

COMMUNICATION SKILLS TO IMPROVE PATIENT SATISFACTION AND QUALITY OF CARE

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While clinicians face increasing time pressure in caring for patients, communication with the patient can suffer. Communication is especially important in caring for the increasingly culturally diverse patient population in the United States. Different values, beliefs, and attitudes about health, illness, and health care can affect illness outcomes. These are best understood through dialogue. Patient-centered communication skills are associated with improved health outcomes, improved patient and clinician satisfaction, and less risk of malpractice suits. This paper reviews techniques to efficiently incorporate patient-centered communication into the medical encounter, with emphasis on interacting with patients of different cultures. (*Ethn Dis.* 2002;12[suppl3]:S3-58-S3-61)

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INTRODUCTION

Clinicians face increasing challenges in caring for patients. While the medical marketplace has constrained and devalued the time spent talking with patients, we practice in an increasingly challenging, culturally and ethnically diverse environment. For example, more than 100 languages are spoken in greater Los Angeles alone.¹ Learning about our patients' attitudes, beliefs, and values in order to negotiate acceptable treatment plans is essential for adherence and favorable outcomes, but this can be a challenge for today's time-strapped clinician.

Morbidity and mortality from many chronic diseases disproportionately affect some ethnic groups. While there are multiple reasons for these disparity and include factors not under clinicians' control, one element can be addressed at each medical encounter—effective communication. Competent clinician-patient communication is associated with enhanced diagnostic accuracy,^{2,3} improved blood pressure⁴ and diabetes control,⁵ and patient satisfaction.⁶ Poor communication skills are linked to risk of malpractice suits.⁷⁻¹⁰ Communication expertise is especially important when caring for patients from different cultures. Clinicians, too, benefit from improved intercultural communication. Ulrey and Amason found less anxiety among clinicians who were more skilled intercultural communicators.¹¹

How can busy clinicians improve communication effectiveness in the medical encounter while remaining efficient in the face of seemingly ubiquitous time pressures? This paper reviews some practical skills that can be helpful in all encounters and focuses on specific skills, knowledge, and attitudes useful for caring for culturally diverse patients.

PATIENT-CENTEREDNESS

Patient-centered care includes allowing patients to tell the story or narrative of their illness, including their beliefs about, and the emotions surrounding, their illness experience. Clinicians who develop "narrative competence"¹² do their patients and themselves a great service. Story telling is a valued and therapeutic part of most cultures; simply getting something "off one's chest" can result in feeling better. Allowing a patient to speak without early interruption is generally the most efficient way to obtain a rich stream of diagnostically important information.¹³ Listening mindfully to a patient's narrative and responding to emotion with empathy strengthens the clinician-patient relationship, increases trust, and leads to improved health outcomes.¹⁴ Additionally, patient-centered interviewing allows the clinician to elicit important psychosocial information, including beliefs about etiology and treatment, important spiritual, family, work and financial information, all of which can affect the choice of treatment, patient education, and treatment adherence. This data, coupled with the equally important biomedical information obtained, is synthesized by the clinician into the patient's *biopsychosocial* story—the most complete and scientific database available about a patient.¹⁵⁻¹⁷ Throughout, the patient feels heard, understood, and cared for.

Sadly, despite the robust incentives noted above, some clinicians discourage patients from telling their stories. They may fear that it will take too long. They may worry that allowing emotions to be expressed in the encounter will be harmful to the patient. They may not know what to do if a patient should cry, or express fear or anger. Consequently, patients do not feel heard, understood,

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Table 1. Steps for patient-centered interviewing

1. Setting the stage for the interview
 - a. Welcome the patient
 - b. Use the patient's name
 - c. Introduce self and specific role
 - d. Ensure patient readiness and privacy
 - e. Remove barriers to communication
 - f. Ensure comfort and put patient at ease
2. Agenda-setting
 - a. Indicate time available
 - b. Indicate own needs; obtain a list of all issues patient wants to discuss
 - c. Summarize agenda
 - i. Negotiate agenda items to cover in visit if list is too long
3. Opening the history of present illness (HPI)
 - a. Open-ended beginning question/statement
 - b. Use open-ended skills to encourage story
4. Continuing the HPI
 - a. Develop physical symptom story
 - b. Focus on impact of symptom on patient's life
 - c. Determine emotion caused by this impact
 - d. Address emotion
 - i. Name
 - ii. Understand
 - iii. Respect
 - iv. Support
5. Transition to clinician-centered interview
 - a. Brief summary
 - b. Check accuracy
 - c. Indicate that style and content of interview will change
 - d. Begin doctor-centered interview

Source. (Adapted from Smith RC. *Patient Centered Interviewing*. 2nd ed. Philadelphia, Penn: Lippincott, Williams & Wilkins; 2002).

and cared for. Clinicians then miss hearing about the psychosocial aspects of a patient's illness (the major issue in at least 30% of visits to primary care providers¹⁸), and may fail to build healthy clinician-patient relationships.^{19,20} Patient-centered interviewing need not add time to an encounter,²¹ and it likely saves time over the ensuing visits through more accurate and complete diagnoses and adherence to treatment plans, all leading to improved outcomes.

Smith has developed a model of patient-centered interviewing¹³ that, in a randomized, controlled trial, led to increased physician confidence with psychosocial issues and improved data-gathering.²² Additionally, the patient-centered part of the interview took only a mean of 10% of the time spent talking with patients. Table 1 shows the 5-step model. The encounter begins with com-

mon courtesy to: 1) put the patient at ease; 2) explain the clinician's role (perceived as a colleague, establish care, consultant, etc); 3) establish the relationship; and 4) ensure the patient's readiness to begin (Step 1). In the next step, the clinician matter-of-factly states the amount of time available for the visit, shares his/her own agenda, and helps the patient generate a list of all the reasons for the encounter, including symptoms, concerns, requests, etc. This is important because most patients bring 3 to 5 concerns to their physicians' offices and the first-voiced concern is often not the most important one to the patient (or the clinician). Failure to generate this list leads to "doorknob complaints": concerns, often serious, almost always time-consuming, brought up by the patient in the final moments of the encounter, while the clinician, hand on

the doorknob, is trying to leave to see the next patient.²³ If there are too many issues to address in the time allotted, clinician and patient should negotiate which items to cover in the visit. This empowers the patient to take control of his/her own care. If an issue sounds worrisome or potentially life-threatening, the clinician will, of course, ensure that it is addressed (Step 2). In practice, these 2 steps are completed quickly:

Clinician: "Hello Mr. Edwards, I'm Dr. Jones. I'll be seeing you today for Dr. Taylor who has the afternoon off. Did you have any trouble getting here?"

Patient: "My ride was a bit late but at least I'm here!"

C: "Well, I'm glad you made it. We've got about 15 minutes together today and I see that we need to review the blood tests you had done yesterday, but before we do that, it would help me to get a list of all the things you wanted to discuss today."

P: "Oh, my blood pressure, of course, but this knee has been hurting for two months."

C: "So, your blood pressure, and your knee is hurting. Anything else?"

P: "Well, I brought this handicapped parking form in; I was hoping you could fill it out for me."

C: "We can look into that together. Anything else?"

P: "No, that should do it."

C: "Fine. We should be able to take care of reviewing the blood tests, your blood pressure control, take a look at that knee and discuss the handicapped parking form. Why don't you start by telling me about your knee?"

In Step 3, the clinician facilitates the patient in telling the story of one of the agenda items, avoiding the temptation (for now) to ask the patient closed-ended questions about cardinal features of the symptom, etc, but simply allowing the patient to relate the history of present illness for a minute or so. In Step 4, the clinician focuses the patient's story to develop the story of the physical symptom, then to focus on the impact of the symptom/problem on the patient's life, and finally elicits the emotion attached to that impact. The emotion is then managed with a model of

Table 2. Guidelines on using interpreters

- Recognize that, by definition, the visit will take (at least) twice as long.
- Use trained interpreters whenever possible.
- Ask for exact translation with cultural interpretation of idioms, etc.
- Place interpreter out of the sight-line.
- Speak directly to the patient and watch him/her when interpreter is speaking.
- Write down key points, instructions and ask interpreter to transcribe for patient.
- Check for comprehension by asking patient to summarize.

empathy: “NURS”—Name, Understand, Respect, and Support:

C: “So, you say that this knee pain is keeping you from looking after your grandchildren and it has you feeling helpless (Name). I can understand how you might feel that way (Understand). This has been a tough time for you (Respect). Let’s see what we can do to make this better (Support).”

The result of the patient telling his story without undue interruption, sharing emotion and hearing an empathic response, is feeling heard, understood, and cared for. This deepens the clinician-patient relationship.

The clinician can hear more of the patient’s story, and elicit and manage more emotions, depending on available time and the patient’s level of psychosocial distress. Step 5 marks the transition to the clinician-centered part of the interview, where the clinician asks closed-ended questions to better elucidate the diagnosis and complete the patient’s database:

C: “I’m going to switch gears now and ask you some questions to better understand why your knee is hurting you, as well as questions I ask all my patients, OK?”

INTERCULTURAL COMMUNICATION

While the patient-centered interviewing skills noted above can be useful in any medical encounter, additional knowledge, skills, and attitudes can benefit clinicians who care for patients from different cultures. Culture can be defined as, “Ideas, beliefs, values, and as-

sumptions about life, created by people and transmitted across generations, that are widely shared among a group of people and guide behavior.”²⁴ In essence, every medical encounter is intercultural: the culture of medicine is foreign to most lay people. Intercultural communication skills can therefore aid all clinicians.

The first step in improving interactions with others is to understand one’s own culture. One’s own values are cultural blind spots until understood.²⁵ For example, many clinicians value punctuality and, as “time people,” may get irritated with “event people,” for whom what is happening now is more important than artificial time constraints. Another example is the value placed by dominant American culture on individuality and self-actualization. Clinicians can become frustrated when caring for a patient from one of the many cultures that value reliance on family over reliance on self, because our dominant biomedical ethical principle, autonomy, may not be dominant for our patient. “Guard against the tendency to assume that all people have similar ways of showing respect, handling time and space, interpreting behavior and gestures and prioritizing values.”²⁵

After understanding one’s own culture and culture-bound values better, clinicians are urged to learn about the cultures frequently encountered in practice. It is helpful to learn about a culture’s values, and beliefs about health, illness and folk illnesses.^{1,26} In addition to asking local cultural representatives, resources with cultural information are available.^{27–30}

A danger of relying solely on lists of cultural values and beliefs is generalizing them to all members of a cultural group. Cultures can consist of subgroups (eg, Latinos include Puerto Ricans, Mexicans, Dominicans, Cubans, etc) with widely different beliefs. Cultural beliefs are also, in part, modulated by socioeconomic status, education, level of acculturation, and English language ability.

Language difference can pose a major barrier to communication. Spanish-speaking patients were shown to be less satisfied with care and have lower comprehension of instructions if their physicians were not fluent in Spanish.³¹ Even patients who can speak English as a second language may prefer to communicate about health issues in their native tongue.³² Clinicians should use an interpreter unless they are fluent in the patient’s language. Trained interpreters are preferred over using family members or employees. Regardless of the interpreter used, some guidelines can help improve the interaction (Table 2).

Sensitive inquiry can help determine a patient’s culturally mediated health beliefs. Kleinman²⁶ recommends specific questions (Table 3). This knowledge can be critical to negotiating a treatment

Table 3. Determining patients’ explanatory model

- “What do you think has caused your problem?”
- “Why do you think it started when it did?”
- “How does it affect your life?”
- “How severe is it? What worries you the most?”
- “What kind of treatment do you think would work?”

Source: Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med.* 1978; 88:251–258.

plan to which the patient will adhere. In follow-up visits, the clinician should specifically inquire about medication side effects, concerns, and the patient's belief about medication effectiveness. For example, in some cultures the shape or color of pills is believed to indicate their potency. Failing to understand this belief can lead to poor compliance and outcomes.

An example of how improved clinician-patient communication can result in better blood pressure control is a study by Inui et al.⁴ Study physicians attended a simple, 2-hour workshop, teaching them to inquire about patient attitudes and medication side effects and to be educators rather than just examining for complications of hypertension. Following the workshop, the study physicians had 30% more patients with controlled blood pressure than a control group of physicians. The study physicians spent less time performing a review of systems and a physical examination and more time eliciting patients' ideas about their medication, exploring barriers to adherence, and sharing the treatment rationale. Amazingly, these more effective communicators also spent less time per patient encounter than the control group physicians did.

BUILDING SKILLS

Communication skills are an important tool for improving the quality of care, especially as our society becomes more diverse. Clinicians interested in honing their patient communication skills are encouraged to take courses offered by the American Academy on Physician and Patient (www.physicianpatient.org) and the Bayer Institute for Healthcare Communication (www.bayerinstitute.org).

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