

DOCTORS & HOSPITALS

By Wendy Levinson, Cara S. Lesser, and Ronald M. Epstein

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Developing Physician Communication Skills For Patient-Centered Care

Wendy Levinson (wendy.levinson@utoronto.ca) is the Sir John and Lady Eaton Professor and Chair of the Department of Medicine at the University of Toronto, in Ontario.

Cara S. Lesser is the director of foundation programs at ABIM Foundation, in Philadelphia, Pennsylvania.

Ronald M. Epstein is a professor of family medicine, psychiatry, and oncology, and is director of the Rochester Center to Improve Communication in Health Care, University of Rochester Medical Center, in New York.

ABSTRACT Growing enthusiasm about patient-centered medical homes, fueled by the Patient Protection and Affordable Care Act's emphasis on improved primary care, has intensified interest in how to deliver patient-centered care. Essential to the delivery of such care are patient-centered communication skills. These skills have a positive impact on patient satisfaction, treatment adherence, and self-management. They can be effectively taught at all levels of medical education and to practicing physicians. Yet most physicians receive limited training in communication skills. Policy makers and stakeholders can leverage training grants, payment incentives, certification requirements, and other mechanisms to develop and reward effective patient-centered communication.

Physicians, medical organizations, and policy makers have become increasingly interested in the patient-centered medical home.^{1,2} The Patient Protection and Affordable Care Act of 2010 encourages pilot projects to test the model. Primary care practices that become medical homes will need to have a number of features and capabilities, ranging from electronic health records to care systems that support the coordinated management of chronic diseases. In addition, a well-designed medical home needs physicians who possess excellent patient-centered communication skills.³

There is growing recognition that the education and training of physicians should increase the focus on helping them acquire these capacities. In its June 2009 report to Congress, for example, the Medicare Payment Advisory Commission (MedPAC) recommended that Medicare payments for graduate medical education be linked to the development of such skills.⁴

As U.S. policy makers grapple with the implementation of health reform, it is appropriate to reflect on what we know about patient-centered communication skills and how they can be nour-

ished. In this article we describe those skills and review their impact on patient outcomes. We demonstrate that patient-centered communication is more than simply being courteous and honest with one's patients; it is, in fact, a sophisticated process. We present evidence that communication skills can be taught and enhanced during the training of new physicians and through continuing medical education for practicing physicians, and we describe how proficiency in the skills can be assessed.

Finally, we observe that the development of patient-centered communication skills, like other requirements of patient-centered care, can and should be fostered through a variety of interventions by a broad range of stakeholders: medical educators, medical organizations, health care institutions, regulators, government agencies, and insurers.

A Complex Set Of Skills

Patient-centered care was identified in *Crossing the Quality Chasm*, a 2001 report by the Institute of Medicine (IOM), as one of the six main elements of high-quality care.⁵ The report defined

patient-centered care as “respecting and responding to patients’ wants, needs and preferences, so that they can make choices in their care that best fit their individual circumstances.”^{5(p.48–50)} Although infrastructure can help facilitate the delivery of patient-centered care, ultimately such care is characterized by continuous healing relationships, shared understanding, emotional support, trust, patient enablement and activation, and informed choices.^{6(chap 2)}

Communication skills are a fundamental component of this approach to care. A substantial amount of evidence demonstrates that patient-centered communication has a positive impact on important outcomes, including patient satisfaction, adherence to recommended treatment, and self-management of chronic disease.^{6–13} In addition, recent research provides compelling evidence that such communication improves clinical outcomes in the management of diabetes, hypertension, and cancer.^{6,14,15}

Conversely, breakdowns in communication are strongly associated with the increased likelihood that patients will initiate malpractice actions.¹⁶ Patients’ most frequent complaints are that physicians do not listen to their concerns, care about their problems, or provide enough information about their treatment.¹⁷

Patient-centered communication seeks to increase health care providers’ understanding of patients’ individual needs, perspectives, and values; to give patients the information they need to participate in their care; and to build trust and understanding between physicians and patients. This communication occurs through both verbal and nonverbal behavior.

Communication skills have been categorized in a variety of ways. There are a number of key functions of communication between physicians and patients, and for each function there are specific skills that enable a productive conversation.⁶ These functions include fostering healing relationships; exchanging information, such as what patients want and need; responding to patients’ emotions; engaging in informed and collaborative decision making; and enabling patient self-management. Each requires a set of specific communication skills.

To assess patients’ wants and needs, the physician must ask questions about patients’ concerns, priorities, and values. The physician must listen attentively to patients’ answers and ask follow-up questions if the answers need clarification.

For example, a patient might say that he wants to have “everything possible” done to treat a life-threatening condition. The astute clinician would realize that “everything possible” could have a number of very different meanings, and

that correctly understanding what this patient wants will require an exploration of his fears about illness and opinions of possible treatments. Further questioning may also be needed to explore what the patient hopes to achieve, to correct unrealistic expectations, and to explore the possibility that treatment might result in increased suffering.

Only after the patient’s values and preferences have been clarified will the physician and the patient be able to make truly collaborative decisions that are in the patient’s best interest. Evidence suggests that after such discussions, patients with terminal illnesses receive fewer intensive interventions in the last week of life, generate lower health care spending, and—with their families—report better quality of life in their final days.^{18–20}

The National Cancer Institute lists six fundamental functions of physician-patient communication: fostering healing relationships, exchanging information, responding to patients’ emotions, managing uncertainty, making informed decisions, and enabling patient self-management.⁶ Appendix Exhibit 1²¹ provides an overview of the role of the physician in each of these functions, as well as examples of the communication skills that each requires. Although only a few sample skills are presented in the exhibit, multiple skills are actually required, each of which may accomplish several functions simultaneously.

Physicians need to perform multiple communication tasks during interactions with patients. These tasks cannot be accomplished by mechanically applying skills. Rather, they require genuine personal engagement and emotional involvement. An expression of sympathy for a patient’s emotional distress requires sincerely feeling concern in addition to using the right words. This emotional labor is part of the physician’s role and responsibility.²²

Teaching Communication Skills

Learning any skill requires practice and feedback. Lectures alone cannot teach a physician how to perform a surgical procedure. Rather, honing surgical skills requires deliberative practice, or a combination of close observation, use of simulation, timely and frequent feedback, increasing responsibility, and mentoring by experienced teachers.²³

Similarly, communication skills should be taught in a systematic way, including practice and constructive feedback. Yet remarkably, once they have left medical school, most physicians never get feedback about their interactions with patients. Practicing physicians have typically

been left to learn communication skills on their own. Not only do many physicians have only a limited repertoire of such skills, but they also might not even realize that additional skills exist that could improve the quality of their communications.

Physicians' personal reactions to issues raised by patients influence the interaction, either positively or negatively. Hence, teaching communication skills, unlike teaching surgical procedures, requires attention to the physicians' emotional reactions, in addition to the cognitive tasks involved.^{24,25} Most communication programs include an opportunity for physicians to examine their own emotional responses and learn how to regulate their impact on relationships with patients.²⁶⁻²⁸

All medical schools are required to teach students basic communication skills.²⁹⁻³² These courses typically include lectures, but they also employ so-called standardized patients—actors trained to portray patients and sometimes trained to give structured feedback to the students. Additionally, the students are observed by residents, who sometimes provide feedback on their interviewing skills. Most of this communication training occurs during the first and second years of medical school.

However, it is in the third and fourth years of medical school, during clinical rotations, when students have the most patient contact and face their greatest cognitive and emotional challenges. Unfortunately, the teaching of communication skills often receives little attention then, compared to the teaching of diagnostic skills and patient management. Despite the challenges,³³ innovative medical school programs are demonstrating improvements in students' communication skills.^{34,35} Typical programs incorporate demonstration of interviewing skills with faculty, experimental learning techniques, individualized feedback, and student self-performance assessment.

With the exception of some primary care training programs, most training programs after medical school do not include communication skills in their curricula. Since 2002, the Accreditation Council for Graduate Medical Education has required the teaching and assessment of "interpersonal and communication skills."³⁶ Yet fulfilling this requirement has received relatively low priority in some residency programs. Hence, residents' learning of communication skills tends to be haphazard, with relatively little feedback.

During the past decade, with the increased attention on patient-centered care, programs have been designed and implemented to teach patient-centered communication skills to practicing physicians. These programs have been

Most training programs after medical school do not include communication skills in their curricula.

provided either by medical societies with a particular interest in communication training, such as the Society of General Internal Medicine, the American Academy of Orthopaedic Surgeons,³⁷ and the American Academy on Communication in Healthcare, or by large medical groups that have a dedicated cadre of physicians, such as Kaiser Permanente in Northern California.

The programs are usually conducted over a short period of time—typically half a day to three days—and include opportunities for physicians to practice communication skills while being observed by colleagues. Role play is the most commonly used teaching method in communication skills programs for practicing physicians because of its ease of use, low cost, and effectiveness. When practicing physicians play the roles of patients as well as physicians, they increase their understanding of patients' experiences and can try new approaches in the role of physician.

For example, a program might have a role-playing session about informed decision making. The "patient" might be told to present barriers to communication, such as insisting that the physician order magnetic resonance imaging (MRI) to assess a headache when it is not medically indicated. In this scenario, the challenge for the physician would be to understand the reason for the patient's preference and negotiate a mutually acceptable plan of treatment.

These programs also make use of standardized patients in scenarios such as breaking bad news, disclosing medical errors, and discussing end-of-life issues. Experienced standardized patients become "connoisseurs of care," who can provide credible feedback. Sometimes a physician goes through the scenario again to practice a new approach.³⁸ Encounters need not be live to serve as teaching aids; reviewing videotapes of encounters with standardized or actual patients can help reinforce clinicians' effective communication strategies and change ineffective ones.

All of these training programs require expert

teachers. Training is most effective when conducted in small groups, in which individual physicians get direct supervision. Furthermore, learning is more likely to change physician communication if there is reinforcement over time, in repeated educational sessions.

The costs of time away from seeing patients poses a major barrier to physicians' availing themselves of such training, as does the lack of incentives to participate. In addition, physicians may suffer the misconception that patient-centered communication results in longer patient visits—when, in fact, effective communication may result in shorter, more efficient visits.^{39–41}

Effects Of Promoting Communication Skills

Numerous studies have been designed to assess the effects of interventions to improve physicians' patient-centered communication.^{42–46} Most have focused on measuring the effects of interventions on communication behavior, rather than on patient outcomes.

A recent systematic review examined thirty-six randomized trials in which the primary outcome was verbal communication behavior. Interventions were characterized by the type of instruction—information, modeling, feedback, and practice—and the level of intensity. Higher-intensity programs used multiple strategies, were delivered more than once, and used live instructors rather than didactic materials. Eighteen of the studies directed the intervention at residents and practicing physicians; fifteen provided education for patients; and three included both physicians and patients.⁴³

High-intensity interventions were more likely to show improvements in physicians' communication, including their asking more open-ended

questions and fewer questions focused on medicine, than low-intensity interventions, such as didactic lectures. Some studies showed that after an intervention, physicians in the intervention group were more likely than control physicians to elicit patients' concerns and exhibit an overall patient-centered communication style, as indicated by patient or observer ratings. Other studies found that intervention physicians improved their ability to express empathy or provide reassurance. Sixteen studies documented improvements in physicians' provision of information and explanations of patients' illnesses or treatments.⁴⁵

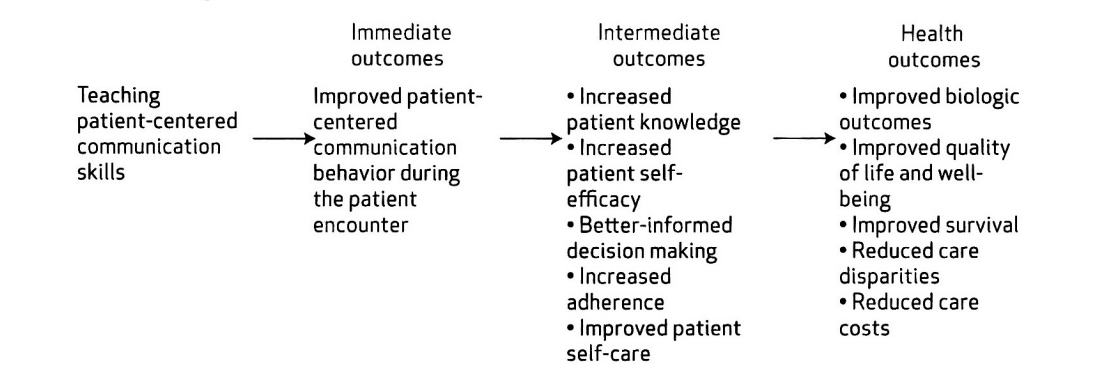
However, those changes are only the immediate outcome of the training: improved communication behavior on the part of physicians. The immediate outcome must result in the intermediate outcome: improved knowledge, adherence to treatment, and self-care on the part of patients. That, in turn, must lead to improved health outcomes, as revealed by disease markers or quality-of-life measures—the ultimate outcome.⁷

The impact of communication training on that ultimate outcome is harder to assess (Exhibit 1). The evidence that training does have an effect is relatively small so far, but it is growing. For example, recent studies in the care of cancer patients demonstrate that communication training of medical oncologists has a positive impact on the emotional well-being of patients and their quality of life.⁶

Patient-centered communication is multidimensional. Any given intervention might have an impact on some but not all functions of patient-centered care. For example, an intervention designed to teach physicians to respond to patients' emotions may be effective in improving patients' experiences with physician care, but it might not improve shared decision making. As a result, tools used to measure impacts need to be

EXHIBIT 1

Link Between Teaching Patient-Centered Communication Skills And Various Outcomes



SOURCE Authors' analysis.

tailored to match the specific aspects of the communication intervention being taught.

Methods For Measuring Patient-Centered Communication

Methods for measuring physicians' communication skills include direct observation of communication behavior, interviews with patients or surveys about their health care experiences, and actual outcome measures. Keeping in mind that each method provides insights into a different aspect of patient-centered care, a set of measures can be derived for each improvement initiative that accounts for the multiple perspectives involved.^{7,47-49}

As indicated in Appendix Exhibit 2,²¹ the most direct measures of communication are watching actual encounters or videotapes of meetings between physicians and patients and observing the presence or absence of particular communica-

tion behavior that was taught during the training. Other studies measure changes in patients' knowledge, attitudes, or actual health behavior.

The most frequently used measures are surveys of patients about the experience of care. In particular, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey⁵⁰ captures many of the dimensions of patient-centered care, is well validated, and is easy to administer. Because many institutions routinely administer this survey, it is possible to compare scores between institutions, or in specific wards or clinical units before and after implementing an intervention designed to improve the skills of physicians.

A few institutions give physicians feedback about how their scores compare with those of their peers on these measures. Individualized feedback is a powerful tool that allows physicians to track their progress, both absolutely and relative to that of their peers, over time.

EXHIBIT 2

Interventions, Assessment Tools, And Resources To Support Patient-Centered Communication

Source	Intervention	Assessment	Resources
Medical school	Curriculum focusing on patient-centered care (usually years 1 and 2)	National Board of Medical Examiners test of communication skills Direct observation in clinical rotations	Standardized patients Trained faculty
Residency program	Curriculum focusing on communication (very rare) Structured observation	Accreditation Council for Graduate Medical Education (ACGME) (requires competency in interpersonal and communication skills and team-based skills) American Board of Medical Specialties (ABMS) certification (requires competency in communication and interpersonal skills and team-based care)	Standardized patients Trained faculty Patient feedback surveys Review of videotaped interactions with coaching
Continuing education	Education depends on practice setting Continuing medical education (CME) courses and workshops (usually in large medical groups)	Maintenance of certification (currently including few tools to assess patient-centered care) Patient feedback Peer feedback	Infrastructure for feedback Resources for workshops, including trained faculty and standardized patients Infrastructure to support patient-centered aspects of practice (such as electronic health records)
Large medical groups	Large-scale training programs with ability to reinforce lessons over time "Train the trainer" programs	Maintenance of certification Patient feedback Peer feedback Patient complaints Malpractice claims	Infrastructure for feedback Resources for workshops, including trained faculty Infrastructure to support patient-centered aspects of practice (such as electronic health records)
Medical payers	Pay-for-performance based on patient satisfaction	Patient satisfaction	Infrastructure for collecting large amount of patient feedback, adjusted for patient severity of illness

SOURCE Authors' analysis.

Payers can increase the demand for patient-centered communication through reimbursement strategies.

Implications For Policy Makers And The Medical Profession

Interventions to support patient-centered communication skills can be implemented by medical educators, medical organizations, government agencies, and insurers. Exhibit 2 presents possible interventions and assessment tools that can be used at various stages of a physician's career, and it indicates the types of resources and supports needed for each.

Training during medical school and residency has two advantages: a captive audience of students, and guidance by professional faculty who have the responsibility to teach and assess those students. Curricula focusing on patient-centered communication have been implemented in medical schools to some degree, but they could be expanded—particularly for medical residents. Health care institutions, including hospitals and medical groups wanting to support patient-centered care, have demonstrated an ability to build systems and a culture to support such efforts.

For example, Kaiser Permanente, in northern California, and Park Nicollet, in Minneapolis, have developed and tested extensive training programs to teach and reinforce patient-centered communication skills. These programs have led to demonstrated improvements in physicians' self-confidence and self-assessed communication skills, as well as improvements in patient satisfaction.^{46,51,52}

Key components of the efforts include fostering physician leaders and trainers, workshops for practicing physicians, remediation for physicians having difficulties, regular patient satisfaction surveys, and, in some cases, payment incentives for high patient satisfaction scores. Annual physician evaluations can and should

include peer and patient evaluation on communication skills.

Furthermore, leaders and administrators can model desired communication skills in their interactions with physicians and staff, setting high expectations for effective communication in all interactions. Making the importance of communication between physicians and patients and among health professionals part of a medical group's culture can have a profound impact on the degree to which patient-centered care is the norm.

Medical groups are well positioned to design an infrastructure to support patient-centered care through the use of electronic communication, effective systems to ensure access to care, patient education programs, and the use of ancillary health care professionals such as physician assistants. A recent American Medical Association Ethical Force consensus report on improving communication and care provides a structured approach to this endeavor for organizations.⁵³

An additional driver to improve communication skills may come from the certifying boards responsible for setting standards. The American Board of Medical Specialties, through its maintenance of certification process, plans to require patient surveys focusing on communication as part of routine recertification for all physicians.⁵⁴ Many of the specialty boards have already implemented peer or patient feedback. Because assessment often drives education, this requirement is likely to lead to an increased number of educational programs on patient-centered communication.

Medicare and other payers have the ability to further increase the demand for patient-centered communication through reimbursement strategies. At present, Medicare and many private payers' approaches to reimbursement are procedure oriented, which means that time spent talking with patients is not well reimbursed.

However, reimbursement strategies can be devised to support patient-centered care through the use of patient survey scores, payment codes for patient education and counseling, or requirements for documented achievement of specific communication tasks, such as conversations on advance planning directives. Complicated conversations, such as breaking bad news or disclosing medical errors, could be reimbursed as "complex procedures."

In addition, Medicare could consider other incentive payments for training programs that demonstrate excellence in the development of patient-centered communication skills. Alternatively, it could fund pilot programs to explore

new approaches to refining training programs and institutional initiatives related to communication skills. Measuring and rewarding patient satisfaction as part of routine practice should be a requirement for becoming a patient-centered medical home for primary care delivery.

Conclusion

Policy makers and health system administrators increasingly recognize the value of patient-centered care, in terms of both quality of care and patient outcomes. They are endorsing a variety of changes in the structure of the health care delivery system to encourage such care. But along with these investments, policy makers and health system leaders must recognize that patient-centered care requires physicians to be formally trained in a set of communication skills that enables them to effectively deliver this type of care.

Many stakeholders have a role to play in developing programs and incentives to encourage physicians' acquisition and ongoing refinement of these skills. Opportunities to enhance patient-

centered communication skills exist at all levels of medical education, particularly through continuing medical education.

Policy makers can send an important message to physicians about the value of these skills by linking payment to evidence of effective patient-centered communication. Professional organizations, such as certifying boards and specialty societies, can leverage board certification and continuing medical education to encourage physicians to focus on refining these skills throughout their careers.

Although health reform has inspired new momentum for patient-centered care, making this vision a reality will require sizable investments in improving the skill set of our physician workforce—including appropriate communication skills. The necessary changes will not occur overnight, but neither are they out of reach. We have a moral imperative to meet this challenge, because doing so will improve the quality of care. Perhaps just as important, it is what patients want and expect from the physicians and health care system that serves them. ■

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ABOUT THE AUTHORS: WENDY LEVINSON, CARA S. LESSER & RONALD M. EPSTEIN



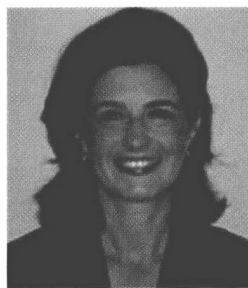
Wendy Levinson is chair of the Department of Medicine at the University of Toronto.

Wendy Levinson is the Sir John and Lady Eaton Professor and Chair of the Department of Medicine at the University of Toronto and chair of the American Board of Internal Medicine's board of directors.

A national and international expert in the field of physician-patient communication, Levinson received her M.D. degree from McMaster University. She completed residencies in internal medicine and has taught and practiced medicine in both the United States and Canada. Her research, which focuses on such aspects of patient-physician communication as the effectiveness of primary care physicians and surgeons in helping patients make informed decisions, is reflected in more than 170 peer-reviewed publications and twelve book chapters. Her many distinctions include the Society of General Internal Medicine's 2009 Robert J. Glaser Award for outstanding contributions to generalism in medicine.

Through her affiliations with the American Board of Internal Medicine and the American Board of Medical Specialties, Levinson encourages medical standard-setting organizations to use their certification processes to support education in and measurement of communication competencies in patient-centered care.

"In theory, people have been concerned about patient-centered communication skills for decades," she observes. "But in practice, these skills have been very underattended to." By creating a "legislative language that addresses the need to increase physician skills to meet patient needs," Levinson notes, the Patient Protection and Affordable Care Act "has created new opportunities and a new impetus to develop the sophisticated set of skills patient-centered communication requires."



Cara S. Lesser is director of foundation programs for ABIM Foundation.

Cara S. Lesser is director of foundation programs for ABIM Foundation. She is responsible for developing and overseeing programs related to advancing a new definition of physician professionalism—including efforts to promote patient-centered care.

Prior to joining the foundation, Lesser served for nearly a decade as the director of qualitative research at the Center for Studying Health System Change. During this time, Lesser designed, oversaw, and participated in the center's core research effort, the Community Tracking Study. She and her colleagues were awarded the first AcademyHealth HSR Impact Award, given to outstanding examples of the positive impact of research on

policy or practice.

Lesser holds a master of public policy degree from the University of California, Berkeley.



Ronald M. Epstein is a professor of family medicine, psychiatry, and oncology at the University of Rochester.

Ronald M. Epstein is a professor of family medicine, psychiatry, and oncology at the School of Medicine, University of Rochester, in New York. He directs the Rochester Center to Improve Communication in Health Care, as well as the Dean's Teaching Fellow Program.

Epstein's research focuses on communication in health care settings and patient-physician relationships, and its impact on health, quality of life, process of care, patients' perceptions and attitudes, and health care costs. The author of more than a hundred peer-reviewed articles and twenty-five book chapters, Epstein also coauthored the 2007 National Cancer Institute monograph, *Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering*.

Board-certified in family medicine and hospice and palliative medicine, Epstein is a graduate of Harvard Medical School. In 2005 he received the Lynn Payer Award from the American Academy on Communication in Healthcare for lifetime contributions to the theory, practice, and teaching of effective communication.