Improving Patient-Provider Communications

“Each patient ought to feel somewhat the better after the physician's visit, irrespective of the nature of the illness.”
-- Warfield Theobald Longcope (1877 - 1953)

At the crux of this famous quotation by a Johns Hopkins medical professor, is the ideal that even if a health care provider cannot provide an effective treatment, cure, or even a diagnosis for a visiting patient, at the bare minimum, the patient should be set at ease simply by having positive communication. The visiting patient may be ill, often in pain, possibly miserable, and at times in danger. Usually there is an unequal division of knowledge with the provider knowing more about a condition than the patient does. The patient may be worried about expenses, his or her livelihood, returning to work or normal daily activities, or the future. Our patients come seeking our help, advice, relief from pain and, whenever possible, a cure. Patients figuratively and quite literally can be placing their lives in the hands of their health care provider. But the patient-provider relationship can be complicated.

According to recent surveys, the average visit with an American doctor lasts only 15 minutes. During this time, the patient must explain the issue, with interruptions by the clinician every few seconds on average. A rushed examination often follows an incomplete history and dialogue. The need for improved communication between providers and patients is well documented. Reasons abound, but the most important is patient safety. An Institute of Medicine (IOM) report documented 98,000 annual deaths due to preventable medical errors. These grave errors may have been related to miscommunication between the patient and clinician. To put this in
perspective, if the Centers for Disease Control counted preventable medical errors as a discrete category, it would be the sixth leading cause of death in the U.S.

How are preventable deaths tied to miscommunication between providers and patients? The IOM cited doctor-patient communication as one of the primary factors of these deaths, along with poor treatment monitoring and follow-up. A 2001 survey found one in five American patients had difficulty communicating with their doctor during a health care visit. Most medical schools now include doctor-patient communication in their curriculum, but more needs to be done to address the problem of health care professionals already in practice.

Several institutes have been developed to promote effective communication between health professionals and patients. For example, the University of Pittsburgh School of Medicine opened the Institute for Doctor-Patient Communication in 2003. Recognizing that there is relatively little research on doctor-patient communication, their goal is to move beyond patient satisfaction studies, for which there is a good deal of research, and investigate issues regarding the relationship between communication and patient behaviors and outcomes. The recently formed Bucksbaum Institute for Clinical Excellence at the University of Chicago seeks to improve the quality of doctor-patient interactions. The institute has established a goal to train physicians throughout their entire careers--training ranges from medical students and post-graduates early in their careers to senior “master” clinicians, all in an effort to assist each of those groups of providers with improved doctor-patient communication.

Of course this begs many questions. What are the strategies medical providers can use to improve their interactions with patients? Can good communication be learned or is it innate behavior? What is the end goal and is the goal measurable? In other words, can we see an amelioration or better outcome following improved communication and is it worth the extra time, effort and training? If the answer to these questions is yes, then is it our responsibility as health care professionals to institute changes in our procedures to achieve these goals?

And with that question, we return to Longcope’s quote above. Of course, it is the physician’s responsibility to make the patient better, but that is not the only duty we owe our patients. Being in health care and being a professional means we have added responsibilities and duties that other fields may not have to their “customers.”

When operating in the business world, the credo you have probably heard is *Caveat Emptor* or "Let the Buyer Beware." This arises from the fact that buyers often have less information about a good or service they may be purchasing, and the seller generally has more information. Should there be defects in the item or something lacking in the service, it may be hidden from the buyer. Thus, the buyer should beware before making a purchase.

But health care is not just a business. Because of the nature of what we do and the potential for life threatening consequences, the credo we must adhere to as professionals differs from the
retail business next door. We live by *Credat Emptor* or “Let the Buyer Trust.” Patients are not and cannot be expected to have the medical knowledge and experience of providers, and society must be able to count on professionals to create trust within the community. This is not just true in health care but in all professions. For example, if you were to construct a building and consulted an architect with your plans, you are not simply expected to beware of what the architect tells you. You are expected and encouraged to have faith in his recommendations—faith that what he instructs will be safe, up to code, and possible to construct. In contrast, a salesman at a lumberyard who supplies your wood is not morally expected to provide the same level of trust. And there is less risk with the hardware store owner who directs you toward the proper fasteners or tools for the job.

Tic-Tac-Toe is a game that, when played properly, is generally a non-winnable event. As long as the player follows certain protocols, the game will usually end in a draw or stalemate. But imagine playing the game with someone who doesn’t know the rules and is incapable of learning them? While you are diligently placing your X’s in the squares to block your opponent, he may place two O’s at a time, thus ensuring a win. The point is that unless both sides of an exchange understand their roles, the outcome can be quite different than expected and, often, less than is ideal. In the next section, we will look at more than just the duties a health care provider has for the patient, but we shall examine both sides of the relationship and see what each participant can and should expect from the other.

What are the roles and responsibilities of the Provider-Patient partnership?

**Patient:** *Doctor, Doctor, I feel like I’m turning into a dog!*

**Doctor:** *How long have you felt like this?*

**Patient:** *Since I was a puppy.*

In order to best examine ways to improve the dialogue between provider and patient, it is helpful to first define the two sides of the interaction. It is obvious that the clinician has certain duties toward the patient, but it may not be as obvious that the patient also shares some responsibility toward the provider. By the same reasoning, the rights of the patient are varied, but the provider should also be afforded certain rights in the encounter.

The approach to medical care has traditionally been one of paternalism. That is to say, medical providers made recommendations in the same the way a parent would to a child. The patient, of course, like the obedient child, was expected to dutifully follow. This approach was effective for patient compliance but often left patients feeling uninvolved in the treatment of their own ailments. Many patients treated their health care like their automobile maintenance—mentally drop it off at the shop and pick it up on Thursday. The medical problem was in their doctor’s hands, and the sense of responsibility was shifted away from the patient.
More recently, providers, patients and other stakeholders in the health care arena have pushed for more of a partnership in the medical encounter. By definition, a partnership is a relationship usually involving close cooperation between two or more parties, where each has specified and joint rights and responsibilities. In the provider-patient partnership, the duties and privileges are shared but differ depending on which side of the clinical fence you stand. Many hospitals, medical centers, and even private offices have drafted Patient Bills of Rights. Some of them are guaranteed by federal or state laws, but many are facility specific.

Most patient bills of rights cover many of the same points. Let’s examine them:

- **Non-discrimination and Respect:** Patients have the right to receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age in an environment where they are treated with dignity, honesty and respect.

- **Information, Comprehension and Informed Consent:** Patients have the right to understand their rights, treatment, diagnosis and prognosis and be given the information necessary to make medical decisions. Patients also have the right to know the names and titles of anyone providing their treatments or procedures and to be advised of any change in treatment plans prior to the changes being made.

- **Risks and Benefits:** Patients have the right to refuse any treatment, examination, or diagnosis and to be informed of the risks in both accepting or refusing treatments and the expected benefits of doing so.

- **Privacy:** Patients have the right to privacy with respect to their personal information and records. They also have the right to share information with loved ones or have a representative present during visits.

- **Records:** Patients have a right to obtain copies of their records, sometimes for a reasonable copying fee, as well as itemized bills with explanations of all charges.

- **Complaints:** Patients have the right to complain to the facility or other staff through appropriate channels if they are unsatisfied with the care they are receiving.

Some facilities include statements concerning patients’ rights to select their treating provider, or expectation of reasonable continuity of care.
We must keep in mind that successful treatment is a two-way street. Patients also have certain responsibilities to their providers, themselves, and fellow patients. Like their rights, patients’ responsibilities are derived from the principle of autonomy and include a commitment of respect for an individual’s physical, emotional, and psychological integrity. Autonomy embraces a person’s right of self-governance and ability to assert control over the decisions which direct his/her own body. Patient’s responsibilities in the health care area generally include:

- **Communication:** Patients have a responsibility to be open, honest, and truthful with their providers, including a complete personal and family medical history.
  
  - Why: A provider cannot be expected to deliver accurate or proper treatments or diagnoses without knowing all the facts that might surround a patient’s condition or history.

- **Comprehension:** Patients have the responsibility to ask questions or seek additional information when they do not understand the information presented to them.
  
  - Why: There may be a language barrier, a hearing impairment, or even a disconnect between the language register the health care provider uses and that which the patient can understand. A patient may not understand the treatment plan if it is presented in a manner too complex for him/her to comprehend — a health literacy issue — or because the patient isn't ready to understand. This happens sometimes when a patient is given a scary diagnosis that he/she simply is not ready to hear.

- **Active Participation:** Patients have the responsibility to actively participate in their treatment plans and in decisions about their health care.
  
  - Why: Nobody should care more about a patient’s health than the patient. Patients should talk to their provider, bring in a list of questions, and ask about things they don't understand.

- **Compliance:** Once a treatment plan has been agreed upon, patients have the responsibility to keep their appointments, perform their home care, and do whatever else they agree to in order to improve. This includes preventative behaviors and those actions that promote a healthy lifestyle.
  
  - Why: According to a recent survey (TeleVox Software), 83 percent of patients don't follow treatment plans their doctors recommend. Surveyed physicians put that number even higher, at 95 percent. Consumer Reports surveyed nearly 700 doctors, and their top complaint was failure of patients to follow medical advice and treatment recommendations.
• Cost: Patients have a responsibility to meet the costs of their health care and not be wasteful in the use of medical resources. Financial hardships should be discussed with the provider or facility promptly.
  - Why: Health care isn’t free and providers shouldn’t have to shoulder the burden for a patient who is unable to pay. There are programs to assist patients with treatment costs and facilities that cater to patients on a sliding scale.

• Conduct: Patients have a responsibility to be aware of their conduct in dealing with other people, including the responsibility to not promote infectious disease or otherwise put others at risk.
  - Why: The behavior a patient exhibits can have a profound effect on others in a health care environment. Just because a patient is ill, he/she does not have a societal right to abandon measures of hygiene or safety.

You will recall from the definition of partnership that the term does not require both sides to have equal and identical rights and responsibilities and in this case, the provider’s side looks more like this:

Provider Responsibilities:

• Beneficence: All advice offered by the provider must have, as its goal, the welfare of the patient.
  - This is an ethical duty a professional owes his or her patient.

• Non-maleficence: Remember the oath “Primum non nocere” or “First do no harm?” The medical provider must not do anything that will harm the patient.
  - Separate from putting the patient’s needs first, this responsibility ensures the patient is not worse after seeing the provider.

• Compliance: Providers have the responsibility to follow federal, state, local and facility rules and regulations and to provide health care services in accordance with their scope of practice.
  - Logic: Professionals have a duty that requires observation of applicable laws and standards. Patients are not expected to know these standards but it is reasonable to expect that their health care providers do.
• Referral: Providers have the responsibility to refer a patient if he or she is unable to perform a necessary procedure, if the patient’s condition falls outside the provider’s competence level, or if the patient fails to improve within a reasonable course of treatment. There is also a responsibility to work with other professional and relevant parties in the best interest of the patient.
  ◦ Why: Continuing to treat a patient who does not improve or whose condition should never have been accepted for treatment under that provider’s care is a breach of professional duties.

• Permission: Providers have the responsibility to allow a patient’s family member to be present during treatments or consultations.
  ◦ Why: A patient may not entirely comprehend the treatment, may be uncomfortable being alone with the provider, or may want another pair of eyes and ears during the treatment or consultation. Such accompaniment may help them remember what occurred and help interpret clinical instructions. It is nearly always a reasonable request and should be accommodated.

• Confidentiality: Providers have the responsibility to keep a patient’s health information private even after the death of a patient.
  ◦ Why: Even before the age of HIPAA, this was the right thing to do. With very few exceptions, patients should know that what they tell their providers or what occurs during a visit is entirely the patient’s sole right to disclose. If there arises a desire on the provider’s behalf to write a paper or otherwise use the patient’s information for research purposes, the provider must ensure that all identifying patient information be removed, hidden, or changed beyond personal recognition.

• Cost: Providers have a duty to keep costs as reasonable as possible for patients and the medical system in general.
  ◦ Why: When care is provided on a fee-for-service basis, providers make their money when a patient comes into the office because he is injured or doesn’t feel well. In the absence of proper patient-centered reimbursement models, providers are often rewarded for performing the most expensive procedures. This needs to be carefully monitored so that the patient’s best interest is always foremost in the encounter.
• Emergency: There must be some system in place for patients, in case of emergency, to either reach the provider, a covering provider, or access instructions on how to best proceed.
  ◦ Why: Patients must have a way to handle emergent situations or triage a condition to make the proper decision where, how and if it requires immediate treatment. If the provider does not have a system in place, the patient may either escalate the situation to an inappropriate level (i.e., calling an ambulance for a splinter) or ignore a condition to their detriment (i.e., ignoring sudden onset weekend chest pain until the provider is back in the office on Monday morning).

• Obtain Consent: Providers are responsible for requiring consent before performing any procedure, either verbally or in writing, including explanation of the diagnosis, proposed goals, alternative procedure, risks, complications and prognosis in advance.
  ◦ Why: Gone are the days when patients unquestioningly put their lives into their provider’s hands in all situations. Patients today are better informed and deserve to have a place in the decision-making process.

• Documentation: Proper recording of all procedures, assessments, care plans, treatments and test results must be performed.
  ◦ Why: Thorough documentation will enable better continuity of care, will assist in the case of litigation, and will ensure better safety for the patient. Remember, if it wasn’t written down, it didn’t happen.

• Education: Continuing education, including all substantive advances in one’s profession, is imperative for all providers.
  ◦ Why: Patients should have the benefit of being treated with sound scientific principles, using the latest proven procedures, and without exposure to unnecessary harm to their bodies or their wallets.

• Keeping Current: Providers must keep their licenses, registrations and professional liability insurances up to date.
  ◦ Logic: Practicing without proper credentials is obviously unethical, illegal and dangerous.
The rights in the Patient-Provider connection are not only afforded to the patient. The medical professional can also expect to have certain rights as well:

Provider Rights:

- **Protection**: A provider has a right to legal protection if he or she is performing duties within the confines of professional and operational standards.

- **Refusal**: Providers have the right to refuse a patient’s request if it falls outside the boundaries of professional, operational, or ethical standards, or is beyond the provider’s scope of practice. Providers can also withdraw from care if there is an ethical or personal conflict with the patient.

- **Privacy**: Providers have the right to personal, professional boundaries and protection from defamation.

- **Full Disclosure**: Providers have the right to complete, honest, and accurate information from patients and relatives.

- **Respect**: Providers have the right to be treated with respect and fairness by patients, relatives, and their facility.

Once we understand each other’s rights and responsibilities, we are well on our way to comprehending what can be done to improve our dialogue. In the following section, we will examine the benefits of better communication.

**Barriers and Benefits of Improved Communication**

“No one has a finer command of language than the person who keeps his mouth shut.”

-- Sam Rayburn (1882 – 1961) politician

Sometimes a barrier and a benefit are different sides of the same coin. For example, the health care system has, in many ways, improved in terms of efficiency and effectiveness, but there has been an internal failure with respect to following patient conditions. Patients get lost in the system and tracking becomes something of a side note. Contributing to this failure is the emphasis on seeing more patients in a shorter period of time. This, of course, is at the expense of focusing on interaction and understanding.

Another complicating factor is the reality that some patients are not able to afford the treatments recommended by their providers. With increasing medical costs and decreased coverage, patients may be at odds with what their provider recommends. A patient may not understand the seriousness of a recommendation and with poor communication, something elective may be
viewed as imperative or a procedure of great importance may be seen as trivial. Or, consider the
situation in which a provider other than a patient's dermatologist discovers a suspicious skin
lesion. The provider may question the patient to see if there is an upcoming routine
dermatological appointment. Since he does not want to alarm the patient, he may not further
disclose the suspect lesion assuming the dermatologist will be doing a complete body scan and
surely will notice it. The patient, on the other hand, may not realize that his upcoming focused
treatment for facial acne is unlikely to involve a full body check, and since he is not interested in
creating a second expense at the dermatologists, does not inquire further. The questionable lesion
will be missed and the discovering provider is not likely to have created a follow-up to see if the
problem was addressed.

In order to ensure better patient compliance, many health care systems and providers are moving
toward a “patient-centered medical home” which promises better follow-ups and reminders to
help patients adhere to provider recommendations. Will it work? Unfortunately, this system-wide
improvement is at odds with one recent survey which found that only one-fourth of healthcare
providers believed it was actually their job to prompt their patients to stay on track and follow
treatment plans between visits. Most felt once they delivered their instructions and
recommendations to their patients, their job was completed. Surprisingly, in that same survey,
most of the providers surveyed agreed patients would be more likely to comply if they were
provided motivation and coaching.

Clear Communication

The English language is wrought with idioms, expressions, and sometimes contradictory phrases.
Consider this exchange:

Provider: How have you been feeling since your last visit?

Patient: I’ve been better.

Such a simple two-sentence exchange is riddled with ambiguity. The patient statement, “I’ve
been better” could easily be a sarcastic comment meaning “I’ve been in better shape than this in
the past” as it could be a true statement of improvement: “I’ve been feeling better lately.” Taking
the time to ascertain what a patient means can be the difference between an effective exchange
and one that is fruitless.

Most complaints about health care providers, whether they are by patients or the public in
general, deal with communication and not with clinical competency. Seeing more patients
naturally means there is less time allocated for each one. Providers, often in a hurry to move to
the next encounter, may skip important questions or clarifications. We may rush through
histories, diminishing the importance of a seemingly offhand patient comment that may have led
down a crucial diagnostic pathway. We may also ask questions that are too difficult for a patient
to understand and use terminology that is too complex for the patient’s comprehension level. For example, a provider might ask a patient if he has any spasm in his trapezius instead of just pointing and asking if it feels tight. A study published in American Family Physician found that most patients read and understand at about an eighth-grade level. But 20 percent of patients comprehend at only a fifth-grade level or even lower. Patients will often disguise the fact that they don't understand us often because they are embarrassed. And regardless of overall literacy rates, according to a 2004 report by the Institute of Medicine of the National Academies, nearly half of all Americans have trouble understanding and using health information in general. Those with low “health literacy” levels, the study found, are far more likely to be hospitalized and use emergency services more often than those with adequate health literacy. This can lead to staggering amounts of wasted health care costs and unnecessary treatments.

Naturally, patient safety is one of the most pressing health care challenges. With the Institute of Medicine report estimating that as many as 98,000 people die in U.S. hospitals each year as the result of lapses in patient safety, data suggests that about 70% of medical malpractice cases are due to relationship and communication issues between clinician and patient. The Joint Commission has estimated that 66% of sentinel events, events that involve death or serious physical or psychological injury, are due to errors in interpersonal communication. And a recent study of Orthopedic Surgeons indicates they believe a minimum of 25% of medical errors are due to miscommunication.

Many studies have also found significant positive associations between doctors’ communication skills and patients’ satisfaction, but good communication improves physical health too. Several studies and reviews have demonstrated a correlation between effective communication and improved health outcomes including better emotional health, resolution of symptoms, function, pain control, and even physiological measures such as blood pressure and blood sugar concentration.

What creates difficulty is the fact that health providers and patients have different views on what makes good and effective communication. These differences influence the quality of interactions, patient compliance, patient education, and health outcomes. Studies show that patients who feel like they have been heard and understood in addition to understanding their provider’s instructions are less likely to have issues with compliance and therefore fewer adverse effects from lack of compliance. Furthermore, a patient is far less likely to sue the provider if something does happen to go awry when they feel they had good communication with that provider. In short, clarity of communication improves patient satisfaction and reduces lawsuits.

In the next section, we will discuss strategies to improve communication.

**Techniques to Improve Patient Communication**
Knock knock
Who’s there?
Interrupting cow
Interrupting co--
MOO!!

One of the most effective things providers can do to improve patient communication is simply to listen more. Providers have a tendency to interrupt patients before they've had a chance to say what's on their minds. A study by Beckman and Frankel found that patients were interrupted an average of 18 seconds into their opening statements and allowed to complete their initial thoughts in less than 25% of office visits. In only 20% of visits was the patient even permitted to complete his opening statement of concern. Most of the time (69% of visits) the provider directed the patient toward a single complaint. A more recent study had similar results—physicians interrupted patients after only 23 seconds. Determining a patient’s major reasons for seeking treatment is paramount in a successful medical encounter. Our role in eliciting useful information from our patients cannot be underemphasized. The use of closed-ended questions (those that require only yes or no answers) control the conversation but leave large gaps in the quality of information delivered.

The “Teach Back” Method

Studies show that up to 80% of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect. The Teach Back Method has been around for many years. It is an effective technique for medical providers and educators to help patients understand their complex conditions and remember the provider’s instructions.

- Ask your patients to repeat in their own words what they need to do when they leave your office. By doing so, you can ascertain your patient's understanding of your instructions.

- Ensure your patients don’t view the Teach Back as a test, but rather a self-assessment of how well you explained the concept. You can place the responsibility on yourself by saying:

"I want to be sure that I did a good job explaining your home care instructions, because stretching and exercises can be confusing. Can you tell me what we decided you should do?"

- Follow up on a future visit to ensure the instructions were not forgotten or that they didn't morph over time:

“I know you said you have been stretching like we spoke about last time. Sometimes, a stretch is no longer appropriate once a patient has been doing it for a while. Can you show me how you’ve been stretching?”
• If your patient is not able to repeat the information accurately, try rephrasing the information, rather than just repeating it. Then, ask the patient to repeat the instructions again until you feel comfortable that the patient really understands the information.

Ask open-ended questions

• Listen more; talk less.

• Don’t interrupt or dominate the conversation.

• Encourage patients to describe feelings and concerns about their condition.

• When you listen, the treatment decisions and care plans will better reflect the patients’ wishes
  ◦ Patient-centered plans are more likely to be adhered to by patients.

Use ICE

• By asking a patient three specific questions, you can ascertain what they are thinking, uncover aspects of their condition, and determine their major concerns:
  ◦ Idea—What is your idea about what is going on?
  ◦ Concerns—What are you most worried about?
  ◦ Expectations—What are you expecting that I can do?
  You may not agree with their self-diagnosis or their expectations, but it is an excellent way to manage those concepts early and identify what may be most effective. This helps you to plan the visit and ensure you can address what the patient is seeking.

Visual aids and illustrations:

• Many people remember information better when it is presented to them visually. You can draw simple pictures or diagrams to help explain your instructions. Whiteboards, iPad sketches, or even laminated posters that you can draw on with dry erase markers can be helpful.

• Don’t be afraid to take a textbook off the shelf. Anatomy pictures and pain diagrams are useful in explaining a patient’s condition. Patients like to know if they have a “textbook case” of something because that usually means it will go away with the proper treatment.

Avoid unclear wording:
A 2007 study - "Babel Babble: Physicians' Use of Unclarified Medical Jargon with Patients," published in the American Journal of Health Behavior - found that 81 percent of physician-patient encounters studied contained at least one unclarified jargon term. Patient comprehension rates were generally low, the study found. Clarify the meaning of words that can be interpreted in multiple ways and whenever possible, use words that have only one meaning, and clarify the meaning of confusing words. Consider the following exchanges:

- “Is your stool different?” vs. “How have your bowel movements been?”
- “Has your gait changed?” vs. “Are you walking differently?”
- “Is there any extremity pain?” vs. “Any pain in your arms or legs?”

Avoid acronyms:

- Acronyms such as "CAT Scan" are common to you, but some of your patients may not understand them.
  - Say or write the complete phrase the first time you use it, and then explain the meaning.

Consider this example:

“We are going to get a PET scan” vs. “We are going to order a test called a PET scan - an abbreviation that stands for Positron Emission Tomography. Here is what it does…”

Avoid Idioms:

- Unless you're sure the patient understands the meaning, idioms should be avoided.
  - For example, instead of talking about “feeling blue" or “under the weather” a better choice of words would be “feeling sad” or “feeling sick.”

Provide a health context for numbers and mathematical concepts:
• Health measurements, such as cholesterol or glucose levels, have little meaning to patients unless you put them into a context the patient can understand.
  ◦ Instead of just telling patients their numbers give them additional information such as high and low parameters or a goal number. For example, "Your bone density level is X. A healthy level would be Y, so we need to talk about how we can improve this."

Take it slowly:
• Avoid confusion by slowing down and pausing to give your patient time to digest the information and possibly ask for clarification. Slowing down will also permit you to check in to see if they are absorbing the information.

Listen actively:
• Encourage patients to talk and tell you what’s on their mind.
• Listen with empathy —this is not taught well in school and is even more difficult with shorter visits and higher volume.
• Communicate your understanding back to the patient.

Read faces:
• If your patient looks confused, stares blankly, or doesn’t seem to be paying attention when you are discussing medical instructions, these are warning signs that you have lost their comprehension.
  ◦ Rephrase, draw, or Teach Back to ensure you have been understood. Repeat any parts of the instructions or information that are imperative and may have been missed. Give your instructions using simpler words and concepts, and draw pictures if appropriate.

Look them in the eye:
• If you are using electronic medical charting, try to look up from your laptop or tablet every few seconds so the patient knows you are interested in what they are saying more than your device. You can’t build a relationship if you are glued to your keyboard and screen.

Produce a comfortable environment:
• Make sure all team members and all aspects of your office encourage communication.
From the registration desk to the exam room, patients should be encouraged to ask questions. Discussions should always be held in private when appropriate.

Use clearly worded signs and train your staff to interact with patients to be sure they understand the office procedures.

Medical environments can intimidate and inhibit patients from asking pertinent questions. Asking a patient if he or she has any questions about anything at all is an effective way to elicit any lacking information and make the patient feel they have been given ample opportunities for interaction.

The patient is the one with the problem

- A spine will never present itself into your office...it is always connected to someone who may be anxious, fearful, angry or confused about the prognosis of their condition. Recognize the patient connected to the problem you are treating and develop an understanding of the patient as an individual, not as a disease or a musculoskeletal condition.

Sit down during patient encounters

- Patients perceive you have been with them longer and are more focused when you sit.

Show their options

- Inform and educate patients on the various treatment options and the course of care.
- This includes treatments you don’t provide, but can refer them to or recommend them for.

Patients with additional special needs may be even more of a challenge. Those with visual or hearing impairments may have difficulty understanding you. Patients with cerebral palsy may be hard for you to understand. The University of Washington has developed a Patient-Provider Communication Program for difficult patients which centers around the mnemonic “FRAME”:

Familiarize
• Get to know the patient and their special needs. Do they wear eye glasses or a hearing aid, and do they use an assistive device to communicate? How can they best express themselves?

**Reduce Rate**

• Providers should speak slowly, using short sentences and frequent pauses. Don’t overwhelm the patient with information, and allow extra time for the patient to respond.

**Assist with Message Construction**

• Let the patient know what you understand and where you are confused. If necessary, restructure your questions so the patient can simply answer “yes” or “no.” Confirm the patient understands the information you are providing.

**Mix Communication Modalities**

• The provider can use pictures or simple drawings to supplement the conversation. Offer other communication methods such as pen and paper or pictures of common vocabulary for the patient to use. Certain electronic devices can be especially useful in this event.

**Engage Patient First**

• Family members may be present, but the provider should talk directly to the patient, involving them in the discussion and decision making. While family or caregivers can act as interpreters, the patient shouldn’t be excluded in the conversation. Always address the patient even if the parent or caretaker is asking the questions.

The Agency for Healthcare Research and Quality (AHRQ) is within the Department of Health and Human Services, and is charged with improving quality, safety, efficiency, and effectiveness of health care for Americans. They launched a campaign targeted at health care facilities called “Questions are the Answers” featuring posters and print ads aimed at clinicians to encourage two-way communication during medical visits. They state “a simple question can reveal as much as a test” and encourage providers to ask at every visit, "What are our goals for today?"

Asking our patients about their health priorities at each visit makes for a more efficient and effective use of time, and patients will feel more invested in their own care. Not only does that improve efficiency, but it also helps improve health outcomes.
You can get tools and tips to share with your patients at: www.ahrq.gov/questions

Summary

“The dandelion swayed in the gentle breeze like an oscillating electric fan set on medium.”
--- Ralph Scott, Washington Post Worst Analogies Contest

As health care providers, we need to embrace programs and procedures that improve patient coaching and follow-up. Telephone call reminders to patients who miss appointments, following up with patients who are given home care instructions, and questioning chronic illness patients about compliance with management procedures, are all ways we can play our part to improve adherence to good quality care. Providers should also remember that in the case of patients trying to undergo changes in preventative behaviors, it is in fact our job to help motivate and coach them. For example, we can recommend support groups for our patients who are ready to quit tobacco or lose weight and help them track their progress along the way.

Remember to ask patients questions about behavioral changes and with some issues, learn where the patient is in terms of being ready for change. When you first tell a patient about a serious condition, that individual may not be ready for change. He/she may need to go through stages of contemplation before he/she is ready to take action to improve the condition. Once the patient is ready, we can then provide tools to foster effective change.

Many people will read the advice from the proceeding sections and think, "Sure, it’s easy for you to say. You haven’t seen how busy my schedule is. If I slow down to communicate more, my front desk person is going to kill me." Yes, if we want providers to improve communication skills with patients, we need improved reimbursement and pay for the extra time needed to do it properly. Medical providers are very good at figuring out what the system rewards and will find ways to earn more by communicating more.

Communication skills should be included at all levels of health care education and should be a mandatory part of clinical curricula. The quality of patient care is not necessarily increased by the quantity of time committed, but rather by the depth with which a provider listens, validates the patient’s concerns, and responds to the patient’s complaints. The explanation of the diagnosis and treatment options are also important factors in the quality of a clinical care episode. These factors play an important part in the way patients perceive, recall, and evaluate their visits with their providers. And we know that people heal faster when communication is stronger between caregiver and patient.

Thanks to the media and especially the Internet, patients have more knowledge about their health than ever before. The development of good relationships between patients and their providers is
more critical now and more difficult to obtain than in simpler times. We have more to explain and more sources to compete with than ever, in addition to a vast amount of misinformation and pseudoscience prevalent on the internet.

But to be a good clinician, you need to be a good teacher. There is certainly an art to distilling complex medical diagnosis and physiology into something all patients can comprehend. In addition, there is an art to modifying your explanation depending on who the patient is. A mechanic, for example, might better understand a musculoskeletal injury if it is put into the context of levers and pulleys. An athlete might better follow you if you describe what functions need to be coordinated properly during an overhand throw. An electrician would likely grasp the neurological angle of a condition when put into the context of wires and conduction abnormalities.

There are myriad ways to explain things to patients and their families. It is important that we begin with the basics and increase the complexity based on the patient’s level of understanding, interest, and curiosity. And if your patient isn’t asking the right questions, ask for them. For example, “You might wonder if this procedure is necessary” or “You’re probably wondering what happens if you don’t get treatment.” The patient may not have actually thought to ask the question or he may have been embarrassed to ask.

The use of analogies, images, and simple language comes more easily to some providers but it is such an important part of our patient interactions. If you find a part of your routine examination or diagnostic explanation tends to get a little too heavy on technical jargon, think about how you can simplify it or point to something that is more familiar to a patient’s everyday life that might be clearer. Your role, in part, is to translate medical language to something our patients can use to improve their health and make informed decisions. The development of better tactics and communication skills will help to facilitate this important change.

Sources:


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