

PERSPECTIVES IN GLOBAL HEALTH: FORUM



How doctors talk: Improving physician-patient communication

The heart of medicine is the personal encounter: the coming together of physician and patient with the shared aim to relieve suffering and ideally heal the whole patient. But all too often the forces of modern medicine conspire against this ideal, narrowing the physician's role to that of expert on the body and leaving no room for a curious and compassionate connection, clear instruction, or even the extra second of attentive listening that might lead to a more informed diagnosis.

The resulting distress is felt on both sides of the stethoscope. Certainly it is experienced by the woman told by her oncologist "I think I can keep you alive for five years," and the man who is interrupted 18 seconds into his story about how he injured himself. But the physician also suffers when he avoids a terminally ill patient out of awkwardness or guilt, or misses a life-saving window because he downplayed the results of an ambiguous pathology report.

Every practitioner carries his or her own anthology of stories, says David Browning, Senior Scholar at the [Institute for Professionalism and Ethical Practice](#) (IPEP) at Children's Hospital Boston and Harvard Medical School, which operates the Program to Enhance Relational and Communication Skills

(PERCS). He adds that practitioners also carry within them an understanding of how to communicate and respond with empathy – that knowledge just gets lost in the time constraints and financial pressures of contemporary practice and education. As a result, while physicians may feel capable of managing a range of physical ailments, many feel less equipped to handle their patients' emotions.

Whether it's the need to tell someone he has a terminal disease, disclose a treatment error, explain the details of an unexpected condition, or simply take a thorough history during a routine physical exam, evidence shows that effective and empathic communication not only alleviates suffering, but it plays a role in the quality of care.

Extensive data has linked effective physician-patient communication to biological, psychological, social, and legal outcomes of care. It has been tied to better adherence, shorter hospital stays, better efficiency and cost effectiveness, less malpractice, and not surprisingly, increased physician and patient satisfaction.

Fortunately, communication is receiving heightened attention at medical schools and institutions worldwide. In response to pressure from accrediting agencies, educators are developing, refining, and studying methods of instruction and assessment, and devising new techniques for disseminating what they've learned.

To be sure, these programs alone can't change the biomedical culture. Nor can good communication skills make up for poor practice. But anecdotal evidence suggests that when physicians are confident in their ability to relate to their angry, frightened, or grief-stricken patients—and can mentally step back from an emotionally charged situation—it can help to lessen burnout and enhance their practice.

David Browning: "Taking time to develop the capacity for empathy and reflection may seem like an inordinate burden on practitioners already strained by the unrelenting demands of their day-to-day work. But the emotional and spiritual burden for clinicians of not developing such a capacity may be even greater."

Teaching Patient-Centered Communication

Awareness that relational skills are important and teachable isn't new. In fact, the movement has been building since the late 1970s and has gathered steam since 1999 when the Institute of Medicine released two influential monographs, *Crossing the Quality Chasm* and *To Err is Human*, both of which describe patient-centered care as a marker of high quality. More recently, communication skills have become a core competency in accreditation, certification, education, and quality-improvement initiatives the world over, according to Dr. Elizabeth Rider, Director of Faculty Development at IPEP, who is focused on developing communication skills programs aligned with competency requirements.

Nearly every leading edge institution that teaches communication skills has its own twist on teaching and evaluating participants' skills. But regardless of their recipe, most share three core ingredients: skills development, self-awareness, and assessment.

Skills Development: What to Say and How to Say It

Every program teaches specific communication skills. In the U.S., these skills include things like shaking hands, making eye contact, asking open-ended questions, and listening actively without interrupting.

Most programs teach these skills by using actors trained as “simulated patients.” The actors role-play realistic scenarios with learners and offer feedback. Depending on the skill being taught and the aim of the workshop, a scene may involve disclosing an unexpected diagnosis or telling a family that their child has a terminal illness.

At Northwestern University's Feinberg School of Medicine simulated patients play two different roles, says Dr. Gregory Makoul, Professor and Director of the [Center for Communication and Medicine](#), who developed the SEGUE Framework, one of the most widely used communication skills teaching and assessment tools in North America. The actors are trained as either “patient instructors” or “standardized patients.” Patient instructors change their personal details, demeanor, and reaction with each student and give on-the-spot feedback, sometimes allowing the student to retry an interaction. Standardized patients, on the other hand, behave identically with every student in order to uniformly assess their skills.

In PERCS workshops, patient-actors improvise each scenario, rather than following a script or template. As a result, says Browning, “each enactment is unique, and the debriefings that follow often move into topics or subject areas that have never before been discussed.”

In some programs, such as at Indiana University, real patients tell their stories and students may conduct a five-minute interview with a hospitalized patient at the bedside.

Whether the scene involves an actual patient or actor the encounter is nearly always videotaped for review and feedback. The videotaping is important because there is often a “big difference between what a person experiences internally and what observers can see,” notes Dr. Rich Frankel Professor of Medicine and Geriatrics and Senior Research Scientist at Indiana University School of Medicine. “Many times students, when asked about the interview, will say, ‘I was shaking so hard I could barely speak.’ But when we show them the video, they can't see when it occurred.”

Frankel is one of the creators of a teaching method called the “Four Habits Model,” which has trained thousands of physicians to communicate better and more empathically from the beginning of the medical encounter to the end. Sometimes learners receive coaching during their improvised scenarios, he says. They may also learn the difference between empathy and sympathy; that is, between saying to a crying patient, “I’m sorry, this must be difficult” versus bursting into tears with the patient.

PERCS brings together nurses, social workers, chaplains, and physicians in its workshops, allowing them to see and assimilate varied ways of handling a situation. Dr. Eric Fleegler, an emergency physician at Children’s Hospital who has participated in the program, says this interdisciplinary approach also reminds participants of other kinds of practitioners who may be available to help them through particularly trying encounters.

In addition to crossing disciplines, PERCS suspends hierarchy, uniting novice and experienced clinicians. In this environment, not only do beginners learn from veterans, says Browning, but experienced clinicians learn from the neophytes who may bring a “beginner’s mind,” a fresh perspective, and a newcomer’s enthusiasm for their work.

Originally developed in 2002 as a continuing education effort focused on difficult conversations in pediatric critical care, PERCS has since been adapted and applied to other kinds of high-stakes conversations, such as those related to the neonatal intensive care unit, anesthesia, and disclosing medical errors. Children’s Hospital recently affirmed the success of the PERCS approach by supporting the formation of the IPEP, with Dr. Robert Truog serving as Director and Dr. Elaine Meyer as Associate Director.



The IPEP team: (l to r) Robert Truog, Elaine Meyer, Elizabeth Rider, Allyson Wall, and David Browning

It’s worth noting that some of the skills taught by communication training programs are culture-dependent. For example, in Japan too much direct eye contact may be a sign of disrespect, and giving bad news is strongly discouraged, as is any communication that might create disharmony in a relationship, says Dr. Thomas Inui, who heads the [Regenstrief Institute for Health Care](#) at Indiana University School of Medicine. The Interpersonal Communication

and Relationship Enhancement program (I*CARE) at the University of Texas M.D. Anderson Cancer Center runs a program on cancer disclosure for senior oncologists in Italy. There, as in other countries, it is common practice to tell a patient's family the patient has cancer before informing the patient, so a typical scenario would involve a couple in which the husband has cancer but the wife says she doesn't want him to know.

Self-Awareness: A Look in the Mirror

Besides teaching specific techniques, communication skills programs encourage participants to look more closely at their habits and assumptions. "Good communication requires the ability to self monitor," explains Dr. Ronald Epstein, Director of the Rochester Center to Improve Communication in Health Care at the University of Rochester School of Medicine and Dentistry. Practitioners who are self-aware are better able to untangle their own reactions or thoughts such as, "he looks like an alcoholic," or "that's so depressing," from the patient's experience.



Dr. Ronald Epstein

The University of Rochester is using a novel approach to teach self-awareness to all third-year students and residents, as well as 75 primary care practitioners involved in a study. The approach, called "mindfulness training," allows participants to stop and be still and quiet for brief moments during the day. They also learn short meditation exercises during which they attend to their breathing, sounds, and sensory input. The exercises are purposely kept simple in order to make the practice accessible to everyone, regardless of spirituality or specialty.

Learners also share a story about a situation in which they discovered something about professionalism, made a mistake, or witnessed suffering. Storytellers are listened to without interruption, validating their experience. Meanwhile participants learn to listen attentively and distinguish their reactions from those of the storyteller. "The purpose of the sessions is to enhance students' ability to

communicate effectively, and also experience greater clarity in their own thinking so that they can make better decisions and avoid medical errors,” says Epstein. “The program builds on recent research findings that show that physicians who experience greater well-being at work communicate more empathically and make fewer errors.”

Assessment: How Did I Do?

The third component of communication skills building programs is assessment—some formal method of evaluation by faculty, peers, and/or patients (simulated and/or real).

PERCS values the feedback from its patient-actors as highly as that of the expert facilitators, notes Browning. “On the videotape, the participant may look like he did all the right things,” he explains. But the actor might say ‘even though you maintained eye contact, I felt as though you weren’t in the room with me.’”

Browning says that kind of feedback—which may be invisible to facilitators—comes closest to teaching the ideal of good communication. This is particularly important in high-stakes conversations during which patients and their families are less likely to remember the words a doctor used than whether or not that doctor genuinely seemed to care.

The University of Rochester relies heavily on peer assessment (in addition to using standardized patients). Having students evaluate one another’s work habits, interpersonal sensitivity, communication, and teamwork provides them with feedback from “sources they regard as credible,” notes Epstein. “It also gives students the clear message that we take communication skills very seriously.”

Patients are another valuable source of feedback about communication skills, says Northwestern’s Makoul. With funding from the American Board of Medical Specialties, Makoul led development of a Communication Assessment Tool (CAT) for assessing students’ and practitioners’ skills. The brief questionnaire, based on extensive research, allows real patients to provide detailed feedback about communication in actual encounters.

Out of Isolation

It’s one thing to teach good communication skills—it’s another to make sure learners retain them. For that reason, more and more instructors are investigating ways to incorporate the principles from their programs into the organizations that house them. “All too often the effectiveness of communication skills programs is compromised because they live within environments that are hostile to any show of empathy or personal connection,” observes Frankel. “Students learn the skills in a protective bubble and then go out into the practice

setting where what they've learned is not validated and may even be negatively valued.”

In contrast, when communication skills are enmeshed within a broader organizational structure, he says, they are more likely to become an integral part of the culture and practice.

At Indiana the Four Habits Model is being used as part of a larger organizational change effort called the Relationship-Centered Care Initiative. The goal, says Frankel, co-leader of the project along with Thomas Inui, is not just to improve communication skills for program participants, but to give physicians a chance to enhance relationships and “rediscover the joy of doctoring.”

But even without such a sweeping initiative, cultural change can build as a grassroots effort. For example, as Children’s Hospital’s PERCS expands beyond critical care and end-of-life conversations and has become an institute, it is now beginning to address disclosure of medical error across all of the Harvard teaching hospitals.

“Medical error is a good place to start the organizational change piece,” says Browning, “because it’s an area in which there is so much external pressure to improve.” Given the influence of today’s patient safety movement, institutions are receptive to innovative approaches both to reducing errors and better disclosing them. “So it is a more straightforward case than that for, say, end-of-life conversations.”

At the same time, the issue dovetails with the message underlying all communication training: *listen to the patient*. “Many errors occur because patients and families are not considered part of the team and their knowledge is devalued relative to professional knowledge,” says Browning. And because the same principles and skills apply, “we don’t teach about disclosing medical error that differently from the way we teach about handling end-of-life conversations,” but the work is more likely to ripple outward.

Browning emphasizes that without a patient-centered approach to teaching and a receptive organizational culture, it can be challenging for programs such as his to make headway. “There are a lot of educators out there taking this on. But if you teach communication skills the same way as everything else in medicine, it will get learned that way. And my concern is we will have people who will feel very competent in these things—and the patients and families won’t feel it.”

For additional information and resources, please [click here](#).

--Written by Natalie Engler for Harvard Medical International

Resources

For the HMI WORLD FORUM "How doctors talk: Improving physician-patient communication"

Organizations

American Academy on Communication in Healthcare
<http://www.aachonline.org/>

Association of Standardized Patient Educators
<http://www.aspeducators.org/>

Books and Articles

"Difficult Conversations in Health Care: Cultivating Relational Learning to Address the Hidden Curriculum," by David M. Browning, Elaine C. Meyer, Robert D. Truog, and Mildred Z. Solomon. In *Academic Medicine*, September 2007.

Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits, written by Debra L. Roter and Judith A. Hall, and published by Praeger Publishers (2006).

Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering, written by Ronald M. Epstein and Richard L. Street, Jr. and forthcoming from the National Cancer Institute.

How Doctors Think, written by Jerome Groopman and published by Houghton Mifflin (2007).

The Biopsychosocial Approach: Past, Present, Future, edited by Richard M. Frankel, Timothy Quill, and Susan Mc Daniel, and published by University of Rochester Press (2003).

Educational Tools

Teaching and Assessment Tools and Best Practices:

"A Practical Guide to Teaching and Assessing the ACGME Core Competencies," by Elizabeth A. Rider, Ruth H. Nawotniak, and Gary D. Smith (HCPPro, 2007).

Northwestern University's Communication Assessment Tool:

"Measuring Patient Views of Physician Communication Skills: Development and Testing of the Communication Assessment Tool," by Gregory Makoul, Edward Krupat, and Chi-Hung Chang. In *Patient Education and Counseling*, August 2007.

SEGUE Framework:

"The SEGUE Framework for Teaching and Assessing Communication Skills," by Gregory Makoul. In *Patient Education and Counseling*, October 2001.

A frequently used method for giving bad news:

“SPIKES: A Six Step Protocol for Giving Bad News: Application to the Patient with Cancer,” *Oncology*,” by Walter Baile, Robert Buckman, and colleagues. In *The Oncologist*, August 2000.

Online Tools:

Drexel University’s [Doc.Com](#) program consists of 40 online learning modules, each presenting a key principle, evidence-based recommendations, and a skills checklist demonstrated by some of the world’s most recognized experts on medical communications. Another program being developed at Drexel called [WebOSCE](#) allows students or practitioners to interact with live standardized patients via the Internet. Students receive feedback, watch videos of ideal behaviors, and are able to watch a videotape of their interaction online.