic testing, procedures, or subspecialty referrals, good communication is essential to timely and accurate diagnosis. Accordingly, communication breakdowns are emerging as a leading preventable cause of diagnostic errors and are the focus of our current work. In this brief, we discuss some of the early lessons and challenges in this work.

Most ambulatory malpractice claims data suggests that diagnostic errors are the largest category among U.S. malpractice claims.[1] Outpatient diagnostic errors may not necessarily involve only rare diseases or unusual disease presentations,[2] but also relatively common conditions such as cancer, ischemic heart disease, and infection. Many such errors involve communication breakdowns, which are at times complex and difficult to define. It is not surprising that those breakdowns occur—ambulatory care involves several settings of care and is longitudinal in nature, making it increasingly chaotic for information processing.

Communication and the Diagnostic Process: A Hard Nut to Crack

Communication challenges are virtually a given in ambulatory care settings, where barriers include time and workload pressures on busy clinicians, the sheer volume of both verbal and electronic communication among providers, and several patient factors that affect information transfer.[1] Identifying the point(s) at which critical communication breakdowns occur is a first step in understanding the origins of error. It is important to recognize that, in health care settings, communication is often intended not only to transmit infor-

mation but also to elicit some response from the recipient. For instance, when providers receive notification of abnormal test results, they might order follow-up diagnostic tests, notify patients, or refer to subspecialists. Thus, the desired outcomes of communication can be viewed in steps: message transmission (sending accurate, complete, and unambiguous information); message reception (perceiving the information accurately and taking appropriate next steps); and message acknowledgment (providing feedback that the message has been received and/or acted upon).[3] Pinpointing the weakest links in those steps can help prioritize interventions.

Our work has shown that errors in the diagnostic process span five interactive dimensions, each of which is closely related to one or more aspects of communication.

- **Patient-provider encounter:** Problems with history, physical exam, or ordering diagnostic tests for further work-up.

- **Diagnostic tests:** Problems with ordered tests either not performed or performed/interpreted incorrectly.

- **Follow-up and tracking:** Problems with follow-up of abnormal diagnostic test results or scheduling of follow-up visits.

- **Referrals:** Lack of appropriate actions on requested consultation or communication breakdown between consultant and referring provider.

- **Patient factors:** Delay in seeking care or non-adherence to appointments.

Challenges Despite Technology

Integrated electronic health records (EHRs) readily address certain problems that are endemic to paper-based record systems, such as illegible handwriting, misplaced documents, and distance barriers between providers. However, the EHR must resolve communication prob-

lems that might contribute to errors in any of the five interactive dimensions above, which is a challenge of itself. Meanwhile, we must also remain vigilant for communication breakdowns that are uncovered or introduced by new technologies. While clinical decision support (CDS) interventions in the EHR can enhance communication by prompting important questions or actions during the diagnostic work-up, we need to ensure that these interventions fit into providers' clinical workflow in order to achieve maximal benefit.[2]

Similarly, the EHR eliminates the need for a physical "paper trail" for referral communication and replaces it with referral requests and results that are always accessible electronically. However, remaining communication vulnerabilities to prevent patients from being lost to follow-up in the referral process must also be addressed.[1, 3]

What Next?

Multidisciplinary interventions that take into account both technology as well as patient and provider behavior in complex care settings are needed to ensure good communication practices that lead to diagnostic error reduction.[2] Our ongoing work, for instance, applies a multifaceted approach to improving EHR-based communication and emphasizes integration of key lessons learned into systems, policies, and procedures.

Finally, advances in provider-patient communication are also needed. Personal health records and secure messaging to improve patient-provider communication are a few such innovations that merit further study. Bringing patients into the communication loop is a potentially powerful but underdeveloped strategy to help ensure the quality and safety of care in the outpatient setting.

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Research Highlight

The Case for Communication Intervention

Bruce S. Ling, M.D., M.P.H., Core Investigator, VA HSR&D Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania

The manner by which patients and their health care providers communicate with each other significantly affects patient perceptions of health care quality and outcomes. Previous work by Hall et al. in 1988 assessing the impact of patient-provider communication in health care settings showed that patient satisfaction improved when physicians: (1) treated patients as partners; (2) used more words with positive connotations; (3) used fewer words with negative connotations; (4) engaged in more social conversation with their patients; and (5) exchanged a greater amount of information. Furthermore, a study by Safran et al. in 1998 found that higher patient ratings of communication are associated with higher rates of adherence to physician recommendation of preventive health activities and higher patient ratings of health status. Kaplan et al. in 1989 showed that blood glucose control and blood pressures improved when there was more patient control and less physician control of the communication, more information provided by the physician, and less negative tone of the communication. In a recent meta-analysis of more than 100 studies, physician communication was significantly positively correlated with patient adherence in which there was a 19 percent higher risk of nonadherence among patients whose physicians communicated poorly than among patients whose physicians communicated well.[1]

Despite these beneficial effects, studies assessing patient-provider communication in clinical settings have determined them to be inadequate. A study published in 1984 by Waitzkin et al. showed that physicians spend less than 1 minute out of a 20-minute visit discussing treatment and planning. While patients typically want more information about their illness, recall of the information physicians communicate is frequently lacking. McBride et al. in 1994 found that patients considered communication to be one of the top three competencies a physician should possess, but frequently rated their own physicians' communication skills to be suboptimal.

As patients who are informed and involved in decision-making are more likely to adhere to medical recommendations, having patients fully informed about alternatives and potential risks of treatment is a worthwhile clinical goal.[2] However, in real practice this does not appear to be occurring. The Braddock et al. study in 1999 audio-recorded 1,057 clinical encounters between patients and their health care providers in which there were 3,552 clinical decisions involved. Information exchange was limited with only a minority of instances having a discussion of alternatives (11.3 percent), pros and cons (7.8 percent), assessment of patient understanding (1.5 percent), and eliciting of patient preferences (21 percent). Similarly, analysis of audio-recorded primary care visits by Ling et al. published in 2008 in which colorectal cancer screening discussions were targeted for analysis, there was a lack of discussion of alternatives (26 percent), pros and cons (17 percent), assessment of patient understanding (6 percent), and eliciting of patient preferences (17 percent) in those instances when a screening test was ordered.

Interventions Enhance Communications

As such, numerous studies have focused on interventions designed to enhance patient-provider communication. A systematic review of the literature in 2004 examined interventions directed at patients to improve patient-provider communications from 25 studies. The review found that interventions involving patients in communication training using techniques such as improved question-asking led to higher levels of patient perceived control over health, preferences for an active role in health care, recall of information, and adherence to recommendations.[3] Physician-directed interventions were also found to be beneficial. A meta-analysis by Zolnierek et al. in 2009 of 21 studies found

that training physicians in communication skills resulted in substantial and significant improvements in patient adherence, with odds of patient adherence 1.62 times higher than when a physician received no training.[1]

While patient-provider communication has traditionally occurred in person, technology has advanced and now allows patients and providers to communicate electronically outside of the clinic setting. Providers and patients can now communicate electronically to address issues such as following-up on test results, asking questions, exchanging information before a visit, scheduling appointments, sending reminders, and renewing prescriptions. In a study conducted by Hassol et al. (2004) as an online survey of 4,282 members of the Geisinger Health System in which patients are able to communicate electronically with their providers and view selected portions of their electronic health record, patients preferred e-mail communication for some interactions (e.g., requesting prescription renewals, obtaining general medical information), whereas they preferred in-person communication for others (e.g., getting treatment instructions). A 2002 Harris Interactive poll found that 90 percent of those with Internet access would like to communicate with their physicians online, with 55 percent stating that the ability to communicate with their doctors electronically would influence their choice of health plans and 56 percent responding that this capability would influence their choice of physicians.

In conclusion, while patient-provider communication is considered an essential component of quality health care, it seems to be inadequately performed in the clinical setting. Development and implementation of communication interventions directed at patients and/or providers, as well as greater utilization of technology-driven approaches such as e-mail, may be beneficial in improving patient-provider communication.

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Conclusion

Mr. Deacon and Dr. Salter's meeting lasts 20 minutes, about the length of a routine clinic visit. Dr. Salter is amazed to learn about the literature in this area and is appreciative of not being judged on the basis of a skill that he was never taught. He is also grateful for the concrete evidence-based feedback and suggestions and is eager to try them out. Mr. Deacon, for his part, feels reinforced in his job and is pleased that Dr. Salter is receptive to the feedback. Both are grateful to Mr. Pawlson for his letter and intend to tell him so at his next visit.

*All names and events in this commentary are fictitious.

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