1999

Patient/physician communication: a comprehensive review of the medical literature, 1989 to 1998

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Patient/Physician Communication:
A Comprehensive Review of the Medical Literature, 1989 to 1998

Thesis submitted to
The Graduate School of
Marshall University

In partial fulfillment of the
Requirements for the Degree of
Master of Arts
in Communication Studies

By

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Huntington, West Virginia

May 3, 1999

This thesis was accepted on May (Month) 3 (Day) 1999 (Year)

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Acknowledgements

I would like to gratefully thank the encouraging support of my friends both in the Communication Studies graduate program and at my workplace. While the kind support of all these individuals is appreciated, I would like to provide special recognition for a few individuals - Barbara Marshall and Kathleen Dempsey for spending the time and effort assisting in the coding process for this project, and Jody Monk, Director of Education and Media Services, Camcare Health Education and Research Institute, for her patience and support while I completed this program.

Additionally I express my thanks to the faculty of the Marshall University Communication Studies Department with special appreciation to my graduate committee: Dr. Camilla Brammer, Dr. Edward Woods, and my faculty advisor and committee chair, Dr. Bertram Gross.

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Abstract

Patient/physician communication is recognized as an important topic in the medical literature. The subject has steadily been increasing in the frequency of reporting in the literature. After a comprehensive review of this literature, positive patient/physician communication has been clearly linked to improved patient and physician satisfaction, increased compliance with treatments, improved health outcomes, decreased risks of litigation, as well as creating a more caring, empathetic relationship. Yet despite these advantages, patient/physician communication does not occupy a significant portion of the medical school curriculum and styles of physician communication that promote positive patient/physician communication are not readily used. This study examines the medical literature during the 10-year period from 1989 through 1998 and categorizes and reviews the major themes presented in patient/physician communication.

Chapter 1: Introduction

Technology and science play important roles in the education and practice of physicians. Knowledge of biology and chemistry figure prominently in almost every "pre-med" program and there are literally hundreds of medical tests the physician has to choose from to help make a diagnosis. Yet with all this, the most basic skill a physician must possess is how to communicate effectively. The importance of this skill is frequently mentioned in the medical literature.

"If any skill is essential to a physician, it's communication (DeAngelis as cited in Morgan and Winter, 1996, p. 638)."

"Effective communication is a central clinical function that cannot be delegated (Stewart, 1995, p. 1423)."

"Despite the remarkable advances in laboratory medicine, radiology, and diagnostic procedures and testing, most physicians still consider the medical interview to be the most valuable component in the clinical evaluation of the patient (Edwards et al., 1996, p. 744)."

"Communication between physicians and patients is fundamental to medical care (Joos, Hickam, Gordan, & Baker, 1996, p. 147)."

"Most essential diagnostic information arises from the interview, and good communication increases patient's knowledge, satisfaction, and compliance, and positively influences health (McManus, Vincent, Thom, & Kidd, 1993, p. 1322)."

Communication between patient and physician plays a vital role in the diagnostic process. Fields (1991) stated up to 90% of the diagnostic information obtained by the physician is generated in the medical interview. Fallowfield (1996) made the observation that the medical interview was the most frequently performed medical procedure any physician would perform, with the average physician conducting between 150,000 and 200,000 interviews during his or her career. Yet very little time in medical school or residency training is spent working on this skill, especially in comparison to the many other procedures taught that the physician may never use. While the role of communication in the patient/physician relationship has been well established, it is an area of medical practice that has been neglected (Joos, Hickam, Gordan, & Baker, 1996; Kaplan, Greenfield, & Ware, 1989). As Gilligan and Raffin (1997) noted, while the importance of communication is clear it is often an area that falls short in terms of quality. At one time, the basis of medical education dealt principally with communication and the relationship between the patient and the physician. This was the case with medical education in the United States from the late 19th century through the early 20th century (Bryan, 1991). The mark of a good doctor was considered to be his ability to interact well with patients.

"Choose a physician as you would a friend," was the advice of Oliver Wendell Holmes (as cited in Rees, 1993). Patients were seen in their homes and not in physicians' offices or hospitals. As Rees noted, as early as the 1930's

some physicians were warning of the potential for hospital-based care to lead to a deterioration of the patient/physician relationship.

Yet with all the positives of the relationship, there were also negatives. Patients were seen as being largely incapable of understanding the circumstances surrounding their illness or its treatment. This approach fostered the development of a paternalistic approach by physicians to the relationship. Patients were often kept in the dark about their condition and had very little input into their course of treatment. This approach to the relationship was dramatized by Cassell's (as cited in Laine & Davidoff, 1996) description of a patient/physician encounter involving his mother in the 1930s, "During the course of the visit when she asked him a question, he slapped her face, saying, "I'll ask the questions here. I'll do the talking." (p. 152)" While this example may be extreme, it does provide some insight into the level of paternalism and physician dominance in the relationship that could have developed.

As the current century advanced, technical innovations in medical care and the increase in specialty care changed the skills emphasized in medical schools and residency programs. Communication skills took a backseat to other more technical skills. Also, as treatment capabilities increased and a wider variety of medications and procedures were required to be learned by students, less time was dedicated to fundamental communication training. As Ubel (1995) described it, "Modern technology has practically eliminated our need to talk to each other (p. 587)." Students find themselves increasingly relying on diagnostic

tests to develop their conclusions on patient condition (Ubel, 1995). Medical students resorted to assembling facts, and often, their future is decided on the ability to recall those facts. Strong science backgrounds - not social skills - had become the requirements for admission to medical schools (Bryan, 1991).

Compounding this problem was the traditional concept of the role of the physician in the relationship. Medical education had for years emphasized the importance of the physician's role while de-emphasizing the role of the patient in the relationship (DiMatteo, 1998). Much of this can be attributed to some of medicine's basic tenets that promote the physician's power over the patient. DiMatteo and DiNicola (1982) comment that the relationship can be at times characterized by "an overly authoritative approach to patient care which implies an obligation on the part of the patient to follow the practitioner's orders blindly (p. 7)." Some of this attitude toward the relationship can be traced back to Hippocrates. Edelstein (as cited in Bellet, 1994) commented on what he call the "Hippocratic Physician": "If the physician is to help, his relationship to the patient must be that of the person in command to one who obeys (p. 929)."

Todres (1993) quoted Abraham Heschel's comments in a speech before the American Medical Association:

> While medical science is advancing, the doctor-patient relationship seems to be deteriorating. In fairness to physicians, the relationship has changed because medicine has changed . . . specialization has forced a change in the image of the practitioner. Yet, there is no necessary clash between

> specialization and compassion, between the use of instruments and personal sensitivity. (p. S383)

Since the technology boom of the middle and late 20th century created specialization, the health economic reform currently underway places new challenges on the physician. Increased emphasis on primary care and outpatient treatment is creating new demands on physicians. Central to physician effectiveness in these roles will be communication (Bryan, 1991). DiMatteo (1998) echoed this as she described communication as an "essential component" in the patient/physician relationship.

The current environment of health care, with its legal and economic ramifications, calls for a stronger emphasis on effective patient/physician communication (Edwards et al., 1996). With changes in health care such as the newly rediscovered importance of the primary care physician and the expansion of HMOs, there is an increased need for communication education with the goal of enhancing the patient/physician relationship (Kaplan et al., 1989). That need has been reflected in a changing focus in the literature.

In recent years, a greater emphasis has been placed on the quality of the patient/physician relationship and the development of a stronger patient role in the process. DiMatteo (1998) cited works such as the Pew Health Professions Commission studies in the early 1990s as driving the medical profession to a more community or patient oriented focus. An increasing awareness on the part

of patients as medical consumers has also contributed to a more outspoken and involved patient population.

The state of patient/physician communication is certainly in a period of change. As DiMatteo (1998) noted, much of this change is positive as patients become more active participants in their own heath care, assuming more responsibility for health decisions, and a more collaborative approach between patients and physicians toward health care is developed. However, problems still do exist in this relationship. Over the years, both the communication studies literature as well as the medical literature have explored this topic in depth. As this paper unfolds, the medical literature will be examined in greater detail, creating a compilation of the most significant articles of the past decade and attempting to create a link with the communication studies literature.

Chapter 2: Literature Review

While the literature reviewed in this paper pays close attention to the patient/physician relationship over the past ten years, the concept of a relationship between patient and physician in its more modern context can be traced to Szasz and Hollender (1956) and their description of the three basic models of the patient/physician relationship. These three models – activity-passivity, guidance-cooperation, and mutual participation – created a framework of the relationship that is still referred to today, albeit by different names. The emergence of "patient-centered" care in the relationship and the increased involvement of the patient in the process as well as increased demands by the patient for information can be directly linked to the work of Szasz and Hollender.

While the topic of patient/physician communication is a frequently cited subject in the communication studies literature, the medical literature contains a much more voluminous number of texts. Attempts to quantify the frequency of reporting on the subject have been rare. Meryn (1998a) conducted a literature search using the MEDLINE database to compare the frequency of reporting on the subject of patient/physician communication from the years 1970 through June of 1997. His findings showed a steady increase in the number of MeSH (Medical Subject Heading) term and keyword term returns over the three decades he reviewed. Specifically he found 379 MeSH term items from 1970 through 1979, 420 MeSH term items from 1980 through 1989, and in the seven

years of the 1990s he reviewed, there were 701 MeSH term items found. This represented an ever-increasing rate of reporting on the subject in the medical literature. Meryn provides the only example of a quantitative report on the frequency of occurrence in the medical literature on the subject of patient/physician communication.

Another approach to examining the literature has been to categorize the subject matter from the broad classification of patient/physician communication to a more narrowly defined focus. Again, very few attempts have been published using this tactic. One of the most significant reviews of the literature was completed by Ong, De Has, Hoos, and Lammes (1995). Ong et al. examined the literature to find answers to four key points:

1. To determine the purposes of communication in the patient/physician interaction.

2. To review the methods of analysis in the patient/physician interaction.

3. To examine the communicative behaviors displayed during the interaction.

4. To examine the impact of communication on certain outcomes.

To study these questions, Ong et al. (1995) used a selective sample of 112 texts from the medical literature spanning the years from 1971 through 1993. In answering these questions, Ong et al. concluded there were three purposes of communication in the patient/physician relationship: (a) to create a

positive relationship, (b) to exchange information, and (c) to make medical decisions. Ong et al. also identified twelve interaction analysis systems used to study the relationship and explained the distinguishing characteristics of each system. In their examination of the communicative behaviors displayed during the interaction, Ong et al. identified five topic areas: (a) task focused versus socioemotional behavior, (b) verbal versus nonverbal behavior, (c) privacy behaviors, (d) high versus low controlling behaviors, and (e) medical versus layperson language behaviors. In their review of outcomes of communicative behaviors, Ong et al. examined four different areas of outcomes: (a) patient satisfaction, (b) compliance, (c) recall and understanding of medical information, and (d) health outcomes. Ong et al. concluded by noting their review showed a shift in the patient/physician relationship from a biomedical focus to a more humanistic approach.

In another approach, Baker and Conner (1994) reviewed the literature from 1987 to 1992. As library and information scientists, Baker and Conner approached the subject as a matter of defining information exchange in the relationship. They grouped texts into four categories that either described the concept of information, information-seeking behavior, barriers to information seeking, or the role of information.

As Baker and Conner (1994) defined the concept of information in the medical encounter, their task was made more difficult by the fairly wide-ranging definition applied to the concept in the medical literature. However, one aspect of

the definition did become clear to them. They concluded that when considered collectively, the definition of information in the patient/physician encounter is driven by the physician's concept of the term and not by the patient's. This may create a problem when the physician's idea of relevant information does not match the patient's. In examining information-seeking behaviors, Baker and Conner concluded while patients may want information they are often reticent about asking for information. Baker and Conner identified many barriers to information seeking including barriers created by the physician and by the patient. However, they paid particular note to the concept of physician communication style as a barrier to information seeking. Finally, in discussing the role of information in the medical encounter, Baker and Conner were unable to specifically address the impact of information on outcomes because none of the studies they reviewed identified information as the variable responsible for a particular outcome. They were able to credit information as having an impact on two areas: patient satisfaction and recall of information. However, the studies they found in the literature often supplied contradictory results.

Simpson et al. (1991) presented a concise but thorough summary of the literature. The consensus statement developed by this panel attempted to answer three questions: What is already known about the patient/physician relationship?; What can be done to improve the relationship?; and, What questions about the relationship have been left unanswered? To answer these questions, a panel of over a dozen individuals considered experts in the field

utilized a process that circulated the questions among the panel members for responses. These were drafted into a consensus statement endorsed by the panel.

The resulting statement highlighted problems with patient/physician communication including: unmet patient needs, missed diagnoses related to psychosocial and psychiatric problems, increased malpractice claims, increased patient anxiety and dissatisfaction, and poorer health outcomes. When examining the issue of the current state of educating physicians to deal with communicating with their patients, the panel had a fairly blunt response: "Traditional medical education at all levels is generally ineffective in teaching clinical communication (Simpson et al., 1991, p. 1386)."

Based on the literature review by the panel, Simpson et al. (1991) offered a list of suggestions for physicians to utilize to improve communication with their patients. Included in this summary list was: encourage patients to talk, do not interrupt patient comments, get the patient's perception of their illness, be an active listener, show empathy, ask open-ended questions, be clear in presenting information, summarize and confirm understanding, and be willing to negotiate a treatment plan.

Looking at priorities for the future, Simpson et al. (1991) asked several questions related to the patient/physician encounter that had not been adequately studied including: what specific elements of the patient/physician encounter affect satisfaction, quality of life, or minimize conflict and malpractice

claims? They also asked several questions about: education issues and what methods were the most effective, what skills were the most teachable, when is the best time to teach communication skills to physicians in training, and how can practicing physicians develop and best apply communication skills.

Simpson et al. (1991) summarized their comments by saying:

> Sufficient data have now been accumulated to prove that problems in doctor-patient communication are extremely common and adversely affect patient management . . . There is therefore a clear and urgent need for teaching of these clinical skills to be incorporated into medical school curriculums and continued into postgraduate training and courses in continuing medical education (p. 1387).

Other researchers have reviewed more narrowly defined segments of the medical literature. Examples of this approach include Stewart (1995) and her review of 21 randomized controlled trials that evaluated the impact of patient/physician communication on health outcomes and Ptacek and Eberhradt's (1996) examination of the literature concerning breaking bad news. These more narrow approaches to the literature will be examined in more detail later in this paper.

While falling outside the years of inclusion for this study, it is worthwhile to make note of the summary of the literature on patient/physician communication done by Roter, Hall, and Katz (1988). This review of the literature creates a good companion to the current study in that it covers the years from 1962 to 1986.

Roter et al. supplied several descriptive reports about the 61 studies in their article including demographic information on patients and physicians as well as study methods. Study methods were broken into four areas: setting, physician and patient previously acquainted, experimental manipulation, and outcomes studied. It is in this last category that Roter et al. create the basis of the framework used in this paper. Five outcome categories were defined and texts were assigned to each. Categories were not mutually exclusive. This categorization showed: 18 studies on recall, 10 studies on compliance, 26 studies on satisfaction, 3 studies on problem concordance, and 13 studies on other outcomes. Additionally, they also reported on several aspects of the communication analysis methods utilized including: the observational method, interaction analysis system used, whether verbal, nonverbal or both channels of communication were studied, and if reliability was reported. And lastly, they developed patient and physician interaction categories that included: information giving, information seeking, social conversation, positive talk, negative talk, and partnership building.

It is in this last area where Roter et al. (1988) synthesized the existing literature into some generalized statements regarding the patient/physician relationship. These generalizations included:

1. White patients tended to receive more information and positive talk.
2. White patients asked more questions.
3. Clinic patients are asked more questions.

4. Clinic patients are given more partnership building statements than private physician patients are.

5. Clinic patients ask fewer questions than private patients do.

6. New patients receive more positive talk than established patients do.

7. Clinic visits are almost twice as long as private physician visits.

8. Visits with staff or attending physicians are shorter than visits with interns or residents.

Roter et al. (1988) noted a wide range of methodologies, sample sizes, and analysis schemes. However, they also comment that this area of communication investigation is relatively young with most studies dating back no more than 20 years. Another comment alluded to the observation that studies designed to show the changes in communication behavior in physicians have been steadily increasing. Roter et al. concluded with the statement:

> The basic characteristics of the provider-patient relationship may be undergoing substantial evolutionary change. There is considerable evidence that patients are becoming more consumerist in orientation, and particularly the new generation of patients are likely to directly challenge physician authority within the medical encounter. There is likewise, evidence that physicians may be accommodating their patients with a more egalitarian relationship and tolerance for patient participation in decision making. The implications of these changes are tremendous and

> they must be given full and serious consideration in conceptualizing how the patient/physician relationship may be articulated in the medical encounter (p. 114).

It is this statement from which the current study intends to build on to show how communication in the patient/physician relationship has developed in the decade after Roter et al. (1988) made these observations.

Chapter 3: Purpose

This paper will take both approaches to describing the literature, quantitatively and categorically, as well as linking the medical literature with pertinent communication theories. This examination of the topic will explore the subject of patient/physician communication in the medical literature in greater depth, performing a content analysis on the literature of the last decade (1989 through 1998). The goals of this content analysis will be to:

1. Quantify the frequency of reporting on the topic of patient/physician communication in the medical literature over the last decade.

2. Determine if the topic of patient/physician communication is continuing to increase in its frequency of occurrence in the medical literature.

3. Describe the different themes prevalent in patient/physician communication in the medical literature through the development of a coding system for the literature.

4. Determine if there has been a shift in emphasis in the frequency of occurrence of the different patient/physician communication themes.

5. Summarize the general findings within each theme in the medical literature.

6. Apply communication theory, where applicable, to the medical literature.

Chapter 4: Methods

A content-analytic approach to the literature will be used to categorize the medical literature into a set of themes. In order to perform this content-analytic approach, texts were selected in an attempt to achieve a census of all texts deemed appropriate for inclusion. To be included, the text must have meet the following criteria: (a) be written in the English language, (b) be a scholarly article not an editorial or letter, (c) published in a scholarly journal or other scientific publication, (d) deal primarily with communication in a face-to-face setting between patient and physician, (e) be published in journals generally deemed to be national or international publications, and (f) focus on patient groups from Western cultures. Additionally, special communication situations such as communicating with the deaf or non-English speaking patients, such as Mull (1993), were excluded. The following is a more complete description of each of these inclusion criteria:

1. Be written in the English language - This criterion allowed the inclusion of articles from journals published in the United States, Great Britain, Canada, and Australia as well as several other Western countries that report in the English language

2. Is a scholarly article not an editorial or letter - Texts selected were scholarly articles, scientific in nature. Editorials and opinion pieces (Horne, 1990; Horder & Moore, 1990; Neufield, 1998; Richards, 1990), and letters-to-the-

editor (Cunningham, Harrigan, Morgan, & Turner, 1997; Trumble, 1994) were not included in the quantitative portion of the paper; however, they were referenced elsewhere in the paper.

3. Published in a scholarly journal or other scientific publication - Only pieces deemed primary research were included. Reports on other research efforts, secondary research reports (Larkin, 1997; Neuworth, 1997), or text that were not considered scientific in nature ("Docs Biggest Deficits: People Skills," 1995; "Enhancing Physician-Patient Communication," 1994) were not included.

4. Deal primarily with communication in a face-to-face setting between patient and physician - The primary focus of study must be communication in the relationship between patient and physician and its impact on other areas of practice. When the topic of communication between patient and physician appeared in a secondary role in the study of certain subjects, these appearances were excluded. An example of the former would be "Physicians' communications style and patient satisfaction," by Buller and Buller (1987). Here the primary topic is clearly communication between patient and physician. An example of the later would be "Clinicians' and seniors' views of reference-base pricing: Two sides of a coin," by Mullett and Coughan (1998). In this example, while communication has a secondary role in the study, it is not the subject of the study despite turning up as a "hit" by the search tool.

5. Be published in journals generally deemed to be a national or international publication - Journals that target a widespread circulation within the

professional community were the source of the articles for this study. While relevant, limited circulation journals, such as state medical journals, were excluded primarily because of the difficulty in obtaining copies of abstracts or articles.

6. Focus on patient groups from Western cultures – There are differences between Eastern and Western cultures in how the general approach to medical interactions is regarded. McDonald-Scott, Machizawa, and Satoh (1992) identified how cultural differences influence the patient/physician relationship. Their work found physicians in the Eastern culture they studied – Japan – were less likely to provide complete accounts of the condition or illness when the prognosis was poor. Their literature review found many examples that highlight differences between Eastern and Western culture. Because of these differences, the texts selected for this study had to deal with patients from Western cultures.

To obtain this census, computerized archives accessed through the EBSCO*host*® service of the MEDLINE literature databases were used. Using the keywords "patient," "physician," and "communication," the literature database archives were searched for relevant articles. The years searched were from 1989 through 1998.

The unit of analysis was the individual article taken as a whole text. Each text was placed into one of ten content categories that were developed after a preliminary review of the literature. The content categories were developed after a sample of 111 texts was identified that met the selection criteria. This preliminary test of the coding scheme created eight categories. During the coding process of the larger body of work included in the census, two additional categories were defined. The creation of the categories during this development process showed them to be mutually exclusive allowing for identification of a single predominate category for text assignment, equivalent with each identifying a single communication theme, and exhaustive as evidenced by the ability to place each of the texts into a single category. This initial research effort permits the claim of face validity in so much as these categories allowed for the efficient assignment of texts. While this claim of validity may not be as strong as desired, it is important to note that there has been no appearance of a similar study in the literature for which to compare these categories.

The ten categories developed and the basic description of their content goals were:

1. Risk management – The goal of the article was to examine communication as a means of limiting risk to the physician. Articles in this category explored the importance of improved communication between patient and physician as a means of limiting risk of legal action against the physician.

2. Compliance – The goal of the article was to look at communication as a means of increasing compliance with medications or treatments.

Compliance with physician directed treatments were examined while attempts were made to relate the effectiveness of patient/physician communication as a source of low or high compliance.

3. Satisfaction – The goal of the article was to assess the relationship between communication and patient satisfaction. The effectiveness of patient/physician communication was explored to determine if higher levels of communication resulted in increased patient or physician satisfaction.

4. Skill Assessment – The goal of the article was to assess the communication ability of the physician. These articles utilized observational techniques, most often video tape recordings of patient/physician encounters, as a means of examining physician effectiveness in the communication event.

5. Patient/Physician Relationship – The goal of the article was to examine communication as a means of improving the patient/physician relationship. Articles placed into this category examined patient/physician communication in the context of relationship development. Included in these articles were examinations into the role of communication as a means of improving relationships when difficulties or problems arose.

6. Outcomes – The goal of the article was to gauge communication's impact on patient outcomes. Articles looked at the medical outcome of patients and investigated possibilities that improved communication would have a positive effect on patient health.

7. Teaching Communication Skills – The goal of the article was to examine the teaching of communication skills to physicians. Articles in this group

examined methods for teaching communication skills and judged their effectiveness.

8. Bad News – These articles explored the subject of how to break sad or bad news in the patient/physician relationship. Different communication tactics are examined and the impact of the communication event on the delivery of a poor prognosis is discussed. In addition to delivering news of a poor prognosis, these articles also examine the communication between patient and physician when there is little or no hope of recovery.

9. Information Exchange – The purpose of the article was to examine the way information moved between patient and physician. The information needs of the patient and physician were also examined in this group of texts.

10. Theory – The goal of the article was to examine the communication techniques used by physicians and apply communication theory to the analysis of communication between patient and physician. Existing theories, previously applied to other communication situations were applied to the health care setting. Also, models were presented based on theoretical explanations of the patient/physician interaction.

Categorization was determined by coders who received training in the identifying features and definitions of each of the categories. Due to the large volume of texts, one coder coded all texts while two other coders coded a random sample of the texts. Ten percent of texts were selected using a random number generator to create an adequate sample for the two additional coders. Intercoder reliability was tested through the use of a correlation coefficient.

After being assigned to one of the ten thematic content categories, each theme was explored in more detail. Within each of these chapters, the texts were reviewed and information was organized around the following structure:

1. Key articles were identified that would be considered significant to the study of the individual theme. Included among these texts would be major literature reviews on the chapter theme or texts that were frequently cited in the literature as having great importance to the topic.

2. Within each chapter, various sub-themes were developed that allowed for the texts to be organized in groups. Each of these sub-themes was explored in greater detail with appropriate references to the texts that contributed to this subject.

3. When applicable, texts from the communication studies literature were introduced. This allowed for the application of communication theory to be applied to the patient/physician relationship as well as drawing on the communication studies research into other relationships that may parallel the patient/physician relationship.

4. Each chapter then ends with a summary of the medical literature, augmented by the communication studies literature, to provide a generalized interpretation of the theme's literature.

Chapter 5: Quantitative Results

The number of texts in the medical literature on the subject of patient/physician communication is quite large. Using the EBSCO*host*® service of the MEDLINE literature databases and the keywords "patient," "physician," and "communication" for the years from 1989 through 1998, 2,282 texts were identified with the Medical Subject Heading (MeSH) or keyword search that included all three search words. In comparing this result with Meryn's (1998a) similar search for the previous two decades, the subject of patient/physician communication appears to be increasing in the frequency of occurrence in the medical literature.

After applying the exclusion criteria identified in the previous chapter to this rather large body of texts, 469 texts were selected for inclusion in the study. The breakdown of these texts by year is shown in Table 1. Placing the contents of this table into a histogram allowed for the application of a logarithmic trend analysis to the graph. The results are shown in Figure 1.

Table 1
Patient/Physician Communication Texts, 1989-1998

	Year									
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Texts	36	34	53	49	56	40	54	44	52	51

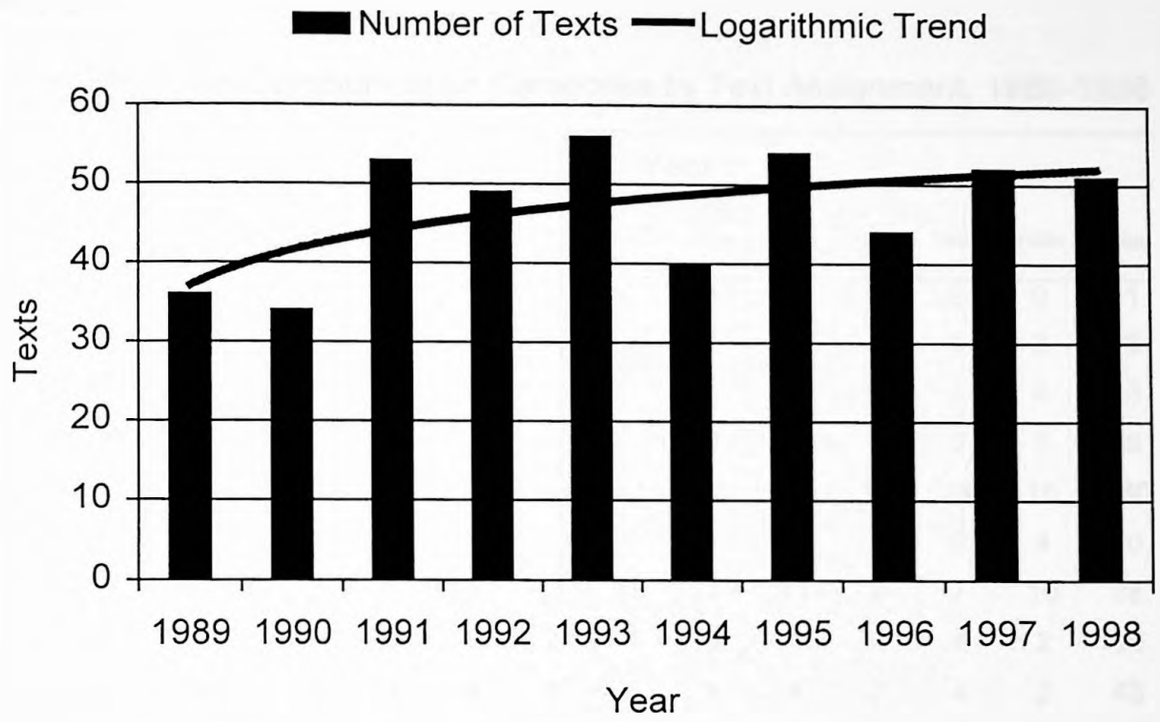

Figure 1.

Texts were assigned to one of ten categories by the primary coder. The results of the assignments are displayed in Table 2. Two additional coders coded a random sample of 10% of the texts in an effort to establish reliability of the coding scheme. Comparisons with the primary coder showed the secondary coders had intercoder reliabilities of 0.78 and 0.50 using Pearson's r. While these scores did not reach the desired level of reliability, it was felt the generally positive reliability did indicate this coding scheme was sufficient to categorize texts for the purposes of this study. In the sample of texts reviewed by both the primary coder and the secondary coders, the assignment made by the primary coder was used for the category assignment when differences did appear.

Table 2

Patient/Physician Communication Categories by Text Assignment, 1989-1998

	Year										
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Risk Management	2	0	1	2	2	1	1	0	2	0	11
Compliance	1	1	1	1	1	1	2	3	1	3	15
Satisfaction	1	3	5	4	7	6	4	6	3	4	43
Skill Assessment	1	5	3	3	2	0	1	2	5	6	28
Relationship	10	13	18	16	21	20	24	16	24	18	180
Outcomes	2	0	1	0	0	1	1	1	0	4	10
Teaching	11	5	9	11	10	2	11	2	7	10	78
Bad News	1	0	5	2	4	3	4	11	4	2	36
Information Exchange	4	3	9	6	5	4	4	2	4	2	43
Theory	3	4	1	4	4	2	2	1	2	2	25

The database used for compiling the texts included in this study also permitted the inclusion of other descriptive data concerning the selected texts. Included in this was the country of publication. A breakdown of this information is shown in Table 3. Additionally it was considered relevant to identify the medical journals in which patient/physician communication texts most frequently appeared. A summary of these medical journals is shown in Table 4.

While the quantitative information is useful in evaluating the importance of the topic in the medical literature, the following ten chapters will provide a more throrough examination of the content of each of the themes that make up the ten categories into which texts were assigned.

Table 3.
Patient/Physician Communication Texts, Country of Publication, 1989-1998

Country	Texts
United States	267
England	136
Australia	17
Canada	16
Ireland	13
Netherlands	5
Norway	5
Germany	3
Switzerland	3
Denmark	1
New Zealand	1

Table 4.
Medical Journals, Most Frequent Appearances for Patient/Physician Communication Texts, 1989-1998

Journal	# of Texts
Social Science and Medicine	24
Academic Medicine	23
Family Practice	22
Medical Education	21
Journal of General Internal Medicine	18
Medical Care	15
Journal of Cancer Education	13
British Medical Journal	12
Journal of the American Medical Association	12
Archives of Internal Medicine	11
Family Medicine	11

Chapter 6: Risk Management

While occupying only a small portion of the total number of texts of the last decade (11 texts for 2.35% of the total texts), the impact of communication problems on the likelihood of patients initiating malpractice litigation has been well documented in the medical literature. Levinson, Roter, Mullooly, Dull, and Frankel (1997) completed one the more recent reviews of literature on this subject in addition to conducting a detailed study on what communication behaviors would trigger litigation from patients. Levinson et al. studied two groups of physicians. The first group was primary care physicians that included general internists and family practice physicians and the second group included both surgeons including both general and orthopedic surgeons. These two groups were further subdivided into groups that had a high rate of malpractice claims (considered to be two or more claims) or had a low rate of malpractice claims (considered to be only one or no claims). The researchers then reviewed audiotapes of the physicians conducting patient interviews noting what behaviors each group used and if there could be any predictability in determining if the physician in question belonged to the high or low claims group.

Their results found two significant findings. First, the predictability of determining if primary care physicians belonged to either claims groups based on their communication patterns with patients was high. Primary care physicians who belonged to the low or no claims group used more facilitative language, oriented the patient to the visit more in addition to supplying more treatment and

disease education, and had a tendency to laugh and show more humor. The low or no claims group also spent slightly more time with the patient (18.3 minutes versus 15 minutes) than the high claims group did and this also was determined to be another predicting factor for group assignment.

Their second finding discovered claims status could not be predicted in the surgeon group based on communication with their patients. Surgeon communicative behaviors for both claims groups was very similar and while the length of the visit did differ between the two sub-groups (14.2 minutes for the low or no claims group and 13 minutes for the high claims groups) the difference was not as significant as it was with the primary care physicians. Because of the design of Levinson et al.'s (1997) study, a causal relationship on why one group of surgeons had been sued as opposed to the other could not be determined other than to say it was not because of their communicative ability during office visits.

Levinson (1997) also examined another group of physicians to determine communication's impact on medical malpractice issues. In her examination of pediatricians, Levinson notes the pediatric consultation is more difficult than the adult consultation because the interview usually consists of not only the patient, but also a parent. Because of the vastly different levels of understanding the pediatric patient may have, the physician must adapt his or her interview style much more so than for an adult interview. Adding to the difficulty of the interview with the pediatric patient is the increased importance of the physician to rely on the interpretation of nonverbal cues to assist in assessing the child. Another

problem related to the pediatric interview is the potential embarrassment of the parent in admitting the child's problem. She reported on one study that found one fourth of all parents left their pediatrician's office without having discussed their greatest concern. Levinson stated the pediatrician faces all the problems of the adult primary care physician compounded with the added difficulties of dealing with the pediatric population.

Ely, Levinson, Elder, Mainous, and Vinson (1995) conducted interviews with 53 physicians who described their most memorable errors that led to remorse or guilt on their part. While many of the cases did result in patient deaths, over one fourth involved no adverse medical outcomes. Many of the perceived causes of the errors were related to communication issues such as the inability of the physician to stay focused on the patient, unresolved anger or dislike toward the patient, and inadequate investigation or follow-up on patient complaints.

Beckman, Markakis, Suchman, and Frankel (1994) conducted a review of 45 plaintiff depositions in medical malpractice cases. They found a very high number of the cases revolved around patient perceptions of the communication process or relationship issues that could have been managed with better communication during the consultation. In 71% of the cases, the plaintiffs' main reasons for initiating litigation was a relationship issue that centered on one of four themes. First, 32% of plaintiffs reported a feeling of having been deserted by their physician. The second theme had 29% of patients reporting they felt the physician's attitude devalued the patient's views. Third, 26% reported they simply

did not like the way information was delivered and felt it was done poorly. Lastly, 13% stated the physician failed to see things from the perspective of the patient. Had the physicians in these cases used more facilitative communication skills with a stronger attempt at generating empathy toward the patient, many of these cases would never have been forced into litigation.

Other reports on the impact of patient/physician communication on malpractice issues include Shapiro et al. (1989) who examined attitudes of sued physicians, nonsued physicians, and suing patients on the causes and deterrents of litigation. All three groups agreed improved patient/physician communication is the most effective means of reducing malpractice litigation. Neale (1993) reviewed 100 medicolegal cases. While he only attributed 7% directly to failure of communication in the patient/physician relationship, several of his other causes could be secondarily linked to the communication process such as in the 37 cases where patients had difficulty coming to terms with their illness or presented with a lack of knowledge about the disease process. Hickson, Clayton, Githens, and Sloan (1992) investigated the reasons 127 parents of infants who suffered permanent injury or death filed malpractice claims. The failure of patient family/physician communication as the root cause of the litigation was found in one third of the cases reviewed. Specifically: 70% of the patients seeking litigation felt the physician did not adequately educate them on long-term complications, 48% felt the physician directly tried to mislead them, 32% felt discussions with their child's physician were not open, and 13% felt the physician would not listen to them. Condon (1992) also found the perception

physicians did not share information openly with their patients was also a significant cause for litigation to be initiated. Likewise, Fielding (1997) reported patients feeling they were ignored was a significant contributing factor to medical malpractice claims. Adamson, Tschann, Guillion, and Oppenberg (1989) reported lesser degrees of satisfaction and higher likelihood of litigation when patients felt explanations were not adequate.

In an interesting experimental study, Lester and Smith (1993) showed a series of simulated patient/physician consultations to 160 adults. Videos depicted either good communication practices or poor communication practices as well as good or bad clinical results. After viewing the tapes, the subjects rated their likelihood of taking legal action. Results showed poor communication has as much of an effect on subjects choosing litigation as poor clinical outcomes.

This review of research shows the patient's perception of the physician's competence is often linked to that physician's communication skills and not necessarily to their clinical ability. With that in mind, physicians must manage how the patients form impressions of them. Additionally, with the time spent with patients often limited to just a few minutes, the physician must also keep in mind, as Short (1993a) notes, the first impression, or primacy effect, the physician will have on the patient. While a genuine, caring approach to the patient/physician relationship is obviously the most desirable, there are times this may be difficult to achieve, particularly if physician frustration or anger is present, such as Ely et al. (1995) found was often present in difficult situations. In instances such as these, physicians may do well to adopt a more dramaturgical approach to their

impression management in an effort for the patient to come away with a positive feeling regarding the consultation. The physician must be aware of his or her communication behaviors and be cautious characteristics associated with dominance in the relationship do not prevail while being sure to enhance characteristics aligned with credibility that would enhance both the appearance of competence and trustworthiness.

As Levinson (1994) noted, improving communication in the patient/physician interaction will not only reduces the risk of litigation but will also have the collateral effect of also improving patient satisfaction and improving outcomes:

> Caring, concerned physicians who communicate well with their patients are likely to provide improved quality of care. Collaborative relationships with patients provide opportunities for physicians to derive the professional and personal rewards of truly meaningful connections with people. While preventing malpractice claims is important, providing high-quality, humanistic care is the best reason to communicate effectively (p. 1620).

Chapter 7: Compliance

Compliance - in its simplest medical definition - is the "extent to which a person's behavior coincides with medical or health advice (Haynes, Taylor, & Sackett, 1979, p. 2)." Compliance plays a significant role in the success of any patient's treatment. The ability for the patient to follow physician instructions and complete a course of treatments with medications, perform exercises, follow-up with specialists, or any other activity the physician orders will have a direct affect on the success of that physician's ability to manage that patient's illness or condition. Even though these instructions are given to the patient in an attempt to improve the patient's condition, many patients do not follow instructions properly or disregard them entirely.

The prevalence of noncompliance is widespread throughout virtually all patient populations. DiMatteo and DiNicola (1982) noted that noncompliance can be found in "patients in all ages, social classes, and ethnic groups, and amidst patients participating in various forms of health care delivery (p. 2)." However, certain populations appear to be at higher risk as noted by Agarwall and Sharma (1998) who showed noncompliance as high as 93 percent in schizophrenia patients and Lowe and Raynor (1995) who reported noncompliance as high as 50 percent in the elderly. In his literature review, Greenburg (as cited in Wright, 1994) found noncompliance with treatments ranged from 50 to 90 percent.

The impact of noncompliance is significant. DiMatteo and DiNicola (1982) report that between 30 and 60 percent of patients eventually drop out of

treatment regimens that included follow-up appointments. As they reported, this leads to wasted staff time and increased costs when the patient decides to restart treatment with another medical provider. Fishman (1995) reported noncompliance leads to 125,000 patient deaths each year in addition to "hundreds of thousands of hospitalizations and millions of lost workdays (p. 174)."

Patient compliance has been consistently reported in the medical literature for many years. While only 15 articles representing 4.06% of the total texts in this study were found over the past decade, the subject has been appearing with increasing frequency.

A variety of approaches and concepts have been forwarded as methods for improving compliance. Several methods of improving compliance deal with the technical aspect of delivering the treatment such as the complexity of the regimen or the inconvenience of the therapeutic location (Cohen, as cited in Cohen, 1979; Blackwell, as cited in Haynes, Taylor, & Sackett, 1979). However, the most cited cause for patient noncompliance has been patient/physician communication.

Given the results of patient compliance studies, Butler, Rollnick, and Stott (1996) commented that the traditional style of patient/physician interaction that used a disease-based model where the physician diagnosed the problem and then offered advice was ineffective in dealing with chronic patients where compliance is a significant issue. They reported on a method of increasing compliance that focused on the way physicians talk with their patients. The

concept of the patient-centered clinical method is promoted as a means of increasing compliance in patients. This model of communication in the patient/physician interaction revolves around several themes. First, power is equalized in the relationship. Second, negotiation takes the place of simple directives from the physician. Third, active listening plays a vital function in the interaction. Fourth, respect from the physician toward the patient, even when compliance fails is essential to future hopes of compliance. Fifth, the physician takes into account the patient's whole psychosocial experience with the illness and does not just focus on the disease itself. As Butler et al. (1996) noted, the transition to this method of patient consultation can be difficult as physicians often revert to the disease-based model developed during their "action-centered training (p.1359)." Lieberman (1996) also concurred on this assessment of medical education by stating the emphasis on medical education revolving around biomedical, reductionism, and high-tech advanced levels of patient care has limited the physician's ability to examine the psychosocial issues as well as needed. Burgess (1989) also reached the same conclusion by stating increased supportive and educational interactions are needed that show a higher degree of concern and empathy to improve compliance.

Butler et al. (1996) also introduce strategies that can assist the physician in maintaining a patient-centered approach. Motivational interviewing is a method of empowering the patient to make his or her own decisions. Among the concepts in this strategy are the avoidance of direct persuasion because of the possibility of creating resistance in the patient and presentation of information in

a neutral introduction of information to the patient. Also important to this strategy is realizing that compliance is not an all-or-nothing goal. Physicians must be willing to work toward compliance in a matter of degrees being able to adapt their information to the state of readiness for change the patient is in. The most important element of this strategy is allowing the patient to take the information, evaluate it, and make their own decisions about what is best for them.

Among the other strategies presented by Butler et al. (1996) are several theory based approaches including: the health belief model, self-determination model, goal-setting theory, and approaches based on concepts such as locus of control and self-efficacy. One approach they suggested is the stages-of-change model. Here, the physician must be aware of one of the three stages of change the patient may be in: precontemplation, contemplation, and preparation stage. The physician must be aware of which stage the patient is in and modify their communication accordingly. For instance, in the precontemplation stage there is little hope to trigger a decision to change. The physician's approach at this stage should be to temper his or her advice to the patient as not to create resistance, but still be able to provide enough information to "plant a seed and leave the door open to change in the future (p. 1360)."

The model presented by Butler et al. (1996) is typical of the current literature aimed at using communication as a means of improving compliance. Donavan and Blake (1992) commented on noncompliance as being a completely rational act from the patient's point of view. In their explanation of noncompliance, Donavan and Blake emphasize the need for the physician to

explore the patient's point of view to better understand the reasons for noncompliance. Donavon and Blake challenge the conventional notion of compliance as being simply a matter of the physician dispensing advice with the expectation of the patient to follow it. They confirmed this concept with a qualitative study involving physician and patient interviews to explore the thoughts behind compliance or noncompliance.

Other researchers also echoed the same themes of patient-centered care as a way of improving compliance. Lowes (1998) summarized the literature on patient-centered care with several points revolving around the key point of the physician needing to find out more. This starts with agreement on what the problem is. From there, negotiate toward reasonable goals. Generate options to help achieve those goals then decide on a regimen that is agreeable to the both patient and physician. Confirm understanding of the regimen and the goals with the patient. And lastly, determine the readiness of the patient to work toward these goals and assist and counsel as need.

Other concepts investigated as having an impact on compliance associated with patient/physician communication are: control issues (Cecil and Killeen, 1997), identification and utilization of support systems (Fishman, 1995), patient education (Lowe and Raynor, 1995), and improved patient satisfaction (Short, 1993c).

Several pieces of research have been done on compliance related to specific disease processes. Leppik (1990) reviewed compliance with medications in patients with epilepsy where investigation of patient lifestyle and identification

of barriers was paramount to obtaining improvements in compliance. Miller (1997) investigated compliance in patients with asymptomatic heart failure noting many patients stopped taking the medications because of side effects and the appearance that there were no longer any symptoms present from their chronic disease. Miller emphasized patient education in the patient/physician relationship. Bryant (1996) examined noncompliance with mammography screening. Among the suggestions to create an improvement in compliance were: meeting the information needs of the patient and repeated, consistent messages from different members of the health care team to encourage compliance. Boyer et al. (1996) reviewed discordance as a cause of noncompliance in patients with diabetes mellitus. Kosoko et al. (1998) concluded compliance in follow-up visits for patient with glaucoma could be best managed by improving the level of communication between patient and physician.

As already noted, several theories have been applied to compliance and numerous models of communication in the patient/physician interaction have been developed. The communication studies literature has also added much to the study of compliance in the broader definition that is not necessarily limited to the patient/physician relationship. From studies such as Marwell and Schmidt (1967), and Wiseman and Schenck-Hamlin (1981), the communication studies literature has contributed concepts that are transferable to the patient/physician relationship. Schneider and Beaubien (1996) studied physician use of the Marwell and Schmidt (1967) compliance gaining typologies. In addition to identifying the 16 strategies used by Marwell and Schmidt, Schneider and

Beaubien (1996) added three new strategies: legitimacy, intermediaries, and procrastination. In their review of physician practices, they found 83.55% of all compliance gaining attempts used one of three strategies: positive expertise, legitimacy, and liking.

Other theories have been tied to patient compliance as well. Burgoon, Birk, and Hall (1991) discuss expectancy theory and Klingle (1996) and Klingle and Burgoon (1995) introduce the closely related Reinforcement Expectancy Theory. Under this theoretical approach, patients weigh the appropriateness of the physician's compliance gaining attempt, rejecting it immediately if it is considered inappropriate for that patient's circumstances. However, if the advice is considered appropriate, the patient stores this information and evaluates it later based on repeated attempts by the physician to gain compliance. If the physician uses consistent, appropriate attempts to gain compliance, the patient will eventually desire to comply in order to gain approval. This theory would apply well to the concepts developed by Bryant (1996) and described earlier. Buller and Street (1991) presented information on the use of the Social Interaction Model and the Health Belief Model on patient compliance.

Any review of the current statistics on the overall state of patient compliance would reach the same conclusion regarding the traditional model of medical interviews promoted in most medical education programs - it doesn't work. Every article reviewed over the past decade has reached the same conclusion. Inadequate communication between patient and physician is the root

of the compliance issue and any effort to improve compliance must first start with improving the quality of this interaction.

Chapter 8: Satisfaction

A consistent topic in the medical literature concerning patient/physician relationships has been the impact of the communication on satisfaction. During the 10-year period covered by this study, 43 texts representing 9.17% of the total texts were identified a being primarily focused on satisfaction. Numerous studies have shown that some noncommunication related problems do exist that lead to patient dissatisfaction such as: availability of services (Williams & Calnan, 1991), waiting times (Hall, 1996; Probst, Greenhouse, & Selassie, 1997)), physician's clinical skill level (Williams & Calnan, 1991), and patient health outcomes (Kane, Maciejewski, & Finch, 1997). However, the overwhelming reason for patient dissatisfaction was the quality of the patient/physician relationship and the communication associated with it (Calnan et al., 1994; Delbanco et al., 1995; Fallowfield, 1992; Joos, Hickam, & Borders, 1993; Phillips, 1996; Williams & Calnan, 1991).

Because virtually all studies in this area reached the same conclusion, no one text stands out as the defining piece of literature in this theme. However, several texts have made significant contributions through the thoroughness of their research methods. Key among these is Bertakis, Roter, and Putnam (1991) and their study of physician interview styles and their impact on satisfaction. Using tape recordings of 550 patient/physician interactions involving 127 different physicians at 11 different locations, the size of this study was much

larger than previous observational studies of the patient/physician relationship. Among the findings were physician dominance and questioning about biomedical topics tended to produce lower satisfaction ratings while increased discussion of and counseling for psychosocial issues created higher satisfaction ratings. As the article summarized, "It is clear that patients are most satisfied by interviews that encourage them to talk about psychosocial issues in an atmosphere characterized by interest and friendliness and the absence of physician dominance (p. 180)." They also noted psychosocial issues are not merely a digression away from the medical interview. They cite one study that reported 30% of patients had psychosocial problems significant enough to warrant physician involvement.

Cardello, Ray, and Pettey (1995) identified eight communicator styles and six dimensions of patient satisfaction in their study of 100 patients surveyed through the use of questionnaires. They found four specific correlations that while not reaching levels of great significance, did allow for some predictability. First, physicians characterized as attentive, very animated, not contentious, and not too dominant or to submissive were perceived as being the most empathetic to the patient. Second, physicians viewed as very relaxed and very animated were considered to have greater ability to enhance patient understanding. Third, physicians displaying moderate dominance and providing explicit communication during the medical interview were characterized as behaving in a professional manner. Lastly, higher levels of attentiveness and impression leaving in the physician left this group of physicians classified as having higher levels of

interpersonal competence. The work of Cardello et al. has some correlation to the four image dimensions of impression management as outlined by Leathers (1997). Cardello et al. (1995) made references to the importance of the likability dimension to patient understanding when patients feel more comfortable with their physician if they like him or her and are more apt to listen more carefully and ask questions for clarification. Additionally, the dimension of credibility comes up in patients who viewed their physician's information giving patterns as being explicit and displaying a moderate level of dominance.

Another study that sought to define the predictive power of correlating physician communication style with patient satisfaction was Bensing (1991). In this study, 12 experienced general practice physicians rated 103 patient/physician interactions as to whether there was a high or low level of psychosocial care. After a further, more detailed assessment by psychologists examining several variables in the communication process, affective behavior, particularly nonverbal affective behavior, had the highest predictive value in determining high psychosocial quality of care. From there a relationship with patient satisfaction was found to be predictable with higher satisfaction correlated with a higher degree of affective behavior in physicians.

With pediatric patients, there has been much interest in discerning parent satisfaction with physicians. Street (1992) investigated 115 pediatric consultations and reported on parent feelings of satisfaction with physician communication. Key among his findings was the identification of a higher degree of satisfaction when physicians displayed more patient-centered care and used

less directive communications. In a separate study, Street (1991) identified improved parent satisfaction when physicians were found to be informative and interpersonally sensitive.

Observational studies of the patient/physician interaction have yielded several notable findings related to patient satisfaction. Rost (1989) found several factors associated with higher levels of patient satisfaction including patients who interrupted physicians more had greater degrees of satisfaction, while patients who were interrupted more by their physicians had lower degrees of satisfaction. Rowland-Morin and Carroll (1990) found several positive relationships to higher degrees of patient satisfaction including: the physician use of silence or delayed reaction times, reciprocity, and the reflective use of interruptions.

Training physicians in communication practices to help improve patient satisfaction has been discussed for both medical students (Klamen & Williams, 1997) and practicing physicians (Bareman et al., 1993; Lewis, Pantelll, & Sharp, 1991). Klamen and Williams (1997), Bareman et al, (1993) and Lewis et al. (!991) each found the interventional programs they studied could significantly improve physician response and create higher levels of patient satisfaction.

While there are several common denominators noted in the studies mentioned thus far, there are some special situations that noted the importance of treating the patient as an individual and tailoring the approach to the patient's needs. One particular group this has been found to be true was the elderly population. Lee and Kasper (1998) found that older patients tended to have a more favorable impression of the physician and be more satisfied with that

physician based on evaluation of their technical expertise as opposed to their interpersonal skills. Greene, Adelman, Friedmann, and Charon (1994) also found older patients had a higher degree of satisfaction with some aspects more closely associated with a more traditional approach to the relationship such as the physician supplying structure to the interview. However, they found older patients still had a need for some patient-centered care approaches such as the allowance for patient-raised topics.

Patient or parent satisfaction only tells half the story of this aspect of the patient/physician relationship. Satisfaction for physicians in the relationship can also be judged. Studying this area of satisfaction separate from the patient impression of the interaction is important since what constitutes a satisfying experience for the patient does not correlate well with similar feelings of satisfaction in the physician (Winefield, Murrell, & Clifford, 1995). Physician satisfaction is needed to keep physicians from falling into the rut of routinized patient care that may lead to burnout and decreased effectiveness (Gould, 1990). In the most comprehensive examination of physician satisfaction in patient/physician communication Levinson, Stiles, Inui, and Engle (1993) found several key points.

Levinson et al, (1993) surveyed 1,076 physicians with a 25 item questionnaire to determine the frustrations felt in the patient/physician relationship. Overall, 93% of the physicians felt at least somewhat or very satisfied with their practice. However, more than a third of the physicians reported frustration in the relationships with 25% of their patients. After analyzing

the reasons for these frustrating visits, Levinson et al. found seven types of frustration for these visits: lack of agreement, lack of adherence, too many problems, feeling distressed, demanding or controlling patients, lack of understanding, and special patient problems such as chronic pain or substance abuse. With the exception of too many problems and special problems, communication played a key role in each of the other five frustration sources. Lack of understanding can be caused by not mutually defining patient and physician goals for care, by not creating a trusting environment of care characterized by affiliative behaviors, and the creation of conflict by not allowing the patient's viewpoint to be introduced into the discussion. Lack of adherence or compliance is directly effected by the level of communication and is explored in more detail in Chapter 7. While feeling distressed about a patient interaction may be addressed during the patient interview, Levinson et al. note the importance of physicians seeking out peers to allow reflection about their work frustrations or fears. The management of a demanding or controlling patient requires the skillful application of communication practices during the interview to keep the physician from feeling manipulated or feels pressured to administer care. Lack of understanding can be addressed by: physicians ensuring patient understanding by using appropriate language, avoiding medical jargon, summarizing, and allowing the patient the opportunity to ask questions for clarification.

The impact of communication in the patient/physician relationship and its effect on both patient and physician satisfaction is well established through the medical literature. Combining these studies with similar studies in the

communication studies literature (Buller and Buller, 1987; Burgoon, Birk, & Hall, 1991; Conlee, Olvera, & Vagim, 1993) reinforces the consistency of findings on the subject. The summary of the literature finds more open, patient-centered approaches to the relationship with attention paid to the psychosocial aspect by the physician will lead to higher levels of patient satisfaction. Additionally, improved communication competency will not only benefit the patient, but will have a significant effect on physician satisfaction as well.

Chapter 9: Skill Assessment

Several researchers have examined the skills physicians display in the communication process with their patients with the goal of assigning characteristics to physician behavior or determining levels of effectiveness in dealing with specific communication events. While these skills are often assessed in studies presented elsewhere in this paper, the 28 texts (5.97% of total texts) included in this chapter's theme primarily look at this skill assessment or behavioral categorization without other interventions such as communciation training.

During the ten-year span covered by this literature review, one article stands out as the most significant contribution to assessing the skills physicians display and their corresponding communication styles. Roter et al. (1997) conducted a study of 127 physicians and 537 patients in an attempt to define physician communication styles. Their analysis revealed five communication styles employed by physicians: narrowly biomedical, expanded biomedical, biopsychosocial, psychosocial, and consumerist.

The narrowly biomedical style is characterized by nearly all discussion concerning biomedical topics with very little psychosocial discussion in the interview. The style is dominated by extensive physician questioning of the patient with most of the interview dialogue consisting of patients responding to these biomedical questions with very little opportunity to interject psychosocial information. The narrowly biomedical style was used in 32% of patient visits.

Expanded biomedical still consists of a high level of physician questioning, but allows for some exploration of psychosocial topics. This style was used in 33% of patient visits. Biopsychosocial style is characterized by still less physician questioning and an improved balance between biomedical and psychosocial topic, although biomedical conversation was still a more predominant topic, albeit at levels far less than for narrowly biomedical or expanded biomedical. Biopsychosocial style was employed in 20% of the patient visits. The psychosocial style had a near even split between biomedical and psychosocial discussion and was characterized by the lowest amount of both physician and patient questioning. This style was seen in 8% of patient visits. The consumerist style cast the physician in the role of consultant who answered patient questions; however, very little of the questions concern psychosocial issues. This style was found in 8% of patient visits.

While most physicians in Roter et al. (1997) used more than one pattern when communicating with their patients, most tended to favor one style over the others for the majority of their patient encounters. Other findings predictive of the selection of style used by physicians included:

1. Younger physicians tended to use the two biomedical styles more frequently.

2. Male physicians tended to use the biomedical patterns more than female physicians do.

3. Female physicians tended to use the biopsychosocial, psychosocial, and consumerist styles more than males.

As a secondary objective, Roter et al. (1997) compared patient and physician satisfaction across the range of styles. The lowest ratings of both patient and physician satisfaction with the interview were found in the narrowly biomedical style. The highest rating of patient satisfaction came in the psychosocial style while the highest rating for physician satisfaction came in the consumerist style.

Campbell, Mauksch, Neikirk, and Hosokawa (1990) developed their own set of patient communication styles. In their study of patient/physician interactions, their four styles were: curative, patient education, caring, and general. The curative style was characterized by a predominance of diagnostic and treatment related conversation and was found to be the primary style in 18% of visits. The patient education style demonstrated the provision of information as its primary characteristic and was found in 12% of visits. The caring style was focused on psychosocial diagnosis and was the predominant style in only 3% of visits. The general style displayed a mix of styles with no one style being the dominant style and was found in the majority of visits (67%). Campbell et al. found concern with what they considered to be an overuse of the general style of communication. As they put it, exclusive use of this style would give the patient an "assembly line (p. 1364)" feeling of receiving care. They asserted more individualized approaches to patient interviews should be explored and increased uses of other styles where appropriate should be used. Campbell et al. developed their styles based on five dimensions: affiliation, control, somatic diagnosis and treatment, information giving, and psychosocial diagnosis and

treatment. Affiliation issues included sensitivity to patient needs, giving comfort and support, and being sensitive to areas of the physical examination. Control issues centered around who maintained a higher level of control in the interview – patient or physician. Somatic diagnosis and treatment issues included items normally found in the biomedical side of the interaction including: history taking, the physical examination, and medical interventions. Information giving issues included: explanations of results of the physical findings and laboratory findings, answering patient questions, discussing prevention, explaining interventions, and providing instructions and education. Psychosocial diagnosis and treatment included issues concerning the questioning of health beliefs and behaviors, current life situation, and providing counseling and therapeutic listening.

Roter, Lipkin, and Korsgaard (1991) explored gender differences in how physicians approach the medical interview. Among their findings were:

1. Women conducted longer medical interviews (22.9 minutes compared to 20.3 minutes for men).

2. Female physicians talked 40% more than male physicians during the history-taking phase of the interview.

3. Patients of female physicians talked 58% more than patients of male physicians.

4. Female physicians engaged in more positive talk, partnership building, question asking, and information giving than male physicians.

5. Patients of female physicians engaged in more positive talk, partnership building, question asking, and information giving than patients of male physicians.

In order to evaluate the skills and styles physicians employed in the patient/physician interaction a variety of research methods have been used. One of the more popular methods has been through the use of questionnaires for both patients and physicians (Cantwell & Ramirez, 1997; Clark et al., 1997; Girgis, Sanson-Fisher, & McCarthy, 1997; Thomson, 1993; Williams, Dale, & Gluckman, 1998) These studies revealed a wide variety of findings, but as Tamburrino (1993) noted, self-reported questionnaires were not considered a reliable reporting method for physician skills in the patient/physician interview as self-assessed physician behavior differed greatly from both patient perceptions and observer assessment.

Other methods have been found to be more dependable. Videotaped analysis of the interaction has been a very frequently used observational tool in the literature (Arborelius & Bremberg, 1992; Arborelius & Timpka, 1990; Bergstrom, Roberts, Skillman, & Seidel, 1992; Edwards et al., 1996; Mertin, Regehr, Hodges, & McNaughton, 1998; Smith, Meyboom, Mokkink, van Son, & van Eijk, 1991). Smith et al. (1991) conducted an extensive assessment of 75 general practice physicians each conducting 15 patient interviews and medical assessments. An evaluation of the interaction found a positive correlation between the performance of the physical examination and the attention paid to the patient's psychosocial concerns.

Another area where videotaped review of physician skills has been employed has been in the study of physician interaction with simulated, standardized patients (Bartlett, Higgenbotham, Cohen-Cole, & Bird, 1990; Doblin & Klamen, 1997; Gordon, Saunders, & Sanson-Fisher, 1989; Harrigan, Heidotting, & Fox, 1990). Doblin and Klamen (1997) conducted an interesting study to determine how well student physicians interpreted patient behaviors. They compared student physician ability to identify anger, seduction, and hypochondriasis in a series of videotaped patient/physician interactions. Their findings showed 90% could correctly identify anger in patients. For seductive behavior, 40% correctly identified this behavior in female patients but only 5% in male patients. The student reviewers were able to correctly identify hypochondriasis in 65% of female patients and 49% of male patients. Student gender did not serve as a predictor of being able to identify any of the behaviors in either gender patient. Other uses of standardized patients involved either direct observation of the patient/physician interaction or analysis of transcripts (Finlay, Stott, & Kinnersly, 1995; Hodges, Turnbull, Cohen, Bienenstock, & Norman, 1996; Meeuwesen, Schaap, & van der Staak, 1991)

Direct observation of patient/physician interactions with real patients has also been studied. Lang (1990) observed physicians conducting physical examinations that caused discomfort to patients. The majority of physicians failed to recognize and respond to the discomfort of the examination.

A variety of tools have been used to observe how physicians interact with their patients and evaluate their effectiveness in using different communication

styles. Assessment, evaluation, and critique of these skills is an essential part of supplying physicians with the information they need to improve their ability to be more effective participants in the patient/physician interaction. Classification of communication styles as demonstrated by Roter et al. (1997) is an important process that will allow physicians to have an understanding of their own communication traits. Knowing how and when to use these various approaches to the medical interview, understanding the limitations of certain techniques, and realizing each patient is unique and may require a different approach from other patients will allow physicians to "develop the skills they will need in their … practices, including effectively communicating with patients, managing time and structuring office visits, and handling difficult encounters (Edwards et al., 1996, p. 748)."

Chapter 10: Patient/physician Relationship

One area of exploration in the medical literature that has steadily increased in its frequency of reporting over that past decade has been examinations of the various components of the patient/physician relationship. Occupying the largest portion of the texts selected with 180 texts being assigned to this category, representing 38.37% of total texts, these texts sought to explain the individual components of the relationship or communication process as a means of adding to the development of the relationship between patient and physician. While some of the texts subsequently made references to the impact of these components on factors such as satisfaction, most of the texts examined here did not include empirical data.

As Inui (1998) noted establishing and sustaining a positive patient/physician relationship is an important goal for the physician to achieve in order to be more effective. He continued that establishing this relationship depends on more than science. Being able to understand the patient's place in the world and how treatments affect the patient's "life-world", requires the physician to truly practice the "art" of medicine as opposed to the science of it. It is in the practicing of this art that the patient/physician relationship and the maintenance of good communication between the two comes into play. Zaner (1990) discusses the "healing relationship" as an opposing viewpoint to the traditional view of the patient/physician relationship that emphasized biology and science. However, there are many barriers to achieving this goal (Quill, 1989).

Quill pointed out physicians must be able to recognize the indirect signs of the possible existence of a barrier to communication that include: verbal-nonverbal incongruity, cognitive dissonance, unexpected resistance, feelings of discomfort in the physician, noncompliance with treatments or follow-up care, ineffective treatments, and continued exacerbation of chronic disease. Awareness of these potential barriers and knowing the means to address them is essential for any physician to be an effective communicator.

Within the overall theme of patient/physician relationship reviewed in this chapter, several sub-themes emerged. These sub-themes – patient-centered care, cooperation between patient and physician, control and power issues, trust, empathy, and the effective use of the nonverbal aspects of communication – when combined create the picture of positive patient/physician relationships.

Foremost among these sub-themes in importance is the shift to patient-centered medicine. While the idea of patient-centered medicine has been evolving over the past 30 to 40 years, it has been picking up new emphasis in the past decade (Laine & Davidoff, 1996). This shift from paternalistic, physician-oriented care represents a fundamental change in the approach to the patient/physician encounter. As Laine and Davidoff noted, while the end result of improved patient health may be the goal of both approaches, the means vary greatly. Physician-oriented care achieved its goal through physician directives with very little concern about each patient's psychosocial situation and with no input from the patient. Patient-centered care looks beyond the simple biological management of the illness and invites the patient's views and input as a way of

developing a treatment program that is best for that individual patient. Besides Laine and Davidoff, many other authors have reported on patient-centered care (Coupey, 1997; Delbanco, 1992; Henbest & Stewart, 1989; Henbest & Stewart, 1990; Thompson, Nanni, & Schwankovsky, 1990).

Soliciting the patient's view is critical to practicing patient-centered medicine. Delbanco (1992) discussed seven dimensions of care physicians need to review when meeting with their patients: "(a) respect for patient's values, preferences, and expressed needs, (b) communication and education, (c) coordination and integration of care, (d) physical comfort, (e) emotional support and alleviation of fears and anxieties, (f) involvement of family and friends, and (g) continuity and transition (p. 414)." Henbest and Stewart (1990) found when a patient-centered approach was used physicians were able to more accurately determine the patients' reason for the consultation, find resolution to the patients' concerns as well as symptoms, and create a feeling in the patients that they were understood by their physicians.

Another essential component in achieving a productive patient/physician relationship is the ability to develop a cooperative approach to the medical interview. An extension of the patient-centered viewpoint, this area is referred to by several names including: collaboration (Branch, Levinson, & Platt, 1996; Schain, 1990), shared care (Hampson, Roberts, & Morgan, 1996), or partnership-building (Clark et al., 1995). All reported the same general results of this cooperative effort as summed up by Branch et al. (1996), "Interviewing patients is most successful, however, when the process is collaborative, not just

an extraction of information (p. 69)." However, as Hampson et al. (1996) noted after their exhaustive review of the literature on shared care, the perfect system to achieve this goal has yet to be developed. While there are certainly examples of quality care involving cooperative efforts between patient and physician, the overall picture of medical practice still leans towards a more physician-oriented approach that excludes the patient from being an active participant in the process. Another component of this cooperative approach is the willingness for both patient and physician to negotiate toward the most effective plan of treatment (Middleton, 1989; Stoffelmayr, Hoppe, & Weber, 1989).

As physicians shift from physician-oriented to patient-centered care there is a shift in power and control in the relationship. As mentioned previously, the traditional approach to the relationship involves a physician adopting a paternalistic viewpoint who exerts a great deal of control and influence over the interview process. In order to shift into a more patient-centered approach, a balance of power is needed between the two parties (Cecil & Killeen, 1997; Luban-Plozza, 1995; Lipkin, 1996; McKay, Forbes, & Bourner, 1990; Ventres & Gordon, 1990). Cecil and Killeen (1997) found the level of control the physician maintained in the interview was related to both satisfaction and compliance, as both of these areas were higher when physician control was less. Lipkin (1996) discussed the importance of patient activation in successful patient education. McKay et al. (1990) and Ventres and Gordon (1990) discussed empowerment techniques that can be used to permit patients to develop a more equal role in the medical interview.

Trust is fundamental to any positive relationship and enhances the credibility of the individual creating the impression (Leathers, 1997). The medical interview has traditionally been plagued by distrust. Since the time of Hippocrates physicians have been told to not trust their patients (Bellet, 1994; Laine & Davidoff, 1996) This belief must be pushed aside in order for a mutually trusting atmosphere to develop that is vital to the development of a cooperative, sharing relationship. The role of trust in the relationship is reviewed by several authors in the medical literature (Gilligan & Raffin, 1997; Klocker, Klocker-Kaiser, & Schwaninger, 1997; Thom & Campbell, 1997; Woolley & Clements, 1997). Woolley and Clements found almost 20% of the physicians in one group they studied felt their patients were being less than truthful during the medical interview. However, this distrust of patients is counterproductive to the goals of the medical interview. Gilligan and Raffin (1997) discuss the four fundamental virtues espoused by Beauchamp and Childress: compassion, trustworthiness, discernment, and moral integrity. The development of a "covenant of trust (p. 6)" is key to creating the level of communication needed to create the positive outcomes associated with good communication.

A significant portion of the medical literature has been devoted to empathy as a trait a physician should be able to present (Battegay et al. 1991; Bellet & Maloney, 1991; Brock & Salinsky, 1993; Neuwirth, 1997; Nighttingale, Yarnold, & Greenberg, 1991; Platt & Keller, 1994; Rosenberg & Molho, 1998; Squier, 1990; Suchman, Markakis, Beckman, & Frankel, 1997; Zinn, 1993). Suchman et al. (1997) commented on the "dehumanization of medical care (p. 678)." Empathy is

the weapon to combat this dehumanizing state. Empathy can provide the physician with a more complete understanding of the patient and create a feeling of caring recognized by the patient (Zinn, 1993). In his review of the literature, Neuwirth (1997) concluded increased levels of empathy had positive effects on patient satisfaction and compliance, decreased the risk of litigation, as well as improved the physician's ability to make a proper diagnosis. Suchman et al. (1997) noted physicians often missed the presence of empathic opportunities. Patient emotion was rarely verbalized and physicians routinely missed the opportunities to make empathic comments toward the patient. Suchman et al. continued to say these missed opportunities create the risk that the patient/physician relationship may be threatened by feelings the patient has not been understood. Platt and Keller (1994) commented these skills are learnable. Roter et al. (1995) found empathic skills could be taught in the 8-hour course they designed and significant improvements could be made to physician behavior in both recognizing and responding to patient concerns.

The reviewers of the empathy skills noted above make frequent references to nonverbal communication as a means of creating an empathetic response. Several texts cite specific areas of nonverbal communication as a means of improving not only empathetic communication but improving overall communication response as well. Mathews, Suchman, and Branch (1993) discussed impression formation on the part of the physician toward his or her patient. Remaining open and avoiding hasty judgement calls regarding the patient through the silencing of internal self-talk and the control of unconscious

processes will keep the physician from forming improper judgements of the patient. Listening is central to patient-centered care. This skill has been identified by various researchers as having a significant impact on the relationship (Duncan, 1991; Rosenblum, 1994; Wissow, Roter, & Wilson, 1994). Using facilitative behaviors that include attentive listening allowed for the introduction of psychosocial information into the interview (Wissow et al., 1994) and helped to establish rapport and promote understanding (Rosenblum, 1994). The use of silence as a means of creating empathy has also been discussed as a means of showing emotion in the medical encounter (Martyres, 1995). Short (1993a) reminded physicians the importance of the first impression they create with the patient. This primacy effect does much to set the stage on how the remainder of the medical interview will progress. Branch et al. (1996) discussed this aspect of the interview as they emphasize the need to start the interview with courtesy towards the patient including proper introduction and a feeling that attention is being given to the patient. On this last point, Njolstad, Aaraas, and Lundevall (1992) commented on the propensity of many physicians to spend too much of the interview time looking at notes and not looking at the patient. Their study showed the frequent reference to the patient's chart hindered communication between the patient and physician.

Creating a strong, open, cooperative and trusting relationship is essential to a positive patient/physician relationship. Much of medical training is dedicated to the more biomedical style of patient interviews with very little time spent teaching the skills needed for patient-centered care (Simpson et al., 1991). While

there are problems associated with the physician investing this much of his or her own emotion and effort into the relationship including as Mathews et al. (1993) note "dependence and power issues, sexual attraction, and deeper exposure of the clinician to the patient's pain (p. 973)," the benefits of empathic, patient-centered care are much greater. Being able to strike the balance characterized as detached concern will allow the physician to present himself or herself as a caring, concerned practitioner regarding the patient's psychosocial issues while still remaining clinically objective to the biomedical needs of the patient.

Chapter 11: Outcomes

One area of research into patient/physician communication that may not necessarily represent a large volume of work, but does have significant ramifications is in the examination of communication's impact on health outcomes. While only 10 articles were identified in this search of the literature representing a mere 2.13% of the total texts, the importance of the work in this theme carries great weight.

The seminal work in this area of study is Stewart (1995). Her comprehensive review looked at random controlled trials and analytic studies on the role of communication affecting health outcomes. In all, Stewart reviewed 21 studies from 1983 through 1993 separated into one of five groups: randomized controlled trials of patient/physician communication during history taking, analytic studies of patient/physician communication during history taking, randomized controlled trials of patient/physician communication during discussion of the management plan, analytic studies of patient/physician communication during discussion of the management plan, and other studies of patient/physician communication. In each of these, health outcomes were measured to determine if communication played a role in improving the patient's health.

After reviewing these studies, Stewart (1995) synthesized the results into one generalized statement, "Patient health outcomes can be improved with good physician-patient communication (p. 1429)." The impact of this statement should not be underestimated. While it is one thing for good communication skills in a

physician to be linked to lowering their risk for malpractice litigation or for it to be tied to improving patient satisfaction; the concept that communication has a clinical impact on patient care has far reaching implications. Just as poor technique in a surgical procedure or poor assessment skills in an examination may create complications related to health outcomes, the consideration of communication skills as having a clinical impact on health outcomes may create the impetus needed for the role of patient/physician communication to be elevated to a higher priority in medical education.

Stewart (1995) discussed several elements in her review that can lead to more effective patient interviews both in the history-taking phase as well as in the discussion of the management plan. Physicians should inquire about the patient's understanding of the problem, as well as elicit their concerns and expectations about care. Physicians should also determine the patient's perception of what impact the patient perceives the problem will have on function. Physicians should ask about the patient's feelings and then be prepared to provide empathetic support. Questions should be presented to allow for full expression of concerns by the patient and adequate effort should be made to allow the patient to feel there has been a full discussion of his or her concerns. During the discussion of the management plan for the patient, the physician should encourage questions from the patient and ensure understanding on the patient's part, including the provision of education or information resources.

A significant finding in her review was the traditional power imbalance in the patient/physician relationship. The most common view of the power structure in the patient/physician relationship is the physician is in a position of power over the patient. Stewart's review showed this approach would not lead to more improved health outcomes when compared with relationships where the power is shared.

One of the more significant and subsequently oft cited studies reviewed by Stewart was Kaplan, Greenfield, and Ware (1989). In this study, patients received training on how to be more participative in the medical interview. The results found the patients who underwent training to increase their participation in the interview had improved health outcomes as measured by improvements in blood glucose levels for diabetic patients, decreased blood pressure in hypertensive patients, and improved function. This patient group used more assertive measures during the interview and received more information as a result of their increased participation.

Since the publication of Stewart's work in 1995, additional research has been presented that continues to reaffirm the role of communication as a clinical determinant of health outcomes. Safran et al. (1998) surveyed 7,204 individuals about the care they received from their physicians. The survey analyzed the relationship between seven characteristics of primary care patient/physician interactions (accessibility, continuity, comprehensiveness, integration, clinical interaction, interpersonal treatment, and trust) and three outcomes (compliance, satisfaction, and improved health). The respondent group categorized as having

an improved health outcome identified several factors that were significantly more prevalent in their physicians. Central to these factors was the physician's comprehensive knowledge of the patient characterized as a "whole person" assessment. This characteristic combined with increased integration of care, thoroughness of the physical examination, heightened interpersonal treatment and higher levels of trust were identified as causes for the patients' self-reported higher levels of improved health status.

Johanson, Larsson, Saljo, and Svardsudd (1998) conducted an extensive review of the literature on the impact of patient/physician communication where the outcome was measured as a change in lifestyle. Combining this review with a study of patient/physician interactions, Johanson et al. identified two primary forms of physician behavior in the relationship: paternalistic and mutuality. Essential to any change in lifestyle is the feeling in the patient that they have choice. Paternalistic relationships, which dominated their study, were less apt to supply the information patients needed to make informed decisions regarding their lifestyle and thus were more prone to stay the course they were currently following. Relationships characterized by mutuality where the physician and the patient engaged in a more open, power sharing interaction allowed the patient to obtain more information and make choices regarding lifestyle that were their own, not forced changes driven solely by physician directives.

Kinmouth, Woodcock, Griffin, Spiegal, and Campbell (1998) conducted a randomized clinical trial comparing a group of patients with recently diagnosed type 2 diabetes treated by a physician group who received specialized training in

conducting patient-centered interviews with a control group whose physicians did not receive specialized communication training. At the one-year mark, patients were surveyed to gauge their feelings on communication, satisfaction, and overall feelings of wellbeing as well as physiological findings on triglyceride and glycemic controls. The results were mixed. Patients in the group using patient-centered care reported significantly higher levels of satisfaction, better communication, and a better feeling of wellbeing. However, physiological signs did not show similar results. Triglycerides were higher in the patient-centered group as was body mass index. There were no significant differences in glycemic control between the two groups. While the patient-centered group may have felt better, they did not have the physiological data to show they were actually in better condition than the control group.

The impact that research in this area of study may have on the future of the patient/physician relationship may be significant. Much of health care is being driven towards outcomes based methods where any intervention – be it a surgical procedure, medication administration, or an interview style – must be able to show significant positive health outcomes in order to be considered appropriate. This area of study had the lowest percentage of texts attributed to it of all the patient/physician communication studies. With the difficulties associated with this type of research – the length of the study period, the frequent involvement of medical testing to measure outcomes as opposed to relatively simply surveys or coding processes, and increased medicolegal issues – outcomes studies related to communication interventions are a relatively rare

occurrence in the literature. With the advent of managed care and capitated payment systems, the use of health outcomes studies are needed to show the value of communication as a clinical tool to improve patient health and potentially reduce heath care costs.

Chapter 12: Teaching Communication Skills

Considering the frequency authors have cited the lack of communication training in medical schools, residency programs, and continuing medical education programs as a prime cause for deficiencies in physicians being ill-prepared to address communication issues with their patients, there has been a great deal of comment in the medical literature regarding the teaching of communication skills. In the ten years this study covered, 78 texts were identified as focusing on the teaching of communication skills to medical students, residents, or practicing physicians representing 16.6% of the total texts. However, while this number of texts does represent a great deal of activity in the medical literature, there is still an overall deficit in the amount of education and training available for teaching communication skills. As Simpson et al. (1991) described, "Traditional medical education at all levels is generally ineffective in teaching clinical communication (p. 303)." And while there have been some improvements in teaching communication skills, "there is extensive variability in the quality and intensity of courses offered (Simpson et al., 1991, p. 303)."

The importance of good communication in the patient/physician encounter is well-established (McManus et al., 1993). Kaplan, Siegel, Madill, and Epstein (1997) summarized four main points as to why clinicians need communication skills. First, during the interview process more precise information can be obtained making the diagnosis more accurate and reliable. Second, empathy can be shown toward the patient allowing the patient to develop the feeling they

are cared about. Third, there is agreement between patient and physician regarding the diagnosis and treatment regimen. And last, patient motivation can be increased to help achieve better compliance. As Kaplan et al. (1997) also noted, physicians who obtain quality training in communication can benefit from using those same techniques with peers and other health care professionals to make for a more positive working environment.

There are many examples in the literature of education and training programs designed to improve physician communication with their patients. These programs occur at all levels of the medical education spectrum: medical school, residency training, and continuing medical education. A variety of techniques, formats, time frames, and instructional methods are employed.

The starting point for learning communication skills for physicians is of course medical school. The medical literature includes an abundance of reports detailing course designs, comparing student skills before and after communication training, as well as reviewing the trends and history of communication training in medical schools. Whitehouse (1991) reported communication skills training in British medical schools accounted for only 2% of the curriculum. Frederikson and Bull (1992) found three-fourths of British medical schools devoted less than 5% of their curriculum to communication training. Frederikson and Bull (1992) were somewhat blunt in their assessment of the 27 British medical schools they surveyed:

> It is also clear that communication skills training is still being treated as a minor subject of low significance and denied its proper place in an already overcrowded curriculum. Medical education pays lip service to communication and interpersonal relations while remaining disease oriented in its approach....It is hard to imagine any field of human activity where effective communication is more important (p. 520).

Cowan, Laidlaw, and Russell (1997) conducted a review of Canadian medical school communication course offerings. Their questionnaire drew responses from 15 of 16 Canadian medical schools and discussed communication training in Canadian medical schools. While all respondents reported making major changes to their curriculum based the 1992 National Workshop on the Teaching and Assessment of Communication Skills in Canadian Medical Schools, there were still major deficits in the quality of the training. It was interesting to note the literature search conducted for this study did not identify any texts summarizing American medical schools in the manner used by Whitehouse (1991), Frederikson and Bull (1992), or Cowen et al. (1997).

In order to teach communication skills a variety of techniques have been used. Besides basic lecture instruction, some courses have utilized simulated patients (Aarass, Lundevall, Njolsad, & Melbye, 1993; Burdick & Escovtiz, 1992; Gordon, Saunders, Hennrikus, & Sanson-Fisher, 1992; Zweifler et al., 1998), role-playing (Mansfield, 1991), and videotaped interactions (Wagstaff, Schreier, Shuenyane, & Ahmed, 1990).

Several texts described communication skills training courses and programs offered by various medical schools (Branch et al., 1991; Burge & Latimer, 1989; Dignan et al., 1989; Doherty, O'Boyle, Shannon, McGee, & Bury, 1990; Evans, Stanley, Burrows, & Sweet, 1989; Irwin, McClelland, & Love, 1989, Joesbury, Bax, & Hannay, 1990; Lassen, Larsen, Almind, & Backer, 1989; Moorhead & Winefield, 1991; Usherwood, 1993; van Dalen, Zuidweg, & Collet, 1989). Several different course formats and lengths are described. Based on student evaluations of the courses, there was an overall positive trend in the texts stating students felt the coursework made them better prepared to communicate with patients. Usherwood (1993) typified this in the finding that 85% of students felt their interviewing skills were improved because of going through the course. However, in contrast to most of the other studies, Moorhead and Winefield (1991) found their review of medical student empathy toward patients did not change when comparing pre-course questionnaires with post-course results.

While there are limitations to self reporting tools attempting to judge effectiveness and usefulness as used in studies such as Usherwood (1993), there have been several comparison studies performed comparing students who received specialized communication training against other students who did not (Davis & Nicholaou, 1992; Evans, Stanley, Mestrovic, & Rose, 1991; Kendrick & Freeling, 1993; Marteau et al., 1991; Robins & Wolfe, 1989). In these studies the results were more objective. The overall findings from studies such as these

suggest medical students' communication behavior can be changed through participation in a focused communication skills training program.

Another area of the medical literature examines communication training for resident physicians (Beckman, Frankel, Kihm, Kulesza, & Geheb, 1990; Briggs & Replogle, 1991; Brunton & Radecki, 1992; Davis, 1989; Langewitz, Eich, Kiss, & Wyossmer, 1998; Morgan & Winter, 1996; Parrot, Huff, Kilgore, & Williams, 1997; Smith, Osborn et al., 1991; Smith, Mettler et al., 1995; Smith et al., 1998; Ventres, 1994). This portion of the literature also included descriptions of communication programs offered as well as studies on effectiveness. In general, as in the review of the medical school programs, communication training in residency programs has been found to be effective and well accepted by resident physicians.

Langewitz et al. (1998) conducted a comparison study involving resident physicians between a control group and a group who received communications training totaling 22.5 hours over a six- month period. Both groups evaluated standardized, simulated patients prior to the communication intervention and 10 months after the start of the program. The residents who received the communication training conducted much better patient interviews according to the reviewers of the simulated patient interviews.

One of the more detailed studies examining the impact of communication training on resident's communication behavior was conducted by Beckman et al. (1990). They examined pre- and post-intervention communication behaviors surrounding a communication program designed to promote humanistic qualities

in the medical interview. The review of videotaped medical encounters between patients and resident physicians found a significant improvement in the post-intervention group in all nine of the skills being evaluated during the medical interview. These skills included items such as: introducing self, acknowledging the patient's agenda, and explaining need for treatment.

Brunton and Radecki (1992) described a unique programs designed to increase physician empathy and understanding of the patient's perspective. They detailed a program where all incoming family medicine residents to their residency program are admitted to the hospital under a pseudonym with a fabricated admission diagnosis and are instructed to behave as if they actually had the affliction they were admitted with. They are admitted in the afternoon and are forced to endure an overnight admission to the hospital with all the associated medical tests and examinations that went with their admission diagnosis, including the initiation of intravenous lines and the uncertainty of not knowing what is happening next. Brunton and Radecki state this program has been successful in sensitizing physicians to the patient perspective and resulted in a decrease of ordering of nonessential tests and middle-of-the-night examinations plus an increased awareness of the need to keep patients informed.

Incorporating communication training into continuing medical education programs for practicing physicians is another area of the literature that has received attention (Baile et al., 1997; Fallowfield, Lipkin, & Hall, 1998; Greco, Francis, Buckley, Brownlea, & McGovern, 1998; Levison & Roter, 1993; Razavi

& Delvaux, 1997; Roter et al., 1995). Just as communication training programs for both medical students and residents found, there can be marked changes in communication behavior even when practicing physicians participate in continuing medical education programs that emphasize communication with the patient.

Roter et al. (1995) presented one of the more thorough investigations of the impact of a communication skills training program on practicing physicians. Their study compared a control group to two other groups of physicians who received communication training lasting eight hours in one of two areas of emphasis: emotion handling skills or problem defining skills. Their results showed several significant findings based on audiotape analysis of patient interviews and questionnaires. First, physician communication behavior can change after a relatively short education program. Second, specific skills designed to elicit psychosocial information are teachable. Third, patients whose physicians had been trained to deal with psychosocial issues had a reduction in emotional distress about their condition. And last, using these skills did not add to the length of the medical visit or require additional medical services.

However, not all continuing medical education programs have reported this level of success. Levinson and Roter (1993) compared two communication skills courses for physicians, one lasting 4 1/2 hours and the others a 2 1/2 day course. Audiotape analysis of behaviors before and after the interventions showed the short course did not have an impact on physician behaviors. The longer course did change physicians' communication behavior as physicians in

this group tended to use more open-ended questions, asked for the patient's opinion, while still giving more biomedical information. Patients interviewed by physicians who attended the longer course also provided more biomedical and psychosocial information than did the patients of physicians who attended the short course. Additionally, patients examined by the physicians who attended the longer course showed fewer signs of distress during the interview.

No matter what level of medical education - medical school, residency training, or continuing medical education - communications skills have been clearly established as teachable, learnable skills that can benefit both patient and physician. The largest problem that exists in delivering this training to physicians or medical students is the quality of instruction. In their review of Canadian medical school communication training, Cowan et al. (1997) cited the most significant barrier to effective communication training programs in medical schools was the lack of adequately trained physicians to do the teaching. They stated one of the most important steps to developing communication programs was training faculty to teach the skills needed by their students. Sleight (1995) also discussed this problem. Sleight described a program at Oxford's medical school where newly appointed faculty members must demonstrate communication skills before a panel of reviewers. Kalet, Earp, and Kowlowitz (1992) discussed another aspect of faculty deficiencies in communication skills. Their study of the reliability of medical school faculty members assessing communication skills of their students showed very poor intercoder reliability

indicating a very poor ability of faculty members to apply consistent evaluations to the communication abilities of their students.

The spectrum of the literature on teaching communication skills is summarized in the Toronto Consensus Statement generated from the Workshop on the Teaching and Assessment of Communication Skills in Canadian Medical Schools (Simpson et al. 1991):

> Sufficient data have now accumulated to prove that problems in doctor-patient communication are extremely common and adversely affect patient management. It has been repeatedly shown that the clinical skills needed to improve these problems can be taught and that the subsequent benefits to medical practice are demonstrable, feasible on a routine basis, and enduring. There is therefore a clear and urgent need for teaching of these clinical skills to be incorporated into medical school curriculums and continued into postgraduate training and courses in continuing medical education. If current knowledge is now implemented in clinical practice, and if the priorities for research are addressed, there may be material improvement in the relationship between patient and doctor (P. 1387).

Chapter 13: Bad News

The most difficult communication task any physician will face is delivering bad news to a patient or family. As Charlton (1992) stated "there is no greater test of the physician's skill (p. 615-616)." The subject of how to break bad news has consistently appeared in the medical literature. In this study, 36 texts (7.68% of the total texts) were categorized as falling under this theme. This category included texts that not only reviewed the practice of delivering bad news, but also examined the unique communication factors present in dealing with patients who are dying.

The topic of delivering bad news benefits from a very thorough literature review by Ptacek and Eberhardt (1996). From their review of 67 articles on the subject, Ptacek and Eberhardt were able to discern the content of the literature review into a consensus recommendation on how to deliver bad news. They also pointed out that the information to be delivered is subjective and what one individual considers bad may not meet another person's criteria of bad news. As they built their definition of what constitutes bad news, several components were required including: a feeling of little or no hope, a threat to mental or physical wellbeing, a significant change in lifestyle, the feeling there are few or no choices, and creating a cognitive change in feeling described as an "emotional deficit (p. 496)" that will continue well past the time the news is delivered.

Ptacek and Eberhardt (1996) identified 13 recommendations built around five factors: location, structure, people, what is said, and how it is said. Important

aspects of location included finding a quiet, comfortable place to deliver the news that affords some privacy. The structure of the communication should allow for enough time to say what needs to be said and to respond to the reaction and any questions that may arise in a setting that assures there will be no interruptions. Additionally, several nonverbal factors are vital to the structure of the delivery including: delivering the news in person with good eye contact, close proximity to the patient or family member being informed, and insure no physical barriers are present. As for people, it is important to identify the support system of the individual being informed and make attempts to have that system in place if needed. When delivering the message, what is said and how it is said can have a lasting impact. The physician should provide some preparation for the news by firing a "warning shot" as described by Ptacek and Eberhardt (1996). Find out what the subject already knows about the situation and build from there. If appropriate, convey some measure of hope. The physician should be attuned to the subject's response and be prepared to explore the emotional reaction of the subject as well as encourage and answer questions. Also, it is important to summarize the discussion, keeping in mind the subject may not be able to recall all that was told to them. Ptacek and Eberhardt encouraged writing down or even audiotaping the consultation as a means of allowing the subject to go back and review the discussion. How it is said also plays a significant role. The news should be delivered in a warm, caring manner with a felling of empathy. The words selected should be simple and direct, avoiding the use of euphemisms and medical jargon. And lastly, deliver the news at a pace the subject can

absorb. Each person will respond differently to the news and the physician will need to monitor the subject's response letting the subject dictate the pace the information should be supplied.

One shortcoming Ptacek and Eberhardt (1996) noted is that the vast majority of the literature takes its views from the physician's perspective. How the patient perceives the event is often reported by how the physician interprets patient feelings. Several researchers have examined the delivery of bad news from the patient perspective (Butow et al., 1996; Garwick, Patterson, Bennett, & Blum, 1995; Johnston, Earll, Mitchell, Morrison, & Wright, 1996; Krahn, Hallum, & Kime, 1993, Strauss, Sharp, Lorch, & Kachalia, 1995). Krahn et al. (1993) developed nine themes after a qualitative analysis involving the parents of 24 infants with recently diagnosed disabilities. All of the factors identified by Ptacek and Eberhardt (1996) are also found in Krahn's et al. (1993) themes. But Krahn et al. also identified some other factors in the delivery that these parents felt important. These included: the provision of information about resources, having the person delivering the news be someone familiar to them, information be personalized and not stereotyped, communication should be equal between the two parties and not in the manner of superior versus subordinate, and the need for the parents to separate process from content.

Butow et al. (1996) compared patient experiences and preferences for being informed about the diagnosis of cancer with published guidelines on how to inform patients of bad news. Their results found that patient preferences were not always consistent with published guidelines. The most significant area of

concern was the amount of emotional support offered by the physician. Patients who needed more support after being informed but did not get it had a much more difficult time adjusting psychologically to the disease. Strauss et al. (1995) also reported parents of newborns with disabilities felt their expectations were not met when the bad news was delivered. While most considered the overall experience positive, there were still problem areas including a greater need for information than was supplied, referral to support groups, more opportunity for discussion, greater emotional support from the physician, and an feeling from the physician that showed a higher degree of caring and confidence. Johnston et al. (1996) also reported more critical patient perceptions if the patient felt they did not have adequate opportunity to ask questions. Garwick et al. (1995) found negative family perceptions about the delivery of bad news concerning their child often centered on the family's perception of an insensitive approach by the physician.

Garwick et al. (1995) also introduced a concise acronym that refines the strategies developed by Ptacek and Eberhardt (1996) and Krahn et al. (1993). Using the word PACE, Garwick et al. (1995) emphasized the need to: (a) plan the setting, (b) assess the patient's or family's knowledge and experience, (c) choose the strategy that works best with the situation, and (d) evaluate the patient's or family's understanding of what was told.

Another area of concern brought up by Ptacek and Eberhardt (1996) is the relative lack of theoretical justification or empirical validation that revealed the way bad news is delivered has a significant impact on the patient's wellbeing or

quality of life. Several texts mentioned possible situations where patient wellbeing may be affected by how the bad news delivered (Bennett & Alison, 1996; Bruhn, 1991; Roberts, Cox, Reintgen, Baile, & Gibertini, 1994). Each of these researchers stated that poor delivery of information may create barriers in the patient/physician relationship or create a situation where information is not easily shared between patient and physician. Dickinson and Mermann (1996) also noted the way in which the delivery of bad news is performed may have a lasting effect on the relationship between the physician and his or her now dying patient. The impact of a poor quality patient/physician relationship and inadequate information sharing on compliance and outcomes are discussed elsewhere in this paper. While the end outcome of the patient's condition may not change, there is still ample opportunity for other positive outcomes such as pain management and delaying death through interventions and supportive care that may still require a positive patient/physician relationship. A poor delivery of the bad news will likely have a negative impact on the patient's ability to effectively manage his or her disease process. This concept was affirmed by Butow, Dunn, Tattersall and Jones (1995) when they reported patient-centered consultations in the delivery of bad news improved patient satisfaction with the experience and facilitated a more positive psychological adjustment to the diagnosis. Bruhn (1991) argued the manner in which a patient is informed of a grave prognosis sets the stage for how that person will handle the disease process both physically and psychologically.

Several texts cited deficiencies in medical school training and physician education as problems (Charlton, 1992; Chishom, Pappas, & Sharp, 1997, Fallowfield, 1993; Langlands, 1991). Dickinson and Mermann (1996) conducted a longitudinal study examining medical school course offerings related to death education and dealing with the terminally ill from 1975 through 1995. The number of full-time courses in the subject was fairly limited, although there had been some increase in courses since the beginning of the study period with nine of 113 schools having full-time courses in 1995. Most death education was delivered in short courses or periodic lectures incorporated into other medical courses. In 1995, 90% of schools surveyed said they used this approach. Dickinson and Mermann also noted the increased trend of medical schools to use instructors from outside the medical profession to augment the education on death and terminally ill patients. They stated this approach created a more humanistic approach to death and better prepared physicians to work through the ethical and emotional issues associated with the delivery of bad news.

Charlton (1992) and Fallowfield (1993) noted the delivery of bad news is often difficult for the physician because of fears of being blamed, facing the emotional response of the patient or family, the risk of lowering a patient's morale, and the concept of failure to cure or heal that many physicians feel is their responsibility. Fallowfield goes on to state medical education programs that emphasize biomedical approaches to the patient/physician relationship as opposed to biopsychosocial or patient-centered approaches, usually leave their students and residents improperly prepared to deal with this difficult

communication task. The result is often a poorly delivered message that damages the relationship and makes the psychological adjustment more difficult. While most programs have yet to emphasize the practice of delivering bad news to patients and families, there are some schools that have incorporated this skill into their curriculum. Knox and Thompson (1989) described one program that used parents of disabled children and terminally ill patients in group discussions with medical students about how bad news should be delivered. Using their first-hand experience, the parents and patients were able to lead the discussion and offer techniques and skills to the students on how the news should be broken. Follow-up one year after the sessions were completed showed students felt more prepared to deliver bad news.

Observational techniques applied to the delivery of bad news have found patient-centeredness is not as prevalent as one might think. Ford, Fallowfield, and Lewis (1996) conducted a content analysis of consultations with 117 newly diagnosed cancer patients. Their findings showed closed-ended questions from the physicians dominated the interview creating a low level of patient-centeredness. Additionally, very little time was dedicated to the psychological needs of the patient with most of the discussion focused on the medical implications of the disease.

One area of discussion on the topic of bad news that has been extensively reviewed over the years was whether to tell the patient or not that there was bad news (Buckman, 1996; Charlton, 1992; Righetti & Giorgio, 1994; Sabbioni, 1997; Seale, 1991; Zakotnik, 1997). During the middle part of the 20th

century, the medical community was apt to refrain from informing patients of a grave diagnosis. Buckman (1996) reviewed several articles and found as late as the 1960s physicians were still reluctant to inform their patients at rates of over 90%. But, as he noted, times have changed. Increased patient autonomy, a more consumerist attitude, a shift to patient-centered care, and medicolegal practice have forced changes in this attitude. Buckman reviewed studies that showed, at least in the United States, there had been a complete turnaround in this attitude. However, he commented while the situation has improved in other Western cultures, the European physicians are still somewhat reluctant to inform their patients of a grave diagnosis. Charlton (1992) conducted an extensive review of several articles spanning a period of over 40 years that reviewed patient and physician opinions about the breaking of bad news. His research also showed an increasing trend over the years to more open communication about bad news.

After the bad news has been delivered, the physician must now deal with communicating with a patient who may not recover. While the situation is certainly dire for these patients, Links and Krammer (1994) commented patients should still be afforded some realistic hope through the disease process. Providing this hope while being cautious not to provide false or unrealistic hope can help the patient make future plans both concerning his or her treatment as well as personal issues of importance.

While the care delivered may be supportive as opposed to curative, there is still a need for the physician to maintain a positive relationship which can be

challenging for the physician (Buckman, 1989; Butow, Dunn, & Tattersall, 1995; Coulombe, 1995; De Valck & Van de Woestijne, 1996; Krishna & Raffin, 1998; Todd, & Still, 1993). Coulombe (1995) emphasized while the situation may be life threatening, the principals of patient/physician communication remain the same. Krishna and Raffin (1998) pointed out aspects of patient/physician communication are even more important in the terminally ill because of the risk of ethical issues developing. They stated good communication between the physician and the patient or family is the best way to avoid ethical dilemmas in the closing stages of life. Todd and Still (1993) interviewed general practitioners on how they approached communication with the terminally ill. They identified the prime objectives of the physicians was to keep the patient comfortable, pain free, in a positive spirit, while maintaining patient dignity.

The medical literature has addressed many areas of the communication process both in the verbal channel, such as Short's (1993) "The Importance of Words", and the nonverbal channel, such as Buis, de Boo, and Hull's (1991) "Touch and Breaking Bad News". Much of the medical literature on the delivery of bad news focused on the nonverbal channel and its importance to patient perceptions. Leathers (1997) stated the most important skills needed in the patient/physician interaction are nonverbal. Of all the communication contexts between patient and physician, the delivery of bad news emphasized this point most. The ability to create the impression of empathy toward the patient while still remaining clinically detached from the patient requires the competent use of appropriate nonverbal cues. Leathers identified five communicative functions of

nonverbal communication in the patient/physician relationship: exchange of emotions, metacommunication, self-concept protection, impression management and formation, and reassurance. In the critical moment of the delivery of bad news, this channel, with the speed in which it transmits its meaning, a physician with good control and use of his or her nonverbal behaviors can create the impression they most desire.

Many aspects of communication in the context of delivering bad news rely on the ability of the physician to impart serious technical information while still being able to present himself or herself as empathic to patient's situation. This can be a difficult juggling task for many physicians; one in which they may feel ill prepared to handle. Using the summaries developed by Ptacek and Eberhardt (1996) and Krahn et al. (1993) would set the framework for delivering bad news in a compassionate, empathetic manner. Remaining flexible to the patient's needs and monitoring the patient's response to the news will help guide the physician along a path to help prepare the patient for the difficult time ahead.

Chapter 14: Information Exchange

A portion of the medical literature has been dedicated to analyzing how information moved between the participants in the patient/physician relationship and how well that information was understood. This segment of the literature included 43 texts representing 9.17% of the total texts. This area of the literature provided some essential information that aids in developing an understanding of how accurate the communication process has been. A starting point for examining information exchange in the relationship was knowing the importance of the physician in the process. Even when confronted by a variety of health care providers, patients viewed the physician as the primary source of their medical information (Crane, 1997) or the source from which they would like to receive information (Meredith et al., 1996).

As the primary supplier of medical information to the patient, the physician occupied the key role in creating patient understanding. Deficiencies existed in patient understanding of the information supplied to them by physicians. Crane (1997) found less than two-thirds of patients were able to provide correct responses about their condition or follow-up treatment after emergency department visits. Calkins et al. (1997) found 89% of physicians felt their patients understood the instructions they gave them. Yet, only 57% of patients reported a similar level of understanding. In a more specific area of information understanding that showed an even more pronounced gulf between physician

perception and patient understanding, Calkins et al. noted 95% of physicians felt their patient knew when to resume normal activity. However, only 58% of patients indicated they knew when it was permissible to resume normal activity. Roter, Knowles, Somerfield, and Baldwin (1990) found a recall rate of only 43% in the patient population they studied. Chan and Woodruff (1997) investigated information understanding in cancer patients. One of their more astonishing findings was that 10% of the patients in the study did not know they had cancer. Of those patients who did know, over a third did not have an adequate understanding of their condition. Understanding on the part of the physicians in the study did not fare much better. The severity of pain the patients were experiencing was underestimated by the physicians in over two-thirds of the patients. Quirt et al. (1997) also found significant differences between what the physician and the patient knew. Quirt et al. found many misconceptions in patients about the disease state – cancer – that the physicians were unaware of, such as only a third of the patients agreed with their physicians about the probability for cure and most who disagreed greatly overestimated their chances.

Not only are there shortcomings in the understanding of information, there are also differences between the physician's perception and the patient's. Laine, Davidoff, Lewis et al. (1996) compared patient and physician opinions on the importance of nine domains to the delivery of quality medical care. The largest difference between patient and physician opinions was found in the area of the provision of information. Patients rated this area as much more important to the overall impact on the quality of health care than physicians did.

Lack of understanding and concordance represents only one deficiency in the communication process. Another problematic area is incomplete information. Stoller and Kart (1995) compared patient diaries of their health problems to the information they actually shared during the medical consultation. While the patients in their study reported a mean of 6.0 symptoms on the day of their consultation, a mean of only 2.4 was reported to the physicians. It was determined patients reported symptoms based on their perceived level of seriousness, the amount of pain associated with the symptom, and the level of uncertainty generated by the symptom. This prioritization by the patient in their reporting of symptoms can be mirrored in the way physicians extract information from their patients. Ridderikoff (1993) found that when pressed for time, physicians tended to look for broader symptoms rather than soliciting details of the patient's illness. White, Levinson, and Roter (1994) identified another problematic area when they examined the closing of the medical interview. They discovered 21% of patients brought up new complaints or symptoms at the closure of the interview that demanded further exploration. As they noted, this indicated a need for the physician to ensure adequate opportunity for patients to present their symptoms and for providing some orientation to the flow of the consultation to permit all symptoms to be brought up.

Middleton (1994) suggested one method aimed at insuring patient symptoms were properly being addressed. Middleton advocated patients bringing written lists of their concerns. While Middleton reported that 71% of physicians thought lists would be helpful in clarifying patient problems, two-thirds

of physicians felt lists would be too time-consuming to go through. Additionally, Middleton noted many physicians had a stereotypic view of the type patient who brought lists to the consultation to the point where the list may become a barrier to patient/physician communication.

Several methods of improving the exchange of information in the medical interview have been examined. Wohrm (1994) discussed the use of illustrations as an adjunct to patient education during the consultation and noted they were able to add structure to the patient's problem presentation and aided in building cooperation between patient and physician. Another method used to attempt to improve the quality of information exchange between patient and physician was investigated by Isaacman, Purvis, Gyuro, Anderson, and Smith (1992) who studied the effectiveness of standardized instructions being given to discharged emergency department patients. Their study found that when standardized instructions were used by the physician, parents of child patients were able to demonstrate a higher degree of recall of information than when instructions were given without the benefit of a standardized list for the physician to refer. Letters to patients from physicians as follow-up to consultations explaining treatments or diagnosis have also been found to be beneficial to patient recall and understanding (Damian & Tattersall, 1991; Eaden, Ward, Smith, & Mayberry, 1998). One technique that has been frequently studied has been the use of audiotapes of the consultation being supplied to the patient. This method has been shown to improve patient recall and understanding as patients are able to go back and review the consultation whenever they had questions about their

treatment or disease process (Deutsch, 1992; Eden, Black, & Emery, 1993; Johnson & Adelstein, 1991; Stockler, Butow, Tattersall, 1993).

Several researchers have investigated the accuracy of the language used in the patient/physician encounter. The use of medical terminology and its impact on patient understanding has been studied (Eagleson, 1992; Hadlow & Pitts, 1991). Hadlow and Pitts (1991) compared the understanding of common medical terms between physicians, other health care providers, and patients. They found a significant gap between physician and patient understanding. While these studies show the importance of common language, there is still a place for medical terminology in the encounter. Wood (1991) noted the need for patients to have a name for their disease. It is in situations such as this where more precise medical terminology may be appropriate.

One of the more common points of misunderstanding between patient and physician is in the area of probability statements (O'Brien, 1989; Cohn, Schydlower, Foley, & Copland, 1995; Mazur & Hickam, 1991). O'Brien (1989) found physicians were able to use probability expressions based on percentage or terms with reasonable agreeability. Mazur and Hickam (1991) found patients also displayed some consistency in their assessment of probability scales. However, Cohn et al. (1995) found a great deal of discrepancy between physicians and pediatric and adolescent patients. Unfortunately, no study was found that compared adult patients' perceptions of probability statements with physician statements.

Patients want information (Doust, Morgan, Weller, & Yuill, 1989; Meredith et al., 1996; Wisiak, Kryoll, & List, 1991) and they look to the physician to supply it (Crane, 1997). However, a great deal of discrepancy existed between patient perceptions and understanding of the information they received and what the physicians believed the patients knew. A variety of measures have been explored to help make this exchange of information more accurate. However, considering the problems found in this area and the impact this area has on health outcomes, this is an area that is in need of additional research to help create a higher degree of consistency in meaning between patient and physician.

Chapter 15: Theory

The introduction of theories, models, or descriptive measures to analyze or apply to the patient/physician interaction has been reported frequently in the medical literature. During the 10-year period reviewed in this study, 25 texts were identified in this theme representing 5.33% of the total texts. This chapter will review three primary sub-themes: the development of models to explain communication behavior in the patient/physician interaction, the application of theory to the interaction, and methods of analysis of the interaction.

During the decade of material reviewed in this study, one model of patient/physician interaction can easily be identified as the singularly most significant development of the past ten years. The Three-Function Model of the Medical Interview introduced by Bird and Cohen-Cole (1990) has been frequently cited as an important influence in the patient/physician relationship by researchers (Nardone, Johnson, Faryna, Coulehan, & Parrino, 1992) and has been adopted as a commonly used approach to the medical interview.

Bird and Cohen-Cole (1990) developed their model based on what they saw as the three primary functions of the medical interview: information collection, responding to patient's emotions, and educating patients in an attempt to influence behavior. Derived from what Bird and Cohen-Cole refer to as the three domains of learning, each function of their model corresponds to either cognitive (information collecting), affective (emotional response), or behavioral (education) domains. Each function of the interview solicits or imparts different

types of information and while some overlap does occur, each function requires a different set of skills and tactics by the physician. As Bird and Cohen-Cole noted, too much emphasis is placed on the information collecting phase of the interview in typical medical education programs, leaving the other two functions markedly short on meeting patient needs. While designed for physicians, Bird and Cohen-Cole advocated this approach to the medical interview can be used by other clinicians as well.

Each function has its own set of objectives and associated skills to meet those objectives. Information collection has three objectives:

1. Obtaining accurate data.
2. Achieving efficient data collection.
3. Determination of the patient's problem.

Among the skills needed are: starting interviews with open-ended questions, working from open-ended to close-ended questions, facilitation, checking, surveying the field or obtain information beyond the primary complaint, negotiate priorities, provide directive comments, summarize, and determine the patient's thoughts on the etiology of the disease.

The second function, responding to patient emotions, has seven objectives:

1. Develop and maintain patient rapport.
2. Reduce interference.
3. Ensure patient satisfaction.
4. Provide relief of distress.

5. Observe for and manage possible psychiatric illness.
6. Improve the physician's satisfaction.
7. Improve physical outcomes through emotional support.

Five skills were identified that will assist the physician in meeting these objectives. Reflection allows the opportunity for the physician to engage in empathy with the patient. Legitimization shows the physician's acknowledgement, understanding and acceptance of the patient's emotional experience. Support from the physician shows a willingness to help the patient through the situation. Partnership allows a framework for shared control in the decision-making aspect of the emotional response. And lastly, respect allows the patient's coping mechanisms to be enhanced.

The third function focuses on educating patients in an attempt to influence behaviors. Three objectives are identified:

1. Determine patient understanding of the illness and treatment options.
2. Actively involve the patient in the treatment process.
3. Work toward high compliance with the treatment plan.

Numerous skills are advised for the achievement of these objectives. These skills revolve around three primary areas. First is education about the illness. Here information is provided to the patient regarding the illness diagnosis and should include determination of the patient's baseline knowledge of the illness and check for adequate understanding. Second is negotiation and maintenance of treatment plan. Mutually developed goals should be identified based on the

physician's recommendations and the patient's preferences and ability to commit to the treatment regimen. And third, motivation should be provided to help achieve the treatment plan goals. To accomplish this, adequate follow-up and compliance checking should be done, problems with compliance should be identified, and renegotiation of the treatment plan should be addressed.

Other models have been introduced to explain and predict behaviors in the patient/physician relationship. Frederikson (1993) introduced the information processing model where he attempted to generate an approach to the relationship as a system of mutual information exchange. Hewson, Kindy, Van Kirk, Gennis, and Day (1996) analyzed patient/physician interactions in complex patient presentations using standardized patients in an effort to develop a model to assist physicians with managing cases of complex or uncertain origin. They developed a construct referred to as the strategic medical management construct that used nine specific strategies for managing these difficult patients. Faulkner, Maguire, and Regnard (1994) presented a flow diagram for dealing with patients presenting with anger while also dealing with advanced disease states. Rosenzweig (1993) discussed a model for building rapport in emergent situations. Nardone et al. (1992) introduced a model for the diagnostic medical interview based on nonverbal, verbal, and cognitive assessments.

The practice of applying communication or behavioral theory to the patient/physician interaction has received some attention in the medical literature. Waitzken (1989) and Waitzken and Britt (1989) introduce a concept they refer to as the Critical Theory of Medical Discourse. Based on structural

theories of communication, this approach to the patient/physician interaction follows the propositions that "medical encounters tend to convey ideologic messages supportive of the current social order, that these encounters have repercussions for social control, and that medical language generally excludes a critical appraisal of the social context (Waitzkin, 1989, p. 220)." As a result, patient/physician encounters may have deeper structures of communication present than the physician may realize. Nessa (1995) also used a structural approach as pragmatics and textlinguistics as well as speech-act theory are used to help explain the patient/physician interaction. Skorpen and Malterud (1997) used the cognitive theory of learning approach with specific attention paid to a concept they refer to as "operational knowledge." Bower (1998) discussed what is referred to as implicit personality theory where the physician is forced to use their own experience of theory and model development as a means of understanding and predicting patient behavior, since, as Bower stated, there is no "relevant, reliable, and predictive model of individual behavior that would apply unproblematically to their everyday clinical work (p. 153)." Daltroy (1993) used attribution theory and decision-making theory to develop a set of 12 techniques physicians can use in routine patient/physician encounters to improve patient satisfaction, compliance and, outcomes. Walsh and McPhee (1992) took advantage of systems theory in their development of the Systems Model of Clinical Preventive Care. Cole-Kelly, Tanoshik, Campbell, and Flynn (1998) also utilized systems theory in their study of integrating the family into routine patient care.

Several techniques of study commonly found in the communication studies literature have found their way into the medical literature. Peryakylya (1997) discussed the use of conversation analysis as a research tool for investigating the patient/physician relationship. Nessa and Malterud (1990) examined the use of discourse analysis in the relationship. Putnam and Stiles (1993) also used discourse analysis in their study of verbal exchanges in the patient/physician relationship.

As the patient/physician relationship is studied, there are a variety of analysis tools available for the researcher to use to investigate the relationship. Many of these tools are described in detail in one of three significant articles on interactional analysis systems. Roter and Hall (1989) presented a summary of the most frequently used analysis systems including the Bales Process Analysis Method, Roter's Interaction Analysis System, and the Verbal Response Mode. Ong et al. (1995) presented a succinct table reviewing 12 coding systems for the patient/physician interaction. The most comprehensive review of existing coding schemes was conducted by Boon and Stewart (1998) in which they reviewed 44 coding systems.

The communication studies literature offers several examples of theory application, model development, or concept development in the patient/physician relationship. Ayers, Colby-Rotell, Wadleigh, and Hopf (1996) explored communication apprehension in the relationship. Sheer and Cline (1995) used information theory and uncertainty reduction theory to develop a model of perceived information adequacy and uncertainty reduction. Buller and Street

(1991) compared aspects of the social interaction model with the health belief model. Burgoon, Birk, and Hall (1991) applied expectancy theory to the relationship as they explored the effect of gender in the interaction. Conlee et al. (1993) examined the concept of nonverbal immediacy associated with the approach-avoidance construct and its effect on patient satisfaction. Cinchon and Masterson (1993) used role theory in their study of mutual role expectations in the patient/physician relationship.

Just as in the communication studies literature, within the medical literature there is a debate on whether quantitative or qualitative methods should be employed to examine communication in the patient/physician interaction. Waitzkin (1990) discussed this debate as he reviews the advantages and disadvantages of each approach. Waitzkin noted quantitative methods often miss the subtle complexities inherent in the relationship while qualitative measures are difficult to evaluate and often impossible to reproduce accurately. Waitzkin offered several compromises he felt are needed for the study of medical discourse:

1. Discourse should be randomly selected from a sample of interactions.
2. Discourse should be recorded to allow other observers to provide comment.
3. Standardized rules of transcription should be used.
4. Multiple observers should assess transcription reliability.

5. Procedures for the interpretation of the discourse should be established in advance, validated through relationships with existing theory, and address both content and structure.

6. Multiple observers should confirm reliability of interpretation.

7. Summaries and excerpts of transcripts should accompany interpretations while full transcripts should be available for review.

8. Text selection and interpretation should be representative of the content and structure of the sampled texts.

Roter and Frankel (1992) addressed this same issue. They also noted the shortcomings of each research method and advocated a cross-method research practice to evaluating communication in the patient/physician relationship. Roter and Frankel were highly critical of what they term the "unusually critical and intellectually isolated positions (p. 1097)" of researchers who exclusively advocate one method above the other.

Regardless of the method of research applied to studying communication in the patient/physician relationship, as Frederikson (1993) noted, no one theory or model has emerged as being adequate in explaining or predicting communication in the interaction. Physicians must remain open to a wide variety of theoretical implications or model use dependent on the particular situation or patient with which they are faced. Being flexible and responsive to patient needs, knowing what communication practices to implement, and having an understanding of the more generally used models of communication - such as

Bird and Cohen-Cole's (1990) Three Function Model of the Medical Interview - will give physicians the skills needed to treat their patients.

Chapter 16: Conclusion

In reflecting on the purposes of this paper, some claims can be made. Patient/physician communication is a very frequently reported topic in the medical literature with 469 texts identified for the ten-year period this paper reviewed. The frequency of reporting the topic has steadily increased over that ten-year period and appears to be following a trend first noted by Meryn (1998a) starting in 1970 of increased frequency of appearance in the medical literature. The topics covered within the overall heading of patient/physician communication are broad with an abundance of research into the impact communication has on the health and attitudes of patients. While being broad, the scope of the literature still allows for some generalizations.

Practitioners often underestimated the impact the physician can have on the patient. Physicians need to be cognizant of their influence on patient condition through the use of appropriate, effective communication. As Bensing (1991) described in his comments about Michael Balint's approach of "the doctor is the drug (P.1301)," the physician's communication affects more than just the quality of the relationship.

If a physician were presented a new pill that when given to patients had been proven to show the clinical effects that not only improve the patient's physical health regardless of his or her disease, but also create higher compliance with treatments, increase satisfaction with medical care, plus lessen the likelihood of suing and still further, increase the satisfaction of the physician

administering the pill while lowering the chance of physician burnout, how many physicians would want to give that pill to their patients? The medical literature reviewed in this paper has clearly shown the beneficial effects of improved patient/physician communication can perform all the magic of this hypothetical pill. Yet even with all this evidence, there is still a reluctance to accept communication as a form of treatment. As noted by many researchers such as DiMatteo (1998), the roots of the medical community's desire to hold on to old ways of thinking run deep. The concept of patient-centered care is relatively new having only emerged in the last 40 years with the early statements by authors such as Szasz and Hollender (1956). Overcoming the mindset that has reinforced the dominance of the physician in the relationship, a philosophy dating back thousands of years to Hippocrates himself, will be a daunting task for proponents of patient-centered care.

However, there has been progress. As evidenced by the increasing recognition of the importance of communication to all aspects of patient care as shown in the increasing frequency of reporting the subject and the almost universally positive findings of the medical literature, patient/physician communication is beginning to be seen as a significant factor in not only areas such as patient satisfaction and compliance but also in the area of health care outcomes. The medical literature contains a diverse assemblage of evidence collected through experiments, focus groups, observational studies, as well as anecdotal reports about the impact of patient/physician communication on all aspects of health care.

As noted, the depth and breadth of research into the communication process between patient and physician has been broad. However, there are still areas that demand exploration. Much of the research has involved a general population of patients. Specific communication practices that are more effective with subsets of patients based on such factors as age or gender still need follow-up. Knowing what practices work best with unique groups of patients would give the physician better knowledge on what communication tactics to employ to achieve a greater degree of effect, much like knowing the effects of a medication and how they may manifest themselves differently based on unique patient characteristics.

In examining the whole of the medical literature on patient/physician communication, two factors present themselves as being very clear. First, communication when done right will have almost universally positive effects on patients and the patient/physician relationship. The second item identified in the medical literature is that physicians do a relatively poor job of communicating with their patients. While much of this stems from their education in medical school and subsequent residency programs, not all the blame can be placed here. Physicians routinely respond to new pharmacological or surgical treatments as they become available. An area of research needing more attention is in identifying and overcoming the barriers to physician use of more positive communication skills.

This study sought to identify the major themes and trends found in the medical literature. While the number of texts selected for inclusion (469) was

large, there still exists the limitation that this was not an all-inclusive census of the literature. While computer archives and databases such as MEDLINE are excellent resources for compiling very thorough collections of articles, there is the possibility that some texts may not have been included. However, given the vast number of texts involved in this study, this project still represents a comprehensive review of the medical literature.

Another limitation concerns the source of the documents. Only texts from the medical literature were included. The contributions of the communication studies literature, while occasionally drawn upon, were left relatively unexplored. Generally, the communication studies literature has had a greater degree of focus on the communication act itself and less of a focus on the participants or the impact of the act on the patient, such as in the study of health care outcomes. Although this area of study has obvious importance and examples of it are found in the medical literature, the area of focus for this study was limited to the medical literature.

The coding scheme used in this study for classification of texts into their thematic areas represented a new approach to defining the medical literature. Other studies had used similar coding schemes, but those schemes did not allow the diversity of topics found in the method used by this study. Therefore, the results from the coding scheme used in this study can not be directly compared with the results of other studies.

Patient/physician communication is in a state of change. While that change may have been initiated decades ago, one must keep in perspective the

entrenchment of the traditional role of the physician in the relationship. Shifting to a more universally accepted and performed patient-centered approach has slowly been evolving. It may take more than one generation of physicians to make this conversion complete. Additionally, not all the problems of the relationship can be placed on the physician with the expectation that they are wholly responsible for the current state and its future. The patient also bears some responsibility. For partnership building in patient-centered care to be effective, patients must assume more responsibility for the treatment of the their illness or injury. This includes not only being an educated and willing participant in the relationship but also in showing the desire to make modifications to behavior or increase compliance with treatments to allow the mutually developed goals of the more modern patient/physician relationship to be realized. And lastly, the system itself bears some responsibility. What is needed is a system that will create an environment that permits the development of a relationship that has been repeatedly documented throughout the literature as improving satisfaction, compliance, and patient health. This not only includes the education system of physicians but also the heath delivery system in which they are forced to practice. This system and its various components – be they hospitals, insurers, or regulating agencies – must be aware of the importance of communication and how, when done properly, improved communication can benefit all the systems participants including patient and physician.

As Lesley J. Fallowfield (1996) concluded:

It is too simplistic to blame all the communication problems within medicine on poor training, as we know that many of out doctors are expected to deliver care within quite unacceptable system constraints. Nevertheless, even within a time-pressured, environmentally unsuitable clinic, there is still time to communicate such things as respect, concern or empathy, with a look, a touch or a turn of the phrase. These things can sometimes make the disease and its treatment more tolerable, strengthen the therapeutic alliance and produce benefits for doctors and patients alike (p. 30).

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