

Patient-Physician Communication: Why and How

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Patient-physician communication is an integral part of clinical practice. When done well, such communication produces a therapeutic effect for the patient, as has been validated in controlled studies. Formal training programs have been created to enhance and measure specific communication skills. Many of these efforts, however, focus on medical schools and early postgraduate years and, therefore, remain isolated in academic settings. Thus, the communication skills of the busy physician often remain poorly developed, and the need for established physicians to become better communicators continues. In this article, the authors briefly review the why and how of effective patient-physician communication. They begin by reviewing current data on the benefits of effective communication in the clinical context of physicians caring for patients. The authors then offer specific guidance on how to achieve effective communication in the patient-physician relationship.

The manner in which a physician communicates information to a patient is as important as the information being communicated. Patients who understand their doctors are more likely to acknowledge health problems, understand their treatment options, modify their behavior accordingly, and follow their medication schedules.¹⁻⁴ In fact, research has shown that effective patient-physician communication can improve a patient's health as quantifiably as many drugs—perhaps providing a partial explanation for the powerful placebo effect seen in clinical trials.¹⁻⁴

Decades ago, physicians were presumed to hone their “soft” communication skills at patients' bedsides, in their rounds as residents, and as students at the elbows of master clinicians. Today, the communication and interpersonal skills of the physician-in-training are no longer viewed as

immutable personal styles that emerge during residency but, instead, as a set of measurable and modifiable behaviors that can evolve. Based on emerging literature on the value of effective communication, medical students and postgraduates are increasingly given instruction on techniques for listening, explaining, questioning, counseling, and motivating. As such techniques are central to delivering a full and tailored health prescription, 65% of medical schools now teach communications skills.⁵ Training in patient-physician communication is also now objectively evaluated as a core competency in various accreditation settings, including the Comprehensive Osteopathic Medical Licensing Examination—USA—Performance Evaluation, the United States Medical Licensing Examination, and the American Board of Medical Specialties' certification.⁶⁻⁸

These efforts to improve and measure communication skills are timely, as the barriers to effective communication between patients and physicians are growing (*Figure 1*). Despite evidence indicating that the average length of the patient-physician encounter has not changed significantly in recent years,⁹ specific survey data indicate a correlation between patient participation in capitated health plans and shorter office visits.^{10,11} Further, hurdles arising from linguistic and cultural differences, already abundant, will only increase in coming years.^{12,13} Medical information and support groups found on the Internet, while potentially a great asset in educating and motivating patients toward better health, have many physicians questioning their traditional role as most trusted counselors.^{14,15} However, even demands associated with time, language, and technology—as Internet-available information, which potentially limits face-to-face opportunities—are not an excuse for neglecting one's communication skills. During the typical 15- or 20-minute patient-physician encounter, the physician makes nuanced choices regarding the words, questions, silences, tones, and facial expressions he or she chooses. These choices either enhance or detract from the overall level of excellence of the physician's delivery of care.

The first purpose of this article is to remind physicians of the importance of, and the opportunities for, more effective communications. The second purpose is to offer physicians practical techniques for improved communication with patients.

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Checklist

- Speech ability or language articulation
- Foreign language spoken
- Dysphonia
- Time constraints on physician or patient
- Unavailability of physician or patient to meet face-to-face
- Illness
- Altered mental state
- Medication effects
- Cerebral-vascular event
- Psychologic or emotional distress
- Gender differences
- Racial or cultural differences
- Other

Figure 1. Barriers to patient-physician communication.

**Why Bother Communicating With Patients?
A Reminder About the Value of Communication**

From obtaining the patient’s medical history to conveying a treatment plan, the physician’s relationship with his patient is built on effective communication. In these encounters, both verbal and nonverbal forms of communication constitute this essential feature of medical practice. Although much of the communication in these interactions necessarily involves information-sharing about diagnosis and therapy options, most physicians will recognize that these encounters also involve the patient’s search for a psychosocial healing “connexion,” or therapeutic relationship.^{16,17} For example, a patient with broken relationships with family, friends, coworkers, or the community in general, will often struggle when describing his illness and symptoms for the first time. That patient’s contact with his physician is often a first step toward reconnection. Therefore, it is essential for the physician to listen to patient concerns, provide comfort and healing, and foster the relationship in general. This aspect of the patient-physician relationship is hard to define and, yet, with little doubt, can be found at the heart of any truly therapeutic relationship.^{16,17} This healing aspect also forms the basis for quality health care.¹⁸

In settings involving the communication of bad news, especially when there is no appropriate biomedical response, the strength of such a therapeutic relationship will be tested, and its value quickly becomes obvious.¹⁹ The physician who

can communicate bad news in a direct and compassionate way will not only help the patient cope, but will also strengthen the therapeutic relationship, so that it endures and further extends the healing process. Specific communication skills that involve preparing in advance, validating emotions, and dealing with family members have been described for this difficult setting.²⁰

More broadly and measurably, research into the degree of care used by physicians in patient-physician communication has been shown to improve patient outcomes. One review of randomized controlled trials on patient-physician communications reported that the quality of communication in the history-taking and management-discussing portions of the interactions influenced patient outcomes in 16 of 21 studies. Outcomes influenced by such communication include emotional health; symptom resolution; function; pain control; and physiologic measures, such as blood pressure level or blood sugar level.¹ The review identified specific elements of effective communication. For example, patient anxiety was reduced in patients whose physicians encouraged questions and also encouraged them to share in the decision-making process. In individual studies, effective communication skills have been correlated to such positive outcomes as adherence to therapy,^{2,3} understanding of treatment risks,⁴ and—in some settings—even to a reduced risk of medical mishaps or malpractice claims.^{21,22}

Obviously, improvement in these types of outcomes is a core goal of long-term patient education aimed at managing chronic illnesses (eg, diabetes and asthma). The high perceived value of effective communication in disease prevention, health maintenance, and quality-of-life, in fact, may be precisely why managed care companies have now outsourced these communication-intensive responsibilities to disease management vendors. Such is an indictment of the limited capabilities of individual physicians to provide such long-term and consistent communications. It is also an acknowledgment of the critical nature of direct human communication and support in achieving good medical outcomes. Examples of how direct contact influences medical outcomes are studies that have documented the way in which disease management programs can lower health-related costs,²³⁻²⁵ reduce emergency department visits,²⁶ control chronic disease,²⁷ and increase patient satisfaction.²⁸

**How to Communicate with Patients
Reminders for the Busy Physician**

Medical professionals debate the best strategies for effective communication, as well as the ability of these strategies to be taught or evaluated objectively.^{5,6,8} Certainly, each physician must develop his or her own style of communication. At the same time, many professional and academic organizations have now also defined key elements of communications skills

needed by physicians. For example, the Accreditation Council for Graduate Medical Education recommends that physicians become competent in five key communication skills: (1) listening effectively; (2) eliciting information using effective questioning skills; (3) providing information using effective explanatory skills; (4) counseling and educating patients; and (5) making informed decisions based on patient information and preference.^{6,29} Although these and similar lists of recommended patient-physician communication strategies are valid and useful, these tips are frequently found only in academic or specialty journals or on the checklists now used to rate physicians in-training.

To help practicing physicians gain and strengthen an effective and personal communication style, and, thus, improve patient-physician communication and rapport, we have assembled our own list of practical steps. We hope that these tips, based on our years of clinical experience and our reading of the recent literature on patient-physician communication, will remind colleagues that they are more than a passive conduit of medical information for their patients; they are interpreters and shapers of their patients' health and full partners in their patient's long-term health status.

1. Assess What the Patient Already Knows

Before providing information, find out what a patient already knows about his or her condition. Many times, other physicians or health care providers have already communicated information to the patient, which can have the effect of coloring patient perceptions and perhaps even causing confusion when new information is introduced. For instance, a nephrologist may talk about the patient "getting better" based on improving renal function tests, while a cardiologist is focused on the patient's severe, irreversible cardiomyopathy. In other scenarios, patients will come to the physician with preconceived notions about a particular condition, perhaps based on less-than-authoritative sources. It is important, therefore, to determine what a patient already understands—or misunderstands—at the outset.

2. Assess What the Patient Wants to Know

Not all patients with the same diagnosis want the same level of detail in the information offered about their condition or treatment. Studies have categorized patients on a continuum of information-seeking behavior, from those who want very little information to those who want every detail the physician can offer.³⁰ Thus, physicians should assess whether the patient desires, or will be able to comprehend, additional information. For the physician without advance knowledge of the patient, this level of need will emerge by degrees as the discussion unfolds and as the physician attempts to synthesize and present information in a clear and understandable manner.

As when obtaining informed consent, a standard first

step in presenting information to a patient would be to describe the risks and benefits of the procedure and then to simply allow the patient to decide how much additional information he or she wants.³¹ However, as suggested elsewhere in this section, this step may require direct questions, strategic silences, and frequent verification that the information is actually being comprehended.

One telling sign of whether the patient is understanding the information is the nature of the questions patients ask; if questions reflect comprehension of the information just presented, a further level of detail may be warranted. If questions reflect confusion, it is advisable that the physician return to basic information. If the patient has no questions or is obviously uncomfortable, this is a good opportunity for the physician to stop the discussion, ask explicitly how much information the patient desires, and adjust accordingly. Continuing to provide further information is not always the best approach.

3. Be Empathic

Empathy is a basic skill physicians should develop to help them recognize the indirectly expressed emotions of their patients. Once recognized, these emotions need to be acknowledged and further explored during the patient-physician encounter. Further, physicians should not ignore or minimize patient feelings with a redirected line of inquiry relentlessly focused on "real" symptoms. Patient satisfaction is likely to be enhanced by physicians who acknowledge patients' expressed emotions. Physicians who do this are less likely to be viewed as uncaring by their patients.³²

4. Slow Down

Physicians who provide information in a slow and deliberate fashion allow the time needed for patients to comprehend the new information. Other techniques physicians can use to allow time include pausing frequently and reinforcing silence with appropriate body language. A slow delivery with appropriate pauses also gives the listener time to formulate questions, which the physician can then use to provide further bits of targeted information. Thus, a dialogue punctuated with pauses leads to deeper comprehension on both sides.

One study found that physicians typically wait only 23 seconds after a patient begins describing his chief complaint before interrupting and redirecting the discussion. Such premature redirection can lead to late-arising concerns and missed opportunities to gather important data.³³

As a side note, patient satisfaction is also greater when the length of the office visit matches his or her previsit expectation.³⁴ In situations involving the delivery of bad news, the technique of simply stating the news and pausing can be particularly helpful in ensuring that the patient and patient's family fully receive and understand the information. Allowing this time for silence, tears, and questions can be essential.^{19,20}

5. Keep it Simple

Physicians should avoid engaging in long monologues in front of the patient. Far better for the physician to keep to short statements and clear, simple explanations. Those who tailor information to the patient's desired level of information will improve comprehension and limit emotional distress.³⁵ Again, physicians should be sure to ask whether patients have any questions so that understanding can be checked and dialogue promoted. It is wise for the physician to avoid the use of jargon whenever possible, particularly with elderly patients.

An important fact for physicians to keep in mind is that, in the United States, between 20% and 40% of individuals between 60 and 80 years of age have not attained a high school diploma.³⁶ In patients of all ages, a physician cannot assume the understanding of treatment risks that are described with percentages or numbers. Such "low numeracy skills" of patients require that physicians take special care in outlining the relative risks of diagnostic procedures and treatments.³⁷

6. Tell the Truth

It is important to be truthful. In addition, it is important that physicians not minimize the impact of what they are saying. For example, euphemisms may soften the delivery of sad information but can be extremely misleading and create confusion.

Saying that a patient has "gone" or has "left us," for example, could be interpreted by an anxious family member as meaning that the patient has left his room to have a radiologic film taken or to undergo a test. Alternatively, physicians who use "D" words (eg, dying, died, dead), when appropriate, effectively communicate the circumstance and minimize confusion.³⁸

7. Be Hopeful

Although the need for truth-telling remains primary, the therapeutic value of conveying hope in situations that may appear hopeless should not be underestimated. Particularly in the context of terminal illness and end-of-life care, hope should not be discouraged.

For example, in situations such as the imminent death of a patient, hope can be conveyed to the family by assuring them that therapy can be effective in allaying pain and discomfort. Thus, even when physicians must convey a grim prognosis to a patient or must discuss the same with family members, being able to promise comfort and minimal suffering has real value.³⁹

8. Watch the Patient's Body and Face

Much of what is conveyed between a physician and patient in a clinical encounter occurs through nonverbal communication.

For both physician and patient, images of body language and facial expressions will likely be remembered longer after the encounter than any memory of spoken words.

It is also important to recognize that the patient-physician encounter involves a two-way exchange of nonverbal information. Patients' facial expressions are often good indicators of sadness, worry, or anxiety. The physician who responds with appropriate concern to these nonverbal cues will likely impact the patient's illness to a greater degree than the physician wanting to strictly convey factual information. At the very least, the attentive physician will have a more satisfied patient.

Conversely, the physician's body language and facial expression also speak volumes to the patient. The physician who hurriedly enters the examination room several minutes late, takes furious notes, and turns away while the patient is talking, almost certainly conveys impatience and minimal interest in the patient. Over several such encounters, the patient may interpret such nonverbal behavior as a message that his or her visit is unimportant, despite any spoken assurances to the contrary. Thus, it is imperative that the physician be aware of his or her own implicit messages, as well as recognizing the nonverbal cues of the patient.

9. Be Prepared for a Reaction

Patients vary, not only in their willingness and ability to absorb information, but in their reactions to physician communications. Most physicians quickly develop a sense for the various coping styles of patients, a range of human reactions that has been categorized in several specific clinical settings.⁴⁰

For instance, a certain percentage of individuals will meet almost any bad medical news in a nonemotional, stoic manner.

Checklist

- Using highly technical language or jargon when communicating with the patient
- Not showing appropriate concern for problems voiced by the patient
- Not pausing to listen to the patient
- Not verifying that the patient has understood the information presented
- Using an impersonal approach or displaying any degree of apathy in communications
- Not becoming sufficiently available to the patient

Figure 2. Communication traps to avoid.

The physician, however, should not interpret this nonreaction as a lack of patient concern or worry. In some cases, these same individuals go on to exhibit distress by other means (eg, an increased reporting of physical symptoms, additional non-verbal communication of pain, or other behaviors aimed at gaining the attention of the treatment team).

At the other end of the emotional spectrum, the sizable proportion of patients with mild or diagnosable depression and/or anxiety will likely react to bad news with frank displays of crying, denial, or anger.

A small percentage of patients who have difficulty forming a trusting relationship with a physician may react to bad news with distrust, anger, and blame. For such patients, establishing a lasting bond of trust with their physicians can be extremely difficult, and although all attempts to communicate should be made, unsettled feelings on both sides are to be expected.

In responding to any of these patient reactions, it is important to be prepared. The first step is for the physician to recognize the response, allowing sufficient time for a full display of emotions. Most importantly, the physician simply needs to listen quietly and attentively to what the patient or family are saying. Sometimes, the physician can encourage patients to express emotion, perhaps even asking them to describe their feelings. The physician's body language can be crucial in conveying empathic concern in these encounters.

The patient-physician dialogue is not finished after discussing the diagnosis, tests, and treatments. For the patient, this is just a beginning; the news is sinking in. The physician should anticipate a shift in the patient's sense of self, which should be handled as an important part of the encounter—not as an unpleasant plot twist to a physician's preferred story line.

Conclusion

Simple choices in words, information depth, speech patterns, body position, and facial expression can greatly affect the quality of one-to-one communication between the patient and physician. To a large degree, these are conscious choices that can be learned and customized by the physician to fit particular patients in clinical situations. Avoiding communication pitfalls (Figure 2) and sharpening the basic communication skills previously suggested can help strengthen the patient-physician bond that many patients and physicians believe is lacking.

These skills are not wholly formed on graduation from medical school or completion of medical residency. Strengthening one's communication skill set takes time and ongoing practice. A reminder of the most fundamental elements of communication, as found in this article, may be helpful and lead to more productive patient-physician encounters and better overall clinical outcomes.

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