

Quality Assurance Methodology Refinement Series

Improving Interpersonal Communication Between Health Care Providers and Clients

By

Bérengrère de Negri

Lori DiPrete Brown

Orlando Hernández

Julia Rosenbaum

Debra Roter



Quality Assurance Project
7200 Wisconsin Avenue, Suite 600
Bethesda, MD 20814 USA
301/654-8338, FAX 301/941-8427
www.urc-chs.com

Contents

Part 1

A Conceptual Framework for Interpersonal Communication

I. Introduction	7
II. Background	9
III. Why Is Interpersonal Communication (IPC) Important?	10
IV. What Are the Characteristics of Effective IPC?	10
V. Guidelines and Norms for Effective IPC	15
VI. Planning and Implementing Training Activities	20
VII. Case Studies	25

Part 2

Case Studies

- A. Honduras
- B. Trinidad and Tobago
- C. Egypt

Appendices

- A. Job Aid
 - B. Training Manual for IPC (Egypt)
 - C. Training Manual for IPC (Trinidad and Tobago)
 - D. Training Manual for IPC (Honduras)
 - E. Data Collection Tools
 - Instrument 1: The Roter Interaction Analysis System (RIAS)
 - Instrument 2: Health Provider's Observation Check List
 - Instrument 3: Physician Questionnaire
 - Instrument 4: Patient Exit Interview (English)
 - Instrument 5: Patient Exit Interview (Spanish)
 - F. Annotated Bibliography
-



Part 1

A Conceptual Framework for Interpersonal Communication





Improving Interpersonal Communication Between Health Care Providers and Clients

I. Introduction

Effective interpersonal communication (IPC) between health care provider and client is one of the most important elements for improving client satisfaction, compliance and health outcomes. Patients who understand the nature of their illness and its treatment, and who believe the provider is concerned about their well-being, show greater satisfaction with the care received and are more likely to comply with treatment regimes. Despite widespread acknowledgement of the importance of interpersonal communication, the subject is not always emphasized in medical training.

Over the past 30 years substantial investments have been made to enhance access to basic health services in developing countries. However, there have been relatively few studies that investigate the quality of the services delivered, and fewer still that study the quality of interpersonal communication.¹ The quality of care research that has been done shows that health counseling and provider-client communication are consistently weak across countries, regions and health services.² Even when providers know what messages to communicate, they do not have the interpersonal skills to communicate them most effectively. They often do not know how to communicate with their patients. Despite widespread acknowledgement of the critical importance of face-to-face communication between client and provider, there are few rigorous studies of health communication in developing countries.³

Evidence of positive health outcomes associated with effective communication from developed countries is strong. Patient satisfaction, recall of information, compliance with therapeutic regimens and appointment keeping, as well as improvements in physiological markers such as blood pressure and blood glucose levels and functional status measures have all been linked to provider-client communication.⁴ Thus, experience in the developed world has shown that providers can improve their interpersonal skills, leading to better health outcomes. The research described here explores whether these findings are valid and replicable in the developing countries.

-
- 1 Roemer MI, Montoya-Aguilar C. Quality assessment and assurance in primary health care. Geneva: WHO Offset Publication, 1988.
 - 2 Nicholas DD, Heiby JR, Hatzell TA. The Quality Assurance Project: introducing quality improvement to primary health care in less developed countries. *Quality Assurance in Health Care* 1991, 3(3):147-165.
 - 3 Loevinsohn BP. Health Education Interventions in Developing Countries: A Methodological Review of Published Articles. *International Journal of Epidemiology* 1990 Dec:19(4):788-794.
 - 4 Hall J, Roter D, and Katz N. Correlates of provider behavior: a meta-analysis. *Medical Care* 1988 26:657-675.

Unfortunately, effective communication does not always occur naturally, nor it is easily acquired. Even when client and provider come from the same geographic area and speak the same language, they often have different educational, socio-economic and cultural backgrounds. Moreover, their expectations about the health encounter may be different, or they may be faced with other problems, such as lack of privacy during the encounter, or time constraints due to heavy patient loads.

Better communication leads to extended dialogue which enables patients to disclose critical information about their health problems and providers to make more accurate diagnoses. Good communication enhances health care education and counseling, resulting in more appropriate treatment regimes and better patient compliance. Effective interpersonal communication also benefits the health system as a whole by making it more efficient and cost effective. Thus, clients, providers, administrators and policy makers all have a stake in improved provider-client interactions.

This monograph discusses the importance of IPC as a tool for improving health care outcomes in developing countries and describes techniques for enhancing provider communication skills. It also provides a job aid and several data collection instruments that can be used in various settings. Our field experiences in Honduras, Egypt and Trinidad, described later in the text, suggest that test results in developed countries are valid and replicable in developing countries. Therefore, we hope that our findings will serve as useful models for implementing future interpersonal communication programs, and that the monograph will help interested health care policy makers and practitioners improve the quality of health care in their facilities through improved interpersonal communication. The monograph can serve as:

- ◆ an introductory overview on provider-client communication skills
- ◆ a framework for assessing IPC skills
- ◆ a guide for developing IPC training activities
- ◆ a resource describing important IPC experiences in selected developing countries.

Because each health care setting requires locally-appropriate strategies, the guide provides only a general framework for action, leaving health care policy makers, managers and providers to develop their own analyses and interventions. Therefore, we encourage readers to modify the content of the monograph as needed and to develop locally-appropriate examples for training and other IPC interventions.

II. Background

The research and training activities reported here were carried out by an inter-disciplinary team of experts in health service delivery, counseling, health communication and training. Our effort began with a literature review⁵ to assess current knowledge on client-provider communications in both developed and developing countries, and to identify the critical issues that needed to be addressed in developing countries.

Following the literature review, we developed a set of IPC guidelines for health care providers.⁶ The guidelines drew on counseling and IPC themes found in the professional literature and on insights gained from the cross-cultural field experiences of our team.

After preparing a preliminary set of guidelines, we developed the format and materials for provider training workshops based on cross-cultural insights into IPC. We found that provider-client communication problems exist worldwide, and that several principles about good communication can be generalized. We expect that IPC improvement initiatives could build on universal principles to develop effective solutions that take into account local socio-cultural factors and resources at hand.

Accordingly, we field-tested our materials in three different developing country settings and collaborated with local health care providers to tailor the IPC guidelines and training course to local socio-cultural environments. Collaboration in Honduras, Trinidad and Egypt enabled us to refine the guidelines and test our methods for training providers on how to apply the guidelines. Following each workshop, we conducted evaluation and observation surveys among trainees to gauge training effectiveness. We found that providers could improve IPC practices with patients in small but important ways, to the greater satisfaction of all parties.⁷ For the most part, physicians were willing to apply IPC skills once they were convinced that use of the techniques would not necessarily lengthen medical visits and that concrete skills could be mastered through short training programs that emphasized practical approaches. A detailed description and analysis of the three country programs is presented later.

5 Quality Assurance Project Working Group on Counseling and Health Communication “Annotated Bibliography” April 1992, Bethesda, MD. (See Appendix F)

6 It is important to acknowledge that both clients and providers contribute to successful communication in medical encounters. While it would be possible to intervene on either side of this relationship, we have chosen to focus on health care providers, since most providers do not currently have, or practice, many of the basic communications skills that would enable them to carry out their responsibilities efficiently and cost-effectively. We recognize that it would also be important to work with health care clients, to help them become aware of their rights, to encourage them to ask questions, and to familiarize them with basic information that allows them to take full advantage of the health care system. Such interventions are outside the scope of this monograph, but are considered by the researchers to be vital topics for future research.

7 DiPrete Brown, Lori, et al. “Training in Interpersonal Communication: An Evaluation of Provider Perspectives and Impact on Performance in Honduras”; March 1995; Quality Assurance Project, Bethesda, MD. (Included here as Case Study A)

III. Why Is Interpersonal Communication Important?

IPC is important because it leads directly to better health outcomes. A pathway is clearly established which links processes, such as the way health care providers communicate, to proximate outcomes, such as patient satisfaction and recall, to final outcomes, such as client compliance with treatment regimes and improved health results. Hence, our emphasis on the importance of improving provider communication skills. Figure 1 illustrates a system linking communication processes with short-term, intermediate and long-term outcomes.

As can be seen in Figure 1, the communication context is shaped by the socio-demographic characteristics of the patient and provider, as well as by the environment in which the communication takes place. The age, sex, ethnicity, and educational background of providers and clients affect how they communicate with each other. Other factors such as degree of privacy, time allotted for encounters, comfort and cleanliness of the clinic, and treatment of clients from the time they enter the clinic until they are seen by a provider, can also inhibit or enhance client-provider interaction.

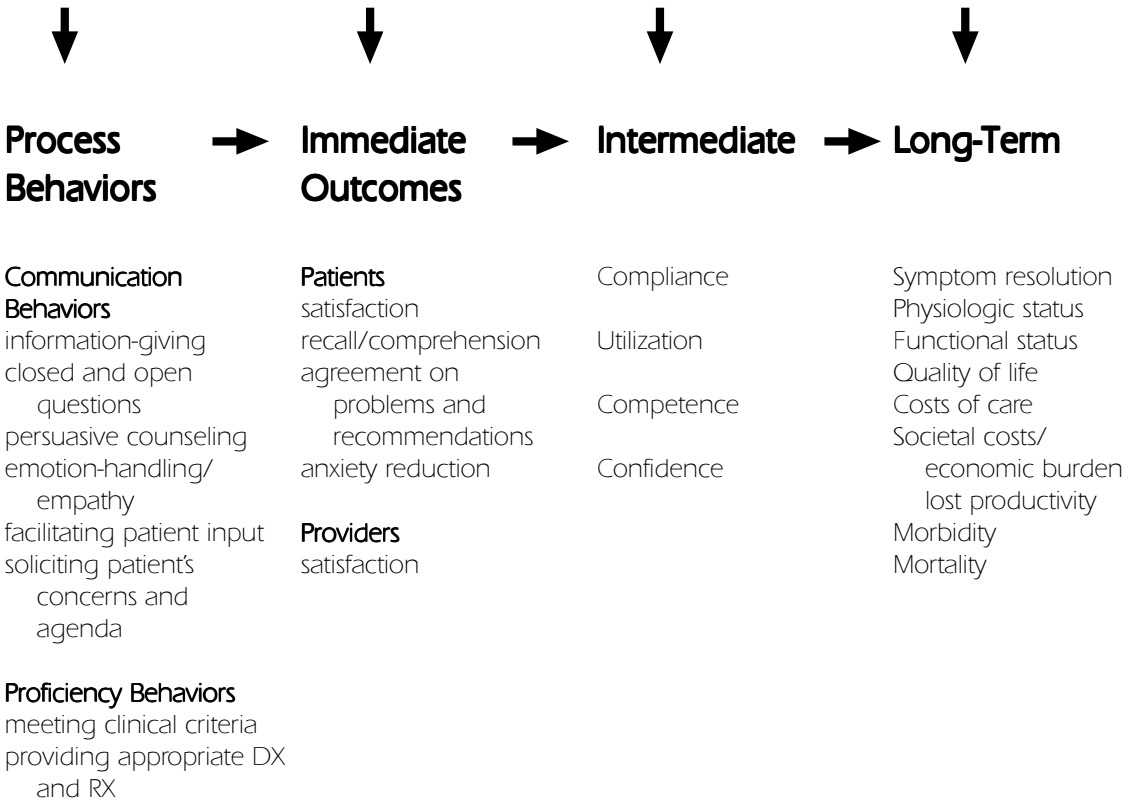
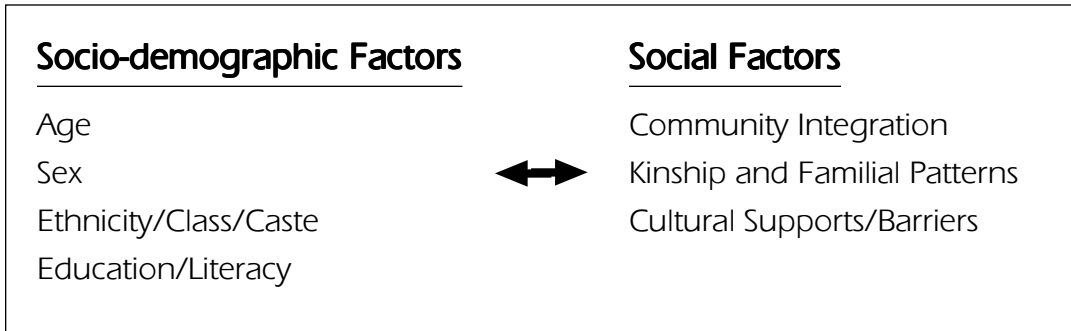
While many of these socio-demographic and environmental factors are beyond their control, providers can improve IPC practices in their own clinics by adopting specific behaviors and techniques which lead to distinct positive outcomes. In the short-term, improved communication leads to more effective diagnosis and treatment of health problems; in the medium-term, to greater compliance with treatment programs, better utilization of services, and enhanced feelings of awareness and confidence for both client and provider; in the long-term, to greater relief of symptoms, enhanced prevention and reductions in morbidity and mortality. In some cases, overall health care costs are also reduced.

IV. What Are the Characteristics of Effective IPC?

IPC is effective when it leads to the following five outcomes: 1) the patient discloses enough information about the illness to lead to an accurate diagnosis; 2) the provider, in consultation with the client, selects a medically appropriate treatment acceptable to the client; 3) the client understands his or her condition and the prescribed treatment regimen; 4) the provider and the client establish a positive rapport; 5) the client and the provider are both committed to fulfilling their responsibilities during treatment and follow-up care.

The above outcomes, however, do not describe the steps in the **process** of effective communication. These steps generally include encouraging a two-way dialogue, establishing a partnership between patient and provider, creating an atmosphere of caring, bridging any social gaps between provider and client, accounting for social influences, effectively using verbal and non-verbal communication, and allowing patients ample time to tell their story.

Figure 1: Organizing Framework for Studying the Effects of Provider Communication



Two-way Dialogue

Good interpersonal interaction between client and provider is, by definition, a two-way street where both speak and are listened to without interruption, both ask questions, express opinions and exchange information and both are able to fully understand what the other is trying to say.

Partnership Between Provider and Client

Providers and clients should view health care as a partnership in which each party contributes to maximize end results. Mutual respect and trust and joint decision-making will result in a greater likelihood of a positive outcome. Both provider and client must realize that, even though the provider is the medical expert, both are responsible for the outcome of their interaction. The patient must disclose all relevant information in order for the provider to determine a proper diagnosis and treatment; the provider must interpret and analyze the information received and effectively explain the condition and treatment options to the patient. Both should make decisions about treatment regimes, with the client making every effort to comply with the prescribed treatment and any necessary lifestyle changes the treatment implies. Providers should foster an active role for patients in their care and treatment. Providers should encourage active questioning and interaction during office visits and should involve patients in their own health care regimes.

Atmosphere of Caring

Patients need to believe that their provider cares about them and is committed to their welfare. Both verbal and non-verbal communication help the provider convey interest and concern to patients. Being attentive, making eye contact, listening and questioning thoughtfully, and demonstrating understanding and empathy make patients feel important and worthy. On the other hand, being brusque or appearing busy or distracted makes patients feel insecure, anxious or fearful of their relationship with the provider.

Effective Bridging of Social Distance

Social distance refers to the socio-cultural-economic factors that make people feel they belong to different class tiers. Education, economic status, class, race or ethnicity, gender and age may all contribute to how close or distant two individuals feel about each other. For example, an illiterate peasant woman and a young, highly trained, city-dwelling male physician who share the same language and were raised within miles of each other are still worlds apart socially. Clients bring to medical visits a whole range of emotional, socio-cultural, economic, educational and psychological traits that affect communication. Social distance should not impede good communication, and providers must realize that many people, even those in their own circles, may not be conversant with their “language.” Therefore, they should strive to bridge any social gap that might exist between them and their clients and establish an open dialogue, a partnership and an atmosphere of caring. Clients must also do their part to bridge the social distance by being candid and communicative.

Social Networks

Social networks refer to those interpersonal relationships that bind people together. Typically consisting of family, friends, acquaintances, neighbors and colleagues, social networks influence differently—depending on the individual and his or her environment—a person’s desire and ability to understand and comply with professional advice. For example, in some societies the mother or mother-in-law is key decision-maker in the extended family. Therefore, teaching the young woman about the benefits and methods of birth spacing may be ineffective if her mother or mother-in-law is uninformed or opposed to this practice. Similarly, in a home where a woman cooks for the whole family, dietary recommendations that could enhance her health may not be put into effect if they interfere with the family’s culinary customs and tastes.

Effective Use of Verbal Communication

Verbal communication consists of spoken and written words people use to convey ideas. In a health care encounter, the choice of words clients and providers use greatly influences how well they understand each other. The medical jargon physicians use to describe symptoms and treatments allows them to communicate clearly and precisely with other clinicians. However, because the scientific and clinical terms may be confusing to patients, the use of such terms with patients is inappropriate.

Patients communicate during medical visits in their particular dialects, accents, cadences and slang, often making comprehension difficult for providers from other parts or regions of the country. Patients also describe health problems in peculiar ways, often reflecting their unique

Use Simple Language

Medical jargon	The clinical spectrum of cholera is broad, ranging from inapparent infection to severe cholera gravis, which may be fatal in a short time period. After an incubation period of 6 to 48 hours, there is an abrupt onset of watery diarrhea. Vomiting often follows in the early stages of the illness. Signs of severity include cyanosis, tachycardia, hypotension, and tachypnea. The symptoms and signs of cholera are entirely due to the loss of large volumes of isotonic fluid and resultant depletion of intravascular and extracellular fluid, metabolic acidosis, and hypokalemia.
-----------------------	--

Simple explanation	Not all persons that get cholera look equally sick. Some cholera patients seem to have a minor illness, while others look very sick. Some others can even die after hours of getting cholera. Because cholera germs spread within 6 to 48 hours of entering the body, the person may suddenly have a lot of watery diarrhea. Many patients also begin to vomit. When the sick person is getting worse, his skin can become blue (especially at the lips, nose, and fingertips), he may begin to breathe quickly, his heart works very rapidly, and blood pressure drops. All this happens because the body has lost a lot of liquids and minerals through diarrhea and vomiting. The body cannot survive when it loses too much liquid and minerals.
---------------------------	--

perspective on the illness' origin or severity. Sometimes local perceptions can influence the way a patient describes the illness' onset and symptoms. For example, if diarrheal diseases are common in their area, patients may not report symptoms of the disease unless they are quite severe. Because they view the symptoms as routine, patients simply neglect to mention them. For the provider, however, detection of early symptoms, even mild ones, is important in making proper diagnoses and developing appropriate treatment regimes.

Effective Use of Non-verbal Communication

Words express only part of a message being conveyed; tone, attitude and gestures convey the rest. Avoiding distractions, such as answering the telephone during a patient's visit or scribbling notes on other cases, and appearing fully attentive communicate positive messages to clients. Smiling, listening thoughtfully, sitting on the same level as the patient also enhance interaction. Much non-verbal communication is specific to cultural customs. For example, while in some cultures direct eye contact is a sign of positive regard and respect, in others it is deemed improper or aggressive, particularly with members of the opposite sex. Also, while in some cultures physical contact during a conversation is considered a sign of affection, in others it might be construed as highly improper. What is important to remember is that all forms of non-verbal communication convey a message.

Often, simple gestures by the provider, such as a warm greeting or a thoughtful question, can help put the client at ease and enhance communication. Such actions do not require great effort but can have significant results. Following is an example of non-verbal communication conveying a positive message.

Non-verbal Communication

Dr. Green is seated behind a desk when Mrs. Sierra enters the examining room. He stands, greets her warmly by saying "Good morning, Mrs. Sierra" and walks to the other side of his desk, where there are two chairs. He offers one chair to Mrs. Sierra and sits in the other. He leans forward and, with his full attention on his new patient, he thoughtfully asks, "How can I help you today?"

Non-verbal communication can have as great an impact as verbal communication but can be more easily misinterpreted. Thus, it is important for health care providers to be aware of the non-verbal messages they convey to their patients and of those their patients convey to them.

Opportunity for Patients to Speak About Their Illness

The medical visit should provide ample opportunity for a patient to describe his or her illness. Storytelling has its own healing value in that it provides patients with a release and opportunity for insight and perspective. It may also afford the health provider the insights needed to understand, interpret and explore the significance of the symptoms and clues the

patient provides. A patient's comprehension and feelings about a medical problem may be extremely important in prescribing appropriate treatment. A great deal of distress, for example, may stem from a patient's perception about the seriousness of his or her illness, not from its actual seriousness. Providers should not minimize a patient's anxieties, but strive to alleviate them.

All of the factors described above have been shown to enhance communication between patient and provider. However, the fact that providers follow individual approaches increases the complexity of formulating a communication skill program. To change provider behavior in concrete ways, the above factors must first be broken down into concrete skills and behaviors as illustrated in the following guidelines.

V. Guidelines and Norms for Effective IPC

Our research and analysis of effective IPC has led us to develop a set of guidelines and norms for health care providers. While these norms should be further tested, refined, and validated, we are confident that the issues and skills presented here are both useful and valid in improving IPC. We define three types of IPC.

- ◆ **Caring/socio-emotional communication:** The objective of caring or socio-emotional communication is to establish and maintain a positive rapport with the patient throughout the encounter. This is an integral part of all IPC and enhances patient disclosure and compliance.
- ◆ **Diagnostic communication/problem solving:** The objective of diagnostic communication is for the patient and provider to share all the information needed for accurate diagnoses and appropriate treatment prescriptions.
- ◆ **Counseling:** The objective of counseling is to ensure that clients understand their condition and treatment options. Counseling helps them to follow treatment regimens and behavioral change recommendations, by ensuring that these are comprehensible, acceptable, and feasible. Counseling emphasizes making decisions together with the client and helping solve actual or anticipated problems.

A provider should convey expressions of caring at the outset of the encounter when rapport with the client is being established; rely on diagnostic or problem solving techniques during the history taking portion of the encounter; and use counseling skills at the end of the encounter to explain treatment and provide health education. However, all three approaches may be applicable throughout the encounter.

Within the broad category of each approach, specific communication techniques or behaviors can be identified which can improve IPC. These and related examples are presented in the following section.

Caring

A caring behavior emphasizes respect for patients and recognition that their concerns are important. Health care providers should display caring throughout the medical encounter in order to establish a trusting relationship and good rapport with the patient.

- ◆ **Frame the encounter** — Set the tone for the interaction by greeting clients in culturally appropriate ways that communicate openness and concern. For example, the provider might frame an encounter by saying “Good morning Mrs. N., my name is Dr. N.. I’d like you to feel free to tell me about any health concerns you have.”
- ◆ **Use appropriate non-verbal communication** — Be sure your posture, eye contact, gestures, tone of voice, manner and attitude are appropriate and conducive to dialogue with the client. For example, a provider who is scribbling notes on a chart when a patient enters, might put down the pen, close the chart, and stand up or lean forward as he greets the patient. This shows the patient that he or she has the provider’s full attention.
- ◆ **Solicit feelings** — Invite patients to talk about how they feel, both physically and emotionally. A provider might ask a patient who is describing symptoms of her headaches, “How do the headaches make you feel? How do they affect your other activities?”
- ◆ **Show positive regard** — Show clients, explicitly and implicitly, that they are respected and valued. For example, a provider might show positive regard for a patient by being courteous, smiling, asking the patient whether he or she is satisfied with the care received so far, or complimenting the patient’s efforts in seeking medical assistance or following treatment recommendations. Positive regard is especially important when dealing with conditions that may have a social stigma attached to them, such as tuberculosis and AIDS. It is also helpful to bridge any social distance between provider and client that might be based on age, sex, social and educational status, race, religion, or ethnicity.
- ◆ **Validate the patient’s experience and efforts** — Recognize the patient’s experience and efforts in an honest and straightforward manner. This may be done through statements of concern, empathy or legitimizing that show the provider cares about the patient and his or her problem. For example, when dealing with a hypertensive patient who does not take his or her medicine regularly, a provider might say, “I’m concerned that you’re not taking care of yourself.” This is likely to be more effective than scolding. Statements of empathy show that the provider understands and shares the patient’s feelings. Legitimizing statements validate the patient’s feelings. For example, a provider might tell a patient who is nervous about surgery, “I understand that you are worried about this operation,” or when counseling a cancer patient, a provider might say, “It’s easy to understand why you feel afraid and angry. Most people in your situation feel the same way at first.”

-
- ◆ **Echo patients' emotions** — Help patients express their feelings by echoing them. For example, when a patient says “I’ve been feeling very depressed lately,” the provider might respond with “It sounds like something is really getting you down.” This technique provides the patient with an invitation to elaborate further on the topic.
 - ◆ **Express support and partnership** — Let clients know you will work with them to help them get better. A provider might say, “I’m going to use all my skills and expertise to help you get better, and I’m counting on you to do your part to take care of yourself.”
 - ◆ **Give reassurance** — Encourage and reassure clients about the outcome of their condition. For example, a midwife might say to a patient, “I know you’re feeling a lot of pain and anxiety right now, but tomorrow you’ll feel much better, and you’ll have a new baby to take home with you.” In reassuring patients, it is important to be honest and realistic about the medical prognosis and to avoid premature or unjustified reassurance.

Diagnosis and Problem Solving

These skills help health care providers gather critical information for diagnoses. Use of data-gathering skills enables them to improve their accuracy and effectiveness in performing this function. The skills involve a variety of questioning techniques designed to encourage the patient to talk about all aspects relevant to the problem.

- ◆ **Listen attentively and actively** — Use gestures to show patients they have your full attention and ask relevant questions to indicate your understanding of what they say. You may want to face patients and nod or comment occasionally as they describe their medical condition.
- ◆ **Encourage dialogue** — In addition to yes/no questions, ask patients open-ended questions that encourage them to provide details about their problem. Often, one open-ended question will elicit a response that covers several yes/no questions. For example, instead of asking a patient “Do you have a fever? Do you get headaches? Are you nauseated?” You may simply say “Tell me about any pain and discomfort you’ve been feeling.” Once the patient describes the condition, you might need to ask one or two yes/no questions to supplement the information.
- ◆ **Avoid interruptions** — Do not interrupt patients when they are speaking. Wait until they have finished their thought before asking a new question. Also, avoid being interrupted by the telephone or other distractions during a patient’s visit.
- ◆ **Avoid premature diagnosis and resist immediate follow-up** — Wait until you have listened to the patient’s full story and have asked all the relevant questions before determining a diagnosis and treatment. The patient’s first complaints are not always the most important ones. Hasty conclusions can lead to diagnostic

error. For example, when a patient reports headache pain, resist the urge to immediately assume the ailment is minor and to prescribe pain relief drugs. Instead you might say “Tell me more about how you’re feeling.” Often, a simple cure for headaches is all that is needed, but at other times the client might respond, “I’m so worried and upset, there are times when I don’t feel like getting out of bed and feel like I could die.” Such a case warrants further inquiry into the psychological and physical causes of the condition.

- ◆ **Probe** — Encourage patients to provide more information by asking questions or inviting them to continue speaking. For example, the provider might use phrases like “Tell me more” or “Please go on” to help patients delve deeper into the nature of their problem and their reaction to it.
- ◆ **Ask about causes** — Help patients share more information about their condition by asking their opinion on the causes of the ailment and what they think might help them. This technique will provide information needed to make a diagnosis and help providers evaluate the patient’s understanding of the illness.

Counseling and Education

These skills enhance providers’ ability to explain to patients their conditions, the circumstances of their illness, diagnoses and treatment options. Providers should remember that patients’ compliance with treatment regimes depends on how well they understand the nature of their illness and how they feel about the prescribed treatment.

- ◆ **Explore patient understanding** — Find out patients’ opinions of their illness by asking how they contracted it, whether they had the problem before and what they did about it at that time. For example, if a mother is seeking care for a child with diarrhea, the provider might ask, “How do you think children usually get diarrhea?” “How do you think your child got it?” “How did you take care of it in the past?”
- ◆ **Correct misunderstandings or misinformation** — Sometimes clients hold inaccurate notions about the etiology or effects of a disease, which can affect their behavior toward treatment and adversely impact on their recovery. Providers should determine a patient’s understanding of his or her problem, and politely correct any misconceptions the client may have. For example, a provider might say, “While many people believe that taking the birth control pill right before intercourse will be effective, that’s incorrect. You need to take the pill every day, whether you are going to have sex or not.” Providers should be careful not to make the client feel uneasy or inadequate for having inaccurate ideas or information, and should strive to educate by providing appropriate information.
- ◆ **Use appropriate vocabulary** — Providers should avoid using jargon or technical language when speaking with patients, making instead every effort to use terms that are meaningful to patients. For example, instead of asking “Have you

had any respiratory difficulties lately?” the provider might say, “Have you had any difficulty breathing lately?” or “Tell me about your breathing?”

- ◆ **Present information in blocks** — It is important to present information in a way that the patient can easily absorb and remember. Providers should explain the diagnosis in a clear and comprehensible fashion, never in a condescending or patronizing manner. Subdividing the information into separate categories may help this process. Presenting separate blocks of information sequentially, enables the provider to monitor for understanding and absorption before moving on to the next block. This kind of presentation helps patients internalize the information presented and enhances the likelihood of effective compliance with the treatment prescribed. For example, the provider may address and sequentially convey brief information on the following topics:
 - name of the disease and its etiology
 - recommended treatment for the patient
 - ways to prevent recurrence of the disease
 - other relevant information.

- ◆ **Use visual aids and/or printed materials when possible** — When conveying information to patients on diseases, preventive or treatment programs, or medical devices, it is often helpful to refer to a visual display. Visual aids help patients better understand and remember the information provided. It is also helpful to make use of pamphlets with simple text and pictures about important health problems, their prevention, and their treatment.

- ◆ **Recommend concrete behavioral changes** — After making a diagnosis and prescribing a treatment regime, providers may recommend certain behavioral changes to their patients that would prevent the illness from recurring. These recommendations should take into consideration the patient’s ability to implement them. Rather than simply emphasizing the end results of the behavioral change, providers should identify and suggest specific steps in the behavioral change. For example, instead of telling a hypertensive patient that he needs to lose 30 pounds, the provider might say, “I’d like you to try to lose some weight by taking a 20 minute walk every day and cutting down on the amount of sugar and oil you eat.”

- ◆ **Select an acceptable and feasible treatment** — To the extent possible, provide the patient with a range of treatment options from which to select the one he or she prefers. For example, in providing family planning services to a mother, discuss available options and help her select the one that is best suited to her lifestyle. Conditions such as pain management, weight loss, etc., may have a number of treatment options from which the patient may choose.

- ◆ **Motivate patients to comply with treatment** — Once a treatment has been mapped out, the provider should try to motivate compliance with the treatment prescribed by pointing out to the patient the importance and benefits of such action. For example, in prescribing antibiotic treatment, a provider might say,

“It is important for you to take your medicine three times a day until all the pills are gone. You may feel better after a few days, but if you don’t take all the pills the illness will come back, and it may be harder to cure the next time.”

- ◆ **Summarize** — Restate the diagnosis, treatment and its recommended steps in simple terms. In summarizing, repeat only key points. For example, a provider might conclude a counseling session by saying “I think you have a respiratory infection. Take these antibiotics with every meal until they are all gone. I’d like to see you again in two weeks to make sure you’ve completely recovered.”
- ◆ **Check for understanding and absorption** — Ask the client to repeat or describe the treatment instructions. Then clarify any misunderstandings the patient might have and find out whether there are any reasons that would impede the patient’s compliance with the prescribed treatment. For example, a provider might say “Just to be sure you understand how to take your medicine, would you tell me how much and how often you’ll take it?”
- ◆ **Additional questions** — Urge patients to ask any additional questions they may have on their current or any other medical problem. Allow ample time for a response. Avoid missing the opportunity to consult. For example, if prompted to share any additional health concerns, a mother seeking care for a baby with diarrhea may mention that she is interested in exploring birth spacing techniques, or that she is not sure of the vaccination schedule for another of her children.
- ◆ **Confirm follow-up actions** — Remind the patient of the next appointment date or of the next treatment action he or she will need to take. Remind the patient what to do if symptoms persist or worsen, and about danger signs that indicate he or she should seek prompt medical assistance.

In this section, we have presented a set of specific guidelines for improving the IPC skills of health care providers. The next section will outline steps in planning and implementing a training program designed to further develop these skills.

VI. Planning and Implementing Training Activities

This section deals with planning and implementation of training activities. The information provided should enable health care providers to conduct small training workshops in their own clinics or enable outside experts to train health care providers in their areas or communities. The training format and methods presented here have been tested in a variety of settings and have proven effective in the IPC training of health care providers. **We have found that revisions in our training methods are always necessary to adapt the techniques to local circumstances and insights. We, therefore, encourage providers and trainers to use their own ingenuity and expertise to modify the techniques to suit local realities.**

Improving IPC skills generally implies some behavior change on the part of health care providers. Programs inducing effective behavior change require both an understanding of the issues and skills involved and practice sessions in the new skills. Practice may entail first conducting exercises among peers in a controlled environment (involving self-evaluations or evaluations and feedback from colleagues or supervisors), then holding supervised or self-monitored practice runs with actual patients and leading eventually to internalization of the new skills when they become second nature to providers who apply them instinctively.

Overall Training Approach

The IPC training program is highly flexible, allowing participants to adapt the program to local socio-cultural realities or to pinpoint specific techniques that can improve daily operations. The training activities employ a variety of methods to ensure that participants develop and learn to effectively apply new IPC skills. The methods used include:

- ◆ participatory plenary sessions that employ brainstorming and question and answer sessions, allowing participants to discover and tailor new IPC skills;
- ◆ dynamic role playing which illustrates various communication strategies and allows participants to practice them;
- ◆ mental rehearsal techniques which allow participants to test the degree of difficulty of individual IPC skills and to develop methods to master them;
- ◆ videotapes on non-verbal communication skills which are used as instructional tools.

Prior to the course, we developed:

- ◆ a guide to help participants practice the skills, which is referred in the text as “the pocket guide”, or “job aid”;⁸
- ◆ a training manual which allows the trainer to adapt the manual to the participants’ needs and to local realities.

Training Agenda and Format

Our IPC training program consists of approximately 20 course hours covering a 3 to 4 day span. The initial session focuses on the relevance of the skills. The following session deals with the guidelines and gives participants an opportunity to practice the new skills. The training course has a prepared list of skills or behaviors the trainer introduces to the group (Table 1).⁹ Each type of behavior is discussed and practiced in the participants’ native language aiming for potential improvements and adaptation to the local environment.

8 The job aid guide is included in Appendix A.

9 Please note the differences between the list and the Section V (Guidelines and Norms for Effective Communication). Section V incorporates revisions that had not yet been made at the time of the training.

Table 1: Interpersonal Communication Behaviors

Overall socio-emotional communication

The following nine behaviors reinforce ways to make people feel comfortable during medical visits:

- Welcome patient in a warm and culturally acceptable manner.
- Use appropriate verbal and non-verbal communication (gestures, attitude, words).
- Inquire about the patient's feelings.
- Acknowledge the patient's initiative (to have come, to have brought the child).
- Enhance legitimizing. (Reinforce feelings that are normal.)
- Show empathy.
- Echo the patient's emotions by encouraging him or her to express feelings freely. (Paraphrase what patient says.)
- Convey support and partnership.
- Reassure the patient. (Ease the patient's concern by suggesting specific things he or she can do.)

The health provider's tone of voice and attitude are primarily responsible for setting the socio-emotional tone of the encounter.

Problem solving skills

Systematic use of data gathering skills enables providers to become more efficient. The following seven behaviors help providers gather necessary information for determining diagnoses:

- Listen attentively (actively).
- Encourage dialogue by asking open-ended questions.
- Avoid interruptions.
- Avoid premature diagnosis (Determine the problem only after all facts have been gathered.)
- Resist immediate follow up by listening carefully before making clinical decisions.
- Probe (explore) for more information.
- Inquire into causes, difficulties and worries related to the problem.

Counseling and Information-Education-Communication (IEC)

The following ten behaviors are effective ways to explain health issues, treatment and decisions taken.

- Check the patient's understanding of the illness.
- Correct misunderstandings about facts.
- Use appropriate vocabulary.
- Present (explain) what the patient needs to know or do in a logical way (in blocks).
- Correct misconceptions.
- Discuss and prescribe concrete behavioral changes that are appropriate for the patient.
- Repeat, summarize key information.
- Motivate the patient to follow the recommended treatment.
- Check on acceptability/mutuality of decision making (if patient will follow the treatment).
- Make sure patient knows when to return for a follow-up visit.
- Ask patient if there is anything else he or she would like to know.

In many of the courses given, we encouraged providers to complement training activities by trying out the skills they learned in their own practice between course sessions. These “transitional” encounters were often taped, allowing providers to work in groups to review their shared experiences, apply the skills in their local setting, and critique their newly acquired skills in a supportive environment. Different agendas for the course are included at the beginning of the training manuals presented in Appendices B, C and D.

Training Materials and Methods Used

The use of training materials that document the concepts and guidelines presented is essential. Without this written documentation, participants do not have an opportunity for self-evaluation and will not be able to follow through in gaining an in-depth understanding of the new skills. The training manuals presented in the Appendices include materials that have occasionally been adapted and completed prior to the start of training sessions with the local team. For example, training methods include:

Role playing. One of the most effective methods for learning skills in a controlled setting is through role playing. Role playing enables providers to “try on” a variety of different styles and identify the ones that best suit them. Role playing also requires providers to play the part of a patient and, therefore, to experience the other side of the health care diad, and learn how providers’ different IPC styles can affect patients’ attitudes. One of the great benefits of role playing is that it can be both educational and fun. A variation on standard role playing is pantomime role playing in which the players act out a particular scene without speaking. Pantomime is particularly useful for analyzing the impact of non-verbal communication such as eye contact, physical contact, postures, gestures, smiles, attitude, etc. Because no words are spoken, players and observers can focus all their attention on the slightly exaggerated non-verbal communication.

Video and audio-taping. Another highly effective training device includes video or audio taping. Seeing or hearing oneself on tape makes one much more aware of one’s own communication style. Video or audiotape can be used in a variety of ways. Role playing can be recorded and played back instantly so that players can see how they acted and how their behavior impacted on others. Real clinical encounters can also be video or audio-taped and played back for group analysis. This technique was used effectively in training workshops in Egypt. The advantage of recording role plays or actual encounters is that the tapes can be played over and over and used to analyze various points. Moreover, tapes can be made following the training program to monitor the program participants’ IPC improvements. (Improvements can be measured more accurately and easily when a recorded baseline for comparison exists.)

Video playing. In Honduras the participants saw a video on IPC provided by the Ministry of Health in addition to a Spanish language video provided by AED.¹⁰ Unfortunately, we did not have a similar video in Arabic. In Egypt, participants expressed, in their course evaluation, a desire to view such a video, which they believed would help them more accurately master the skills required.

¹⁰ “A Traves del Espejo: El Papel del Consejero en la Prevencion del SIDA”, Video AIDSCOM/AED 1991.

Mini case study or simulation guide. Throughout the course, mini case studies or simulation guides were used to develop understanding and reinforcement of IPC skills. Often these mini case studies were developed or adapted in-country, based on actual encounters. For example, to “Practice problem solving skills: Gathering data to understand client situations and problems,” participants received simulation guides for role playing of the health provider and patient. Practice sessions with open-ended questions and increased interaction between participants led to improved skills. Examples of these mini case studies are presented in the training manuals. Mini cases for Honduras can be found in Annex 8 and 8bis (Appendix D). In Egypt, the last day of training focused on improving the quality of IPC skills among colleagues and on teamwork. Following a brainstorming exercise in which participants complained about poor leadership, poor group dynamics and poor supervision in their work environment, trainers developed three mini case studies to be used as group exercises at a later date. These exercises are presented in Annexes 8, 9, and 12 of the Egyptian training manual in Appendix B.

Evaluation form. At the end of the course, participants were asked to complete evaluation forms assessing trainer effectiveness. The forms provided participants with the opportunity to comment on their learning experience and course methodology. At the same time, it provided trainers with the necessary feedback for improving their workshops. Moreover, each training day began with a plenary discussion among participants, which allowed them to focus on essential elements discussed the previous day. Sample evaluation forms in Spanish and English are presented in Appendix D, Annex 10 (Honduras) and Appendix B, Annex 13 (Egypt).

Training Supervision, Monitoring, Evaluation and Follow-up

An effective training program does not end at the conclusion of the workshop but represents an element in a protracted learning cycle. After the workshop or intensive training program, providers are expected to return to their clinical settings and apply what they have learned to their daily work environment. Effective supervision and support is critical at this time to ensure that providers adopt the new skills within their old settings. In order to establish a true learning environment, supervision should be supportive rather than constraining, providing feedback and encouragement rather than threats or punishments. An important aspect of supervision and feedback is monitoring—a process in which information is collected in an ongoing manner to measure progress toward established goals or objectives. Monitoring can take a variety of forms, including (but not limited to):

- ◆ providing self-evaluation on a variety of behaviors, using a check list or other standard form such as a questionnaire
- ◆ having a supervisor or colleague observe an encounter with a patient
- ◆ recording audio or video tape encounters, followed by self and/or team evaluations
- ◆ conducting exit interviews with clients.

Sustained routine monitoring of clinical practices is an effective tool for improving the quality of health care services and follow-up of training programs. Monitoring procedures and protocols should be simple, user-friendly, and limited to a few key questions or observations that will yield information by which progress and the design of follow-up training activities can be gauged.

Follow-up is the process by which trainers, supervisors or colleagues determine which skills need reinforcing, additional training, or further development. Follow-up is based on the understanding that learning occurs through repetitive drill, practice, and constructive feedback. Follow-up is, therefore, an integral part of the learning cycle, as it allows for focusing on problem areas or delving deeper into areas of particular interest to participants.

Six months after the IPC training in Egypt, a follow-up effort was carried out in response to a wish by physicians to improve the quality of health services delivery and enhance patient satisfaction. These activities consisted of field visits to work sites, discussions with health providers on the relevancy of the IPC skills acquired during the training session, observation of provider-patient encounters, the compilation of physician questionnaires, and the recording of patient exit interviews. Details of the results of these follow-up activities are explained in the next chapter which presents the country's case study.

VII. Case Studies

Sections I through VI have presented a conceptual framework, outlined training strategies and described tools that can help improve the quality of IPC between providers and patients. This section presents our research experiences to date in three countries—Honduras, Trinidad and Tobago, and Egypt. We hope that our field experiences will complement the theory presented, so that readers may feel confident in experimenting with IPC improvement efforts.

In all three countries we focused on training doctors. In Honduras and Egypt a number of nurses were included in the IPC training effort. We expect that the materials derived are appropriate for training all professional health personnel, but may need some adaptation and simplification for use with peripheral health workers or community health volunteers.

In each of the three countries the training sessions covered approximately 10-15 hours of classroom work, which included presentation, discussion and practice of the new skills. The training manuals are included in their entirety in the appendices, because we felt they could provide, with minor adaptations, the basis of IPC interventions in new settings. The training manual used in Trinidad most closely follows IPC improvement models that are used in developed countries. The training manual for Honduras relates more to a developing country setting. The training manual for Egypt is based on the manual from Honduras, but benefits from revisions and improvements that were made as a result of the Honduras experience.

All three countries also used a job aid, the IPC Pocket Guide, to reinforce the training content. The job aid is presented in Appendix A in English and Spanish. In our experience, we found that it was important to allow each training group to modify the job aid as they saw fit, adapting and personalizing the IPC norms to the local environment and to individual needs.

All three case studies had a research component. The research component in Honduras was the most rigorous in terms of sampling, methods, and research design. It was based on analysis of audio-tapes and of patient exit surveys. As a result of the IPC interventions, the research resulted in improvements in practices and in documented satisfaction of providers and patients. In Trinidad, the research also relied on audio-tapes and exit interviews. Even though sampling methods were simpler, we found that the method was able to detect improvements in practices and satisfactions. In Egypt we attempted to replace the audio-tapes with an observation check list and had an even smaller sample. Unfortunately, the observation method used was not reliable, and we were unable to detect improvement in provider practices. We feel that this situation resulted from a lack of adequate training for all observers. We hope to continue to experiment at a later date using a different research procedure.

While our field experiences yielded much information on how IPC improvement strategies can be adapted to different cultures and health settings, we feel that our findings are still incomplete and that many additional insights on cross-cultural and organizational issues will emerge as these survey tools and approaches are applied to other geographic regions (such as Africa and Asia), and in other settings (especially peripheral health services in rural areas). We would like to encourage those who experiment with IPC interventions to share their experiences with the QAP staff, so that these experiences can be used to further develop the IPC framework and its strategies.