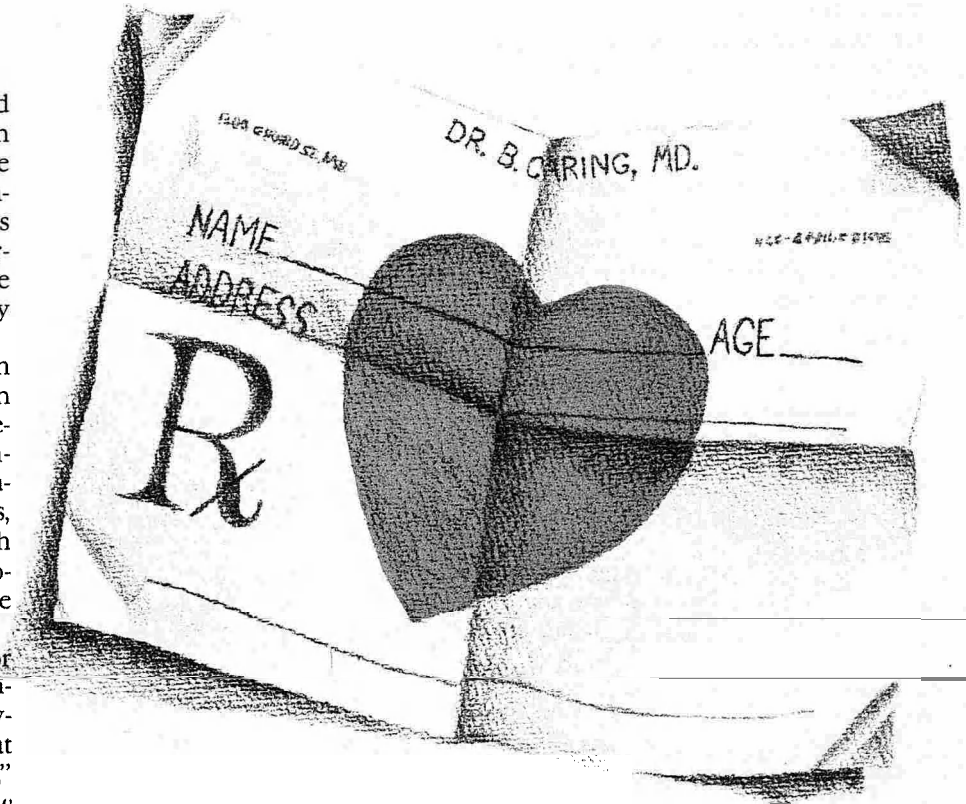
Rx for Better Doctors

By Bernard L. Rosenbaum

Many doctors are appallingly bad at listening to patients and explaining diagnoses and treatments. The prescription is communications training for physicians and medical students.



Medical education in the United States suffers from a deficiency in communication-skills training. Despite the proven importance of physician-patient communication, many doctors possess only rudimentary interpersonal skills, and are appallingly unable to ascertain the effects of what they say on their patients.

In 1984, the Association of American Colleges proposed sweeping reforms in medical education. Among them: replace the traditional "information-intensive" approach to medical education with a focus on acquiring skills, values, and attitudes, and place as much emphasis on developing caring professionals as on creating knowledgeable and highly skilled practitioners.

Communication skills, especially for patient interviews, should be an integral part of that reform. "Interviewing is a core clinical skill, one that determines a physician's competence," writes Dr. Mark Lipkin Jr. in the *New York Times*. But, he adds, most are not doing this well." Lipkin is director of the National Task Force on Medical Interviews.

Failing to interview and communicate well can directly affect diagnostic accuracy, treatment decisions, patient compliance, rehabilitation, and overall patient satisfaction. A number of studies make that clear:

■ In a study of 800 pediatric visits in a hospital outpatient clinic, one-quarter of the mothers said they didn't have a chance to mention the problems most on their minds, one in five felt she wasn't given a clear explanation of what was wrong with her child, and half were unsure of what had caused their children's illnesses.

■ A University of Manchester, England, study of 75 women who were receiving radiotherapy following mastectomies found 19 women with signs of clinical depression within a year of the operation and 25 who had developed sexual problems. But fewer than half of the depressed women were diagnosed as such by their own physicians, and in no cases were the sexual problems recognized.

■ More than three-quarters of the doctors studied by Bonnie Ivorstead at the University of Wisconsin failed to give understandable instructions, and most of the patients made at least one error in understanding their doctors' advice on medications.

■ A significant determinant of how well patients adjusted to surgery was the personal impact of information their physician had given them, reports Dr. Steven Auerbach at Virginia Commonwealth University. He concludes that perceptions of interpersonal support and caring can critically influence patient adjustment and ability to cope with life-threatening surgery.

■ A physician's feelings about a patient, the illness, the role of the sick person, and the doctor's own role all

Rosenbaum is president of MOHR Development Inc., 30 Oak Street, Stamford, CT 06905.

influence diagnostic accuracy, treatment decisions, and the doctor's style of communicating with the patient, note Dr. Richard Gorlin and Dr. Howard P. Zuchner in a May 1983 article in the *New England Journal of Medicine*. At times, those attitudes determine the outcomes, they say.

■ In a study of 74 office visits, only 23 percent of the patients were provided the opportunity to complete an opening statement of concerns. In 69 percent of the visits, the physicians interrupted the patients' statements and directed questions toward specific concerns. That controlling style of communication resulted in the loss of relevant information, says the study, which appeared in 1984 in the *Annals of Internal Medicine*.

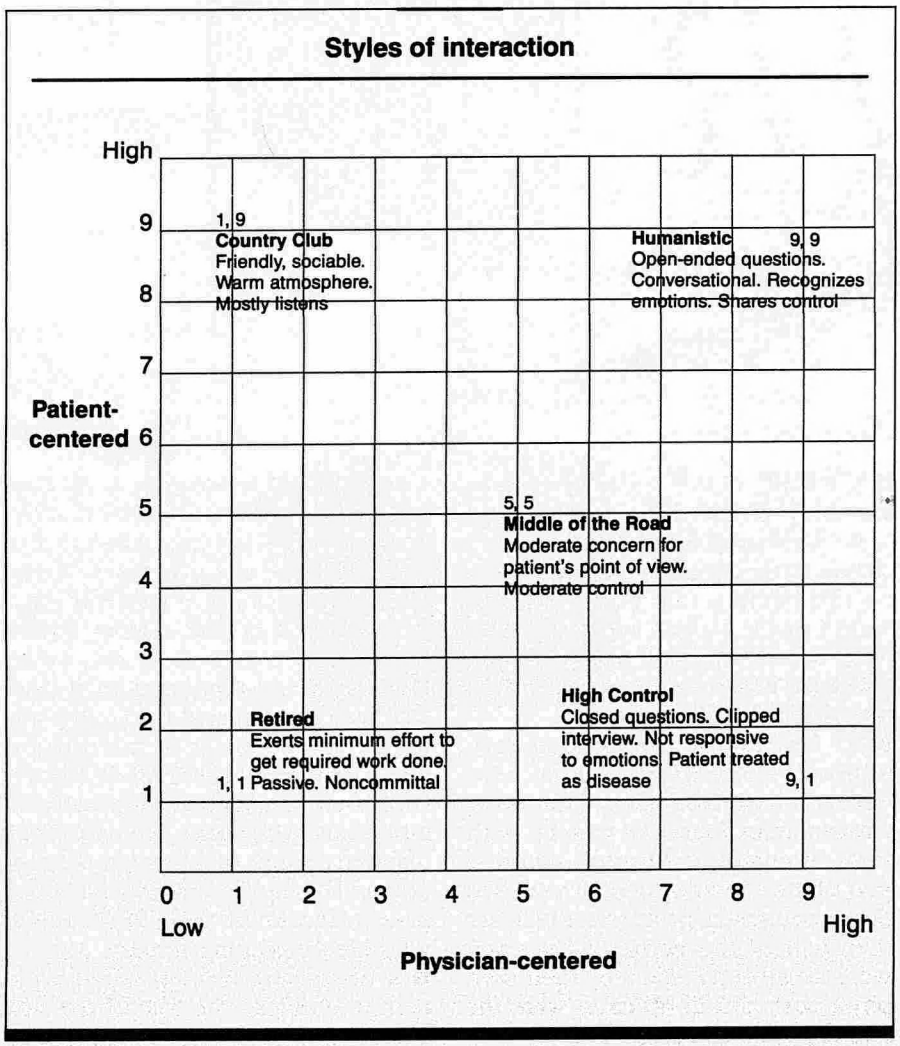
Styles of interaction

Before discussing a program to improve physicians' communication skills, it helps to examine the range of interaction styles.

In a survey of 2,500 medical interviews conducted by British, Dutch, and Irish physicians, researchers in Manchester found a range of styles, from physician-centered to patient-centered. Graphing the styles on a nine-point grid, in much the same way as Blake and Mouton have done with management styles, yields five distinct approaches to patient communication. The figure displays the grid and the placement of five approaches.

For example, doctors who are neither very patient-centered nor very physician-centered (1,1 on the grid), exert minimal effort in the relationship and are passive and noncommittal. At the opposite end of the spectrum (9,9) are "humanistic" doctors, who are both highly patient-centered and highly physician-centered. They question their patients in an open-ended manner, avoid jargon, seek clarification, and encourage patients to participate in decision making.

As reported in the November 1986 *Psychology Today*, the study indicates that patients are more satisfied and more likely to adhere to medication or behavior-modification programs if their doctors take the "humanistic" approach. Naturally, circumstances may require high control (9,1) or an extra measure of warmth and a minimum of direction (1,9). But overall, the "9,9" doctor achieves the best patient-care results.



Critical communication skills

Communication skills also may be tied to professional performance. Research by MOHR Development found that high-performing technical professionals, including scientists, engineers, and systems analysts, were significantly stronger in "people skills" than their less successful colleagues.

Nine specific skills, clustered into three groups, emerged from the investigation.

First are the three "tracking" skills, which allow the physician to stay on the patient's wavelength:

■ reading cues—recognizing and accurately assessing a patient's reactions to see if patient and physician are both "on track" and to decide on treatment;

■ emphasizing—listening and confirming to understand what the patient is saying and how he or she feels;

■ testing for acceptance—stopping to test reactions to the patient's statements or actions if cues are unclear.

Next are persuasive skills:

■ clarifying needs—identifying the patient's perceived and unperceived needs and concerns through skillful questioning;

■ communicating benefits—making appropriate statements that show the patient how a procedure will benefit him or her;

■ gaining commitment—asking for the patient's commitment to comply with treatment procedures;

The "shaping" skills are used to guide a patient gently in a specific direction:

■ reinforcing desired responses—encouraging desired patient responses by acknowledging or agreeing with them, and then expanding on them;

■ creating need awareness—making the patient aware of the importance of an unperceived need so that he or she is willing to consider appropriate treatment;

■ handling objections—removing obstacles blocking the path to patient commitment.

Teaching interpersonal skills

How many medical schools teach future doctors effective communication skills? Very few, says Lipkin of the National Task Force on Medical Interviews: "Although 120 of 138 medical schools say they are teaching communication skills, a great many of them do a very poor job."

The opportunity to convey such skills is not lost once the physician's schooling is complete. While some physicians are psychologically inaccessible, say Gorlin and Zuchner, most want to develop more comfortable relationships with their patients. Role modeling, the authors point out, is an effective tool in teaching complex interpersonal behavior.

Role modeling, like any training that uses observational learning or behavior modeling, contrasts with the passivity of textbook and lecture-hall education, since immediately relevant experiences are more readily remembered and reproduced. Behavior modeling is based on a fundamental learning principle: once shown an example of effective behavior and given the opportunity to practice it in a reinforcing environment, people are better-equipped to adopt the behavior to their own use.

The American Board of Internal Medicine agrees. Commenting on the role of "attendings," or senior physicians who act as mentors to less-experienced colleagues, ABIM explains the learning process:

"Residents will find their understanding of the words 'integrity,' 'respect,' and 'compassion' enhanced by exposure to physicians who demonstrate sincere concern and caring for the patient. Going to the bedside and being available to talk with the patient, patient's family, and the resident characterize the role of the attending.

"It must be noted that a role model is one who is not merely observed and emulated by others, but also one who can and will explain why and how he or she reacts in various clinical situations. Role models are often identified by quiet strength in hectic emergencies and their judicious decisions even when situations are complex or unclear. It is not uncommon for junior housestaff to consider their immediate senior residents as role models and for medical students to follow the example of their interns."

But the ABIM approach is unstructured and vulnerable to chance events. The learning experience must be formalized by including models that ensure the demonstration of interpersonal competence in realistic medical activities: taking a history, telling a patient the prognosis for a chronic disease, and conducting pre- and post-operative discussions.

Such modeled behaviors can be demonstrated on videotape. Observational learning then provides guided skill practice, feedback and reinforcement, transfer of training to patient interactions, and reinforcement from senior staff.

Just as that learning design has improved the interpersonal skills of hundreds of scientists working in industry, it can develop physicians who are highly competent, caring, and personally effective. In that way, the training and development profession, with its expertise in instructional design, can resuscitate the human side of medical education.