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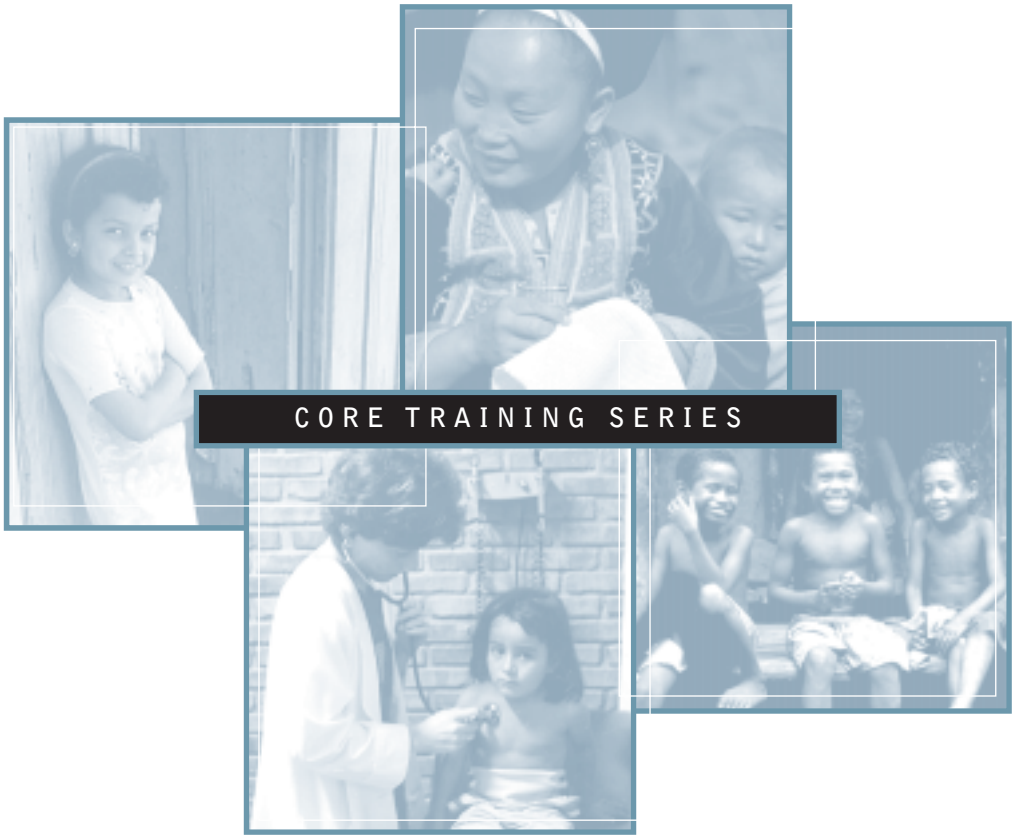

Improving Interpersonal Communication Between Healthcare Providers and Clients

Reference Manual

QA
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Improving Interpersonal Communication Between Health Care Providers and Patients

Introduction

Effective interpersonal communication (IPC) between health care provider and patient is an important element for improving patient satisfaction, treatment compliance, and health outcomes. Patients who understand the nature of their illness and its treatment and believe the provider is concerned about their well-being show greater satisfaction with the care received and are more likely to comply with treatment regimens. Several studies conducted in developed countries show strong positive health outcomes and improved quality of care associated with effective communication. Provider-patient communication has been linked to patient satisfaction, recall of information, compliance with therapeutic regimens, and appointment keeping (Curtin 1987; DiMatteo 1994; Hall 1988; Ong 1995). Thus, being able to communicate effectively and knowing which messages to communicate are equally important skills. For these reasons, IPC is beginning to be emphasized in health professional training. Research indicates health counseling and education, as well as provider-patient interactions and communication, can improve with adequate training and follow-up (Fallowfield 1998; Kopp 1989; Levinson 1995; Roter 1998b).

Over the past several decades, substantial investments have been made to maximize access to basic health services in developing countries. Studies investigating quality of care, including the quality of IPC, are increasing. As the number of studies increases, the results, effects, and outcomes of provider-patient interactions will enrich the wealth of data already seen in the literature (Roter 1998).

It cannot be assumed effective communication always occurs naturally (Kim 1999). Acquiring effective interpersonal skills requires observational practice and application of interpersonal communication principles (Fallowfield 1998; Kopp 1989). Even when patient and provider come from the same geographic area and speak the same language, they often have different educational, socioeconomic, and cultural backgrounds (Huntington 1990). Moreover, expectations about the health care encounter may differ between patient and provider. The patient and provider also may be faced with other problems, such as lack of privacy during the communication encounter, time constraints due to heavy patient

loads or family pressures, or fear of lack of confidentiality.

Effective communication enables patients to disclose critical information about their health problems, and it allows providers to diagnose and treat health problems more accurately. Ultimately, patients' and providers' feelings of confidence in the care being provided can be influenced positively by the assertion that states IPC skills are a hallmark of technical competence (Donabedian 1988; Mechanic 1998).

This monograph will introduce the importance of effective interpersonal communication, its characteristics, its three essential elements and the framework linking communication processes to patient behaviors. The overall communication context is influenced by both patient and provider socioemotional-cultural attributes and the environment in which the interpersonal encounter occurs. Both patient and provider are partners in this dynamic exchange, and both contribute to successful communication. This monograph focuses on health care providers, because often they do not possess or practice many of the basic communications skills needed to carry out their responsibilities effectively and efficiently. The monograph also acknowledges the importance of patients becoming aware of their rights, asking questions during health care encounters, and acquiring the basic information to allow them to take full advantage of the health care system. However, the issues associated with patient communication processes are outside the scope of this monograph and will not be addressed directly.

Why Is Interpersonal Communi-cation Important?

IPC leads to behavior that supports treatment regimen compliance and/or lifestyle changes and, therefore, better health outcomes. Effective IPC leads to:

- Positive rapport between patient and provider
- Disclosure by the patient of sufficient information to make an accurate diagnosis
- A medically appropriate treatment or action acceptable to the patient
- An understanding by the patient of his or her condition and prescribed treatment regimen
- The commitment by both patient and provider to fulfill their responsibilities during treatment and follow-up care (de Negri 1997)

The relationship between the process behaviors (e.g., the way health care providers communicate) and the outcomes (short-term, intermediate, and long-term results) must be recognized to understand how these outcomes are reached. As seen in Figure 1, the communication context is shaped by the sociodemographic characteristics of the patient and provider, as well as by the communication environment. The age, sex, ethnicity, and educational backgrounds of providers and patients affect how they communicate with each other. Other factors, such as degree of privacy, time allotted for encounters, comfort and cleanliness of the facility, and treatment of patients from the time they enter the facility until they depart, also can inhibit or enhance patient-provider interaction. Although many sociodemographic and environmental factors are beyond their control, providers can improve IPC practices in their own settings by adopting specific behaviors and techniques that lead to increased patient knowledge and positive behavior change.

Provider-Patient Communication Framework

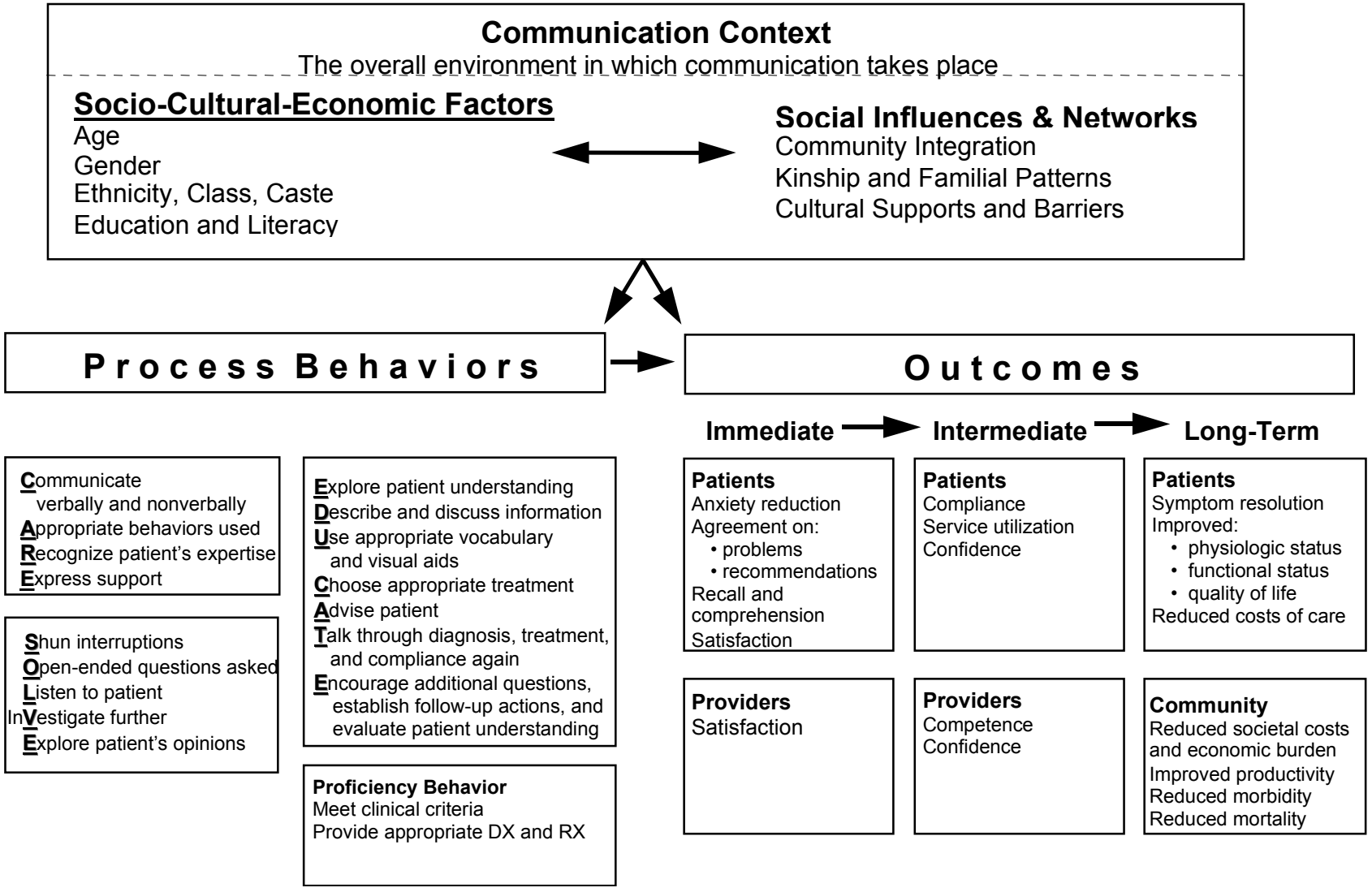

Figure 1

What Are The Character-istics of Effective IPC?

The process of effective IPC generally includes encouraging a two-way dialogue and establishing a partnership between two experts—the patient and the provider—that creates an atmosphere of caring. This, in turn, bridges any social gaps between provider and patient, accounts for social influences, effectively uses verbal and nonverbal communication, and allows a patient ample time to tell his or her story and ask questions.

Effective IPC content is personalized according to the patient's educational level and ability to understand technical information and the proposed regimen and treatment instructions. The provider needs to verify the patient's ability (recall) to repeat essential information and instructions. Effective use of IPC process and content together ensures patients understand their health condition and treatment options, as well as the selected regimen.

Another way to describe IPC is to define its three elements:

- *Caring and socioemotional communication*: establishing and maintaining rapport and trust (**CARE**)
- *Diagnostic communication and problem solving:* exchanging information to determine diagnosis and treatment (**SOLVE**)
- *Counseling and education:* ensuring patients understand their health problems, treatment options, and regimens selected (**EDUCATE**)

Patients carry out their own decisions best. Providers who make good counselors do not make patients' decisions for them; they help patients make their own decisions. However, providers do decide medical matters while sharing facts and feelings about these matters.

The following matrix contains examples of the provider's and patient's responsibilities regarding the exchange of factual information and sensitivities.

	Share Facts	***Share Feelings***
Provider's Job	• Give clear, accurate information the patient wants and needs • Help the patient to apply this information to his or her own life	• Care for the patient by showing understanding, respect, and honesty
Patient's Job	• Describe health condition and personal situation • Ask questions and make sure of understanding	• Express concerns, expectations, and wishes

(Adapted from *GATHER Guide to Counseling*, Population Reports, 1998)

Two-Way Dialogue

By definition, good interpersonal interaction between patient and provider is a two-way street in which both speak and listen without interruption. Both ask questions, express opinions, exchange information, and understand fully what the other is trying to say.

Partnership Between Provider and Patient

Providers and patients should view health care as a partnership in which each party strives to maximize the results. Mutual respect, trust, and joint decision making will result in a positive outcome. Both provider and patient must realize even though the provider is the medical expert, *both* are responsible for the outcome of their interaction. The patient must disclose all relevant information for the provider to determine a proper diagnosis and treatment, and 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 regimens, with the patient making every effort to comply with the prescribed treatment and any necessary lifestyle changes implied. Providers should urge patients to take an active role in their own care and treatment and

encourage active questioning and interaction during office and hospital visits.

Atmosphere of Caring

Patients need to believe their provider cares about them and is committed to their welfare. Both verbal and nonverbal communication help the provider convey interest and concern to patients. A calm, clean, well-functioning environment that is comfortable and inviting communicates a respect for and commitment to patients and their needs. Cluttered, disorganized, noisy environments might be perceived by patients as uncaring, uninviting, even unprofessional atmospheres.

Effective Bridging of Social Distance, Social Influences, and Networks

Social distance refers to the socio-cultural-economic factors that make people feel they belong to different groups. Education, economic status, class, race or ethnicity, gender, and age all may contribute to how close or distant two individuals feel in relation to each other. For example, an illiterate village woman and a young, highly trained, city-dwelling male physician can still be worlds apart although they may share the same language and may have been raised within miles of each other. Social distance should not impede good communication, and providers must realize that many people, even those in their own circles, may not understand medical language. Therefore, providers should strive to bridge any existing communication and understanding gaps between them and their patients and establish an open dialogue, a partnership, and a caring atmosphere. Patients also must do their part to bridge any social distance by being candid and communicative (Roter 1991).

Social networks refer to those interpersonal relationships connecting family, friends, acquaintances, neighbors, and colleagues. They influence a patient's desire and ability to understand and comply with professional advice in various ways, depending on the individual and his or her environment. For example, in some societies, the mother or mother-in-law is the key decision maker in the extended family. Therefore, teaching a pregnant woman about maternal care practices may be ineffective if her mother or mother-in-law is uninformed about or opposed to these practices. Similarly, in a home where a woman cooks for the extended family, dietary recommendations that could enhance her health may not be followed if they interfere with the family's culinary customs or add to the family's financial problems.

Effective Use of Verbal and Nonverbal Communication

Verbal communication consists of spoken and written words people use to convey ideas. During a health care encounter, the words patients and providers use greatly influence how well they understand each other. Although medical language allows providers to communicate clearly and precisely with each other, scientific and clinical words may be confusing and inappropriate when used with patients.

During health care visits, patients often communicate in their own dialects, accents, and slang. This can make comprehension difficult for providers from other regions of the country. Patients also describe health problems in unique ways, often reflecting their perspective on the illness, its origin, or severity. Sometimes local circumstances influence how patients perceive their illnesses, and/or symptoms. For example, if diarrheal diseases are common in their area, patients may not report symptoms of the condition unless they are quite severe because they view the symptoms as routine. For the provider, however, detection of early symptoms, even mild ones, is important in making proper diagnoses and in developing appropriate treatment regimens.

Warm greetings or thoughtful questions by providers often can help put patients at ease and enhance the interpersonal relationship. Such actions do not require great effort but can have significant results.

Nonverbal communication conveys information words alone often do not. Nonverbal communication includes gestures, body movements, positions, and even silence. Providers who appear fully attentive, avoid distractions, smile, and sit on the same level as the patient all convey an important message of caring, listening, and empathy.

Many aspects of nonverbal communication are specific to cultural customs and norms. In some cultures, for example, direct eye contact is a sign of positive regard and respect, while in others it is deemed improper or aggressive, particularly with members of the opposite sex. Physical contact during a conversation (touching the patient's arm or hand) is considered a sign of affection in some cultures; in others, it is construed as highly improper. Remember all forms of nonverbal communication convey a message, and simple gestures, such as a smile or leaning toward the patient while listening, can convey a positive message and reap the desired results.

Use Simple *Verbal* Communication

A. Medical Jargon

The clinical spectrum of cholera is broad, ranging from an apparent 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.

B. Simple Explanation

Not all persons who get cholera look equally sick. Some cholera patients seem to have a minor illness, while others look very ill. Some others even can die within hours of getting it. Because cholera germs spread within 6 to 48 hours of entering the body, the person suddenly may have a lot of watery diarrhea. Many patients also begin to vomit. When the sick person is getting worse, the skin can become blue (especially at the nose and fingertips), he or she may begin to breathe quickly, the 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, and it cannot survive.

Use Simple *Nonverbal* Communication

Dr. P. is visiting Mrs. X. in the hospital. When he arrives, he notices Mrs. X. has been crying and looks very upset. Dr. P. slowly pulls a chair alongside Mrs. X.'s hospital bed, sits down, and calmly begins his conversation with her.

C. Opportunities for Patients to Speak About Their Illnesses

The health encounter or visit should provide ample opportunity for patients to describe their illnesses. Storytelling has its own healing value because it provides patients with a release and the opportunity for insight and perspective. It also may afford the health care provider the insights needed to understand, interpret, and explore the significance of the symptoms and clues the patients provide. 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 how a patient *perceives* 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.

Principles And Guidelines For Effective IPC

The previous sections have discussed how to enhance interpersonal communications between provider and patient. However, providers often follow individual approaches to IPC. Good IPC skills, following useful, valid principles and guidelines, have been found to change provider behavior in concrete ways (Kim 1999). The following guidelines and principles use the three previously defined types of IPC—*caring and socioemotional*, *diagnostic communication and problem solving*, and *counseling and education*. All three IPC types are applicable to a certain degree within every health encounter or visit.

- *Caring and socioemotional:* Expressions of caring are conveyed at the outset of the encounter, and rapport or trust with the patient is established. This is an integral part of encouraging patient disclosure and compliance.
- *Diagnostic communication and problem solving:* Both the provider and patient share all the information needed for diagnosis or problem solving.
- *Counseling and education:* This component ensures the patient understands options for treatment. The provider chooses an appropriate regimen and instructions and aids patients in following treatment regimens and behavioral-change recommendations by ensuring these are comprehensible, acceptable, and feasible.

Caring (CARE)

Caring behaviors emphasize respect for patients and validation of their concerns. Health care providers should display caring throughout the medical encounter to establish a trusting, open relationship with the patient.

Communicate immediately, both *verbally* and *nonverbally*, to set the tone of the encounter. Show openness, genuine concern, and positive regard for the patient. Greet the clinic patient by standing, leaning forward, and smiling while saying, "Good morning, Mrs. N. Welcome. My name is Dr. P." Offer Mrs. N. a chair, face her, and say, "I am here to provide assistance, so please tell me what problems bring you here today. I will listen carefully and sometimes ask a few questions so all the information is clear to both of us. Together we will look at what is best for solving this problem."

Use communication behaviors **A**ppropriate to the patient's age, gender, social position in the family and community, language use and comprehension, and degree of discomfort or distress. Be sure

your posture, eye and physical contact, gestures, tone of voice, manner, and attitude are respectful and conducive to productive dialogue. For example, if making notes on a chart, stop; put down the pen, close the chart, and focus full attention on the patient. Look at the patient (not at the floor or out the window) and use simple language in a moderate, comforting tone of voice. Reaching out and touching the patient during the dialogue can instill a feeling of caring, but this behavior may be used only if culturally appropriate. To maximize the productivity and effectiveness of a two-way dialogue, respond positively to the client's statements, responses, and display of emotions by adjusting what and how something is said, gestures, and facial expressions.

Recognize the patient's experience, efforts, and emotions in an honest, straightforward manner. Statements of concern and empathy show caring toward the patient and his or her problem. Empathetic statements demonstrate understanding and sharing of the patient's feelings. For example, when dealing with a hypertensive patient who is not taking his or her medication regularly, say, "I'm concerned that you're not taking care of yourself." Tell a patient who is nervous about surgery, "I understand you are worried about this operation." When counseling a cancer patient, say, "It's easy to understand why you feel afraid and angry. Most people in your situation feel the same way at first." Provide the patient with an invitation to elaborate further on the topic by echoing his or her feelings. For example, when a patient says, "I've been feeling very depressed lately," respond with, "It sounds like something is really getting you down."

Express support and partnership by letting patients know you will work with them to help them get better. 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 and to follow the treatment plan."

Diagnosis and Problem Solving (SOLVE)

These IPC skills help health care providers gather critical information for problem identification and diagnosis. Use of information-gathering skills enables them to improve their accuracy and effectiveness. The skills involve a variety of questioning techniques designed to encourage the patient to talk about all aspects of his or her problem(s).

Shun interruptions while the patient is speaking. Wait until he or she has finished a thought before asking a new question. Avoid being interrupted by the telephone, people entering the room, or other

distractions during your encounter with the patient.

Use **O**pen-ended questions, encouraging patients to provide details about their problem(s). One open-ended question will elicit more information than several yes or no questions. Instead of asking a patient, "Do you have a fever? Do you get headaches? Are you nauseated?" say, "Tell me about any pain and discomfort you've been feeling." Allow the patient to describe the condition or symptoms; ask one or two yes or no questions to supplement the information, if needed. A patient may say, "I'm having nausea, vomiting, chills, and cramping in my stomach. It's been going on for two days now. I feel terrible, and the cramping is getting worse." Then you could ask any number of yes or no (closed-ended) questions, such as, "Is the cramping here in your stomach area?" "Is your cramping here close to your right groin area?" "Do you feel nauseated now?" or "Have you vomited today?"

Listen to the patient's full story and ask all relevant questions before determining a diagnosis and treatment. The patient's first complaints are not always the most important ones. Vital information shared by the patient may be gathered only when clarifying questions are asked by the provider. Hasty conclusions, which lead to diagnostic errors, should be avoided at all costs. For example, when a patient reports headache pain, resist the urge to assume immediately the ailment is minor and to prescribe pain relief. Instead, you might say, "Tell me more about how you're feeling." A simple cure for headaches is often sufficient, but at other times, the patient might respond, "I'm so worried and upset; there are times when I don't feel like getting out of bed, and I feel so bad. I want to die." Such a case warrants further inquiry into the psychological and/or physical causes of the condition.

In**V**estigate even further by asking more questions and inviting the patient to continue speaking. Use phrases such as,"Tell me more" or "Please go on" to help patients delve deeper into the nature of their problem(s) and their reactions. Further inquiries and listening often reveal information that may be missed unless probed for at the time of the health encounter or visit and may be necessary for a correct diagnosis and treatment plan.

Explore the patient's opinion on the causes of the problem and what he or she thinks might help. This technique will provide needed information to make a diagnosis and help to evaluate the patient's understanding of the illness. **E**ncourage and reassure the patient about the outcome of his or her condition. It is important to be

honest and realistic about the medical prognosis and to avoid premature or unjustified reassurance. For example, a midwife might say to a patient in uncomplicated labor, "I know you're feeling a lot of pain and anxiety right now, but your labor will soon be coming to an end, and you'll have a new baby."

Counseling and Education (EDUCATE)

The skills in this category enhance providers' abilities to explain their patients' conditions, diagnoses, and treatment options. Providers should remember patients' compliance with treatment regimens depends on their understanding of their illness, their feelings about the prescribed treatment, and their willingness to follow instructions.

Explore patients' understanding and opinion of their illness by asking how they contracted it, whether they have had the problem before, and what they did about it previously. For example, if a young child has been hospitalized with diarrhea, ask the mother, "How do you think your child got diarrhea?" "How do you think children usually get diarrhea?" "How have you taken care of it in the past?" This type of information gathering provides clues as to how much or how little the patient or caretaker truly knows about the illness. You should recognize the extent of the information and education the patient or caretaker may require and the degree of misunderstanding or misinformation needing correction.

Sometimes patients hold inaccurate notions about the etiology or effects of an illness or disease, which can affect their behavior toward treatment and can have an adverse impact on their recovery. After determining a patient's level of understanding of his or her problem, any client misconceptions should be corrected politely. Clients should not be made to feel uneasy or inadequate for having inaccurate ideas or information; instead, educate them by providing appropriate information. For example, say, "While many people believe diarrhea is caused by changes in the weather, that's incorrect. It is caused by germs in the water, which can be killed by boiling. So, you need to boil all the water your child drinks and store it in a way to stop germs from getting in. That means after boiling the water, store it in covered containers that have been washed with boiling water."

Describe and **D**iscuss information with the patient in a way that can be absorbed and remembered easily. The diagnosis should be explained in a clear, comprehensible fashion, never in a condescending or patronizing manner. Subdivide the information into separate categories or blocks. Presenting these blocks

sequentially will enable the patient to understand and absorb the knowledge before you move on to the next block. This kind of presentation helps patients internalize the information. The patient's absorption and internalization of information enhances compliance with the prescribed treatment. For example, you may convey brief information sequentially in the following manner:

- Name of the disease and its etiology (if known)
- Recommended treatment for the patient
- Ways to prevent recurrence of the disease or to manage chronic disease
- Other relevant information, including risk(s) of not following the regimen

Use appropriate vocabulary, visual aids, and/or printed materials when informing patients of the diagnosis and recommended treatment. Avoid using jargon or technical language when speaking with patients, making every effort to use meaningful terms. Instead of saying, "You have acute bronchitis. That's why you are having dyspnea," say, "You have an infection in your lungs. That's why you are having breathing difficulties." Visual aids help patients to understand and remember the information provided. It is also helpful to use pamphlets with simple text and clear pictures concerning important health problems, their prevention, their treatment and, in the case of chronic illnesses (e.g., diabetes, hypertension), their management requirements. The patient can use materials at home as a useful reminder or reinforcement of their prescribed regimen.

Choose an acceptable, feasible treatment plan and, if possible, provide the patient with a range of treatment options. Develop the treatment regimen that the patient is *most* likely to follow successfully. For example, discuss available options for a patient presenting with gallbladder inflammation symptoms—dietary, medications, a combination of both, and/or surgery. Or, in the case of a hypertensive coronary disease patient, discuss the essential combination of nonsmoking, exercise, dietary habits, medication regimen and stress reduction.

Advise the patient (after diagnosis and treatment regimen selection) regarding certain behavioral changes that would prevent the recurrence of the condition. Carefully consider the patient's ability to implement the recommendations. Rather than simply emphasizing the end results of the behavioral change, identify and suggest specific steps to take. For example, instead of telling the heart attack patient to begin a regimen of dietary limitations, exercise, and

weight loss, say, "Ideally, you could exercise by walking every day to begin losing weight, and you could reduce your daily use of sugar, sweets, oil—even cooking oil. Let's discuss what you can realistically accomplish every day."

Once a treatment plan has been mapped out, advise the patient to comply with the prescribed treatment by pointing out the importance and benefits of such behavior. In prescribing posthospitalization antibiotic treatment for a patient recovering from a respiratory infection (bacterial pneumonia), say, "It is important 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 as prescribed, the illness will come back, and it may be harder to cure next time."

Target your final comments to the patient. Summarize and repeat only *key* points, using simple terms to validate the patient's understanding and to restate the diagnosis and treatment. Say, for example, "Your lung infection has improved enough for you to go home from the hospital. Take these antibiotic pills three times a day with your meals until they are all gone." Clarify any misunderstandings the patient might have and find out if anything would impede the patient's compliance with the prescribed treatment. For example, say, "Just so I can be sure you understand how to take your antibiotic, would you tell me how often and when you'll take it?"

Encourage additional questions and **E**stablish follow-up actions with the patient. Urge the patient to ask additional questions about his or her current or other medical problem. Allow time for a response to utilize the opportunity to provide further assistance and/or counseling. If prompted to share additional health concerns, a patient with a respiratory infection, for example, may mention all the members of the family have repeated sore throats and coughs. Reiterate to the patient the date of the next appointment, next treatment action, or next appropriate follow-up action. Say, "I would like to see you here in the outpatient clinic in two weeks to make sure you've completely recovered." State clearly what the patient should do if symptoms persist or worsen and what danger signs would indicate the need for prompt medical assistance. Say, "If your coughing gets worse or you have difficulty breathing, you should go to the village dispensary right away. Take your medicines with you. Tell them you were here at the district hospital." **E**valuate whether the patient clearly understands directions for follow-up and emergency care by asking the patient to repeat the information.

Conclusion

The set of principles and guidelines for effective IPC presented in the previous sections will guide us through the training course for improving interpersonal communication. The three process behavior elements of *caring, diagnosis and problem solving,* and *counseling and education* focus the provider's attention on the most important aspects of patient-provider interactions. These process behaviors, coupled with the provider's proficiency at meeting clinical criteria and providing appropriate diagnosis and treatment when effectively applied, can result in better outcomes for the patient, the provider, and the community at large. The provider-patient communication framework (Figure 1) illustrates these interrelationships. Improving the quality of interactive skills is the training course objective; the training materials, exercises, and references will provide the knowledge base and application opportunities to accomplish this successfully.

ANNOTATED BIBLIOGRAPHY

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   Physicians caring for cancer patients receive little formal training in difficult communications, such as breaking bad news, discussing life support, and addressing patients' emotional concerns. The authors conducted a three-day workshop in communication skills for nine oncology attendings and three fellows. Participants in a preworkshop questionnaire selected topics for the workshop. Small groups of four to five participants interviewed simulated patients, who role-played scripts based on the selected topics. Sessions were held on self-awareness; one on planning for continuing the work of the group after the workshop was included. Responses to pretest and posttest questionnaires showed the workshop increased the participants' confidence in a number of communication areas and also in managing physician burnout. Process issues, such as patient death and expectations for cure, also were discussed.

   Interactive workshops offer a promising way of teaching communication skills and aspects of the physician-patient relationship to oncologists. Conclusions regarding outcome, however, are preliminary and tentative; long-term results are uncertain.

   Key words: communication; medical oncology; physician-patient relations

2. Bain, D.J.G. 1977. Patient knowledge and the content of the consultation in general practice. *Medical Education* 11:347–50.

   The relationship between verbal exchange and patient comprehension in doctor-patient consultations has been measured by means of audiotape recordings. The results provide objective evidence of differences in outcomes for similar presenting illnesses in different social groups, and these results tend to support the hypothesis that people from lower socioeconomic classes may not derive as much benefit from medical advice as do those of middle and upper classes. The author identified deficiencies in clinical relationships that, if corrected, will improve doctor-patient communication in consultations in general practice. If patient comprehension and

compliance are viewed as essential, communicative as well as clinical skills have to be accepted as part of the general practitioner's training.

Key words: patient comprehension; sociodemographic characteristics

3. Bartlett, E. et al. 1984. The effects of physician communication skills on patient satisfaction, recall, and adherence. *Journal of Chronic Diseases* 37 (9/10):755–64.

   This study examined the effects of physician interpersonal skills and teaching on patient satisfaction, recall, and adherence to the regimen. The ambulatory visits of 63 patients to five medical residents at a teaching hospital in Baltimore were studied.

   It was found quality of interpersonal skills influenced patient outcomes more than quantity of teaching and instruction. Secondary analyses found all the effects of physician communication skills on patient adherence are mediated by patient satisfaction and recall.

   Key words: patient recall; satisfaction; adherence; interpersonal skills

4. Curtin, R.B. 1987. "Patient-Provider Interaction: Strategies for Patient Compliance." (Ph.D. dissertation, University of Wisconsin.)

   Pharmacy students and volunteer patient subjects were enlisted to state simulated medical consultations in which prescription instructions were communicated. Three classes of variables were considered as they related to the specified outcomes: 1) pharmacy student background characteristics, which included both past role-socialization experiences and a preconsultation exposure to one of three randomly assigned communication strategies; 2) patient background characteristics, including past experience with the health care system; and 3) the process and content of the interaction that occurred between these two participants in the medical consultation.

   The most important finding to emerge from this study was the interaction process and content, specifically with regard to the nature, quality, and quantity of the information that is disclosed in the consultation, is related most significantly to the outcomes of patient satisfaction and patient comprehension and recall of

medical instructions.

Key words: information giving; patient recall; comprehension; satisfaction; compliance

5. de Negri, B. et al. 1997. *Quality Assurance Methodology Refinement Series: Improving Interpersonal Communication Between Health Care Providers and Clients.* Bethesda, MD: Quality Assurance Project**.**

   This publication 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 suggest test results in developed countries are valid and replicable in developing countries. Therefore, our findings should serve as useful models for implementing future interpersonal communication programs. The monograph serves as an introductory overview on provider-client communication skills, a framework for assessing IPC skills, a guide for developing IPC training activities, and a resource describing important IPC experiences in selected developing countries.

   Key words: interpersonal communication; training; Honduras; Egypt; Trinidad; provider-client communication

6. DiMatteo, M.R. 1994. The physician-patient relationship: Effects on the quality of health care. *Clinical Obstetrics and Gynecology* 37 (1):149–61.

   This paper examines other research done on physician-patient communication and how it affects the outcomes of patient care. In summary, the paper states the traditional paternalistic model of physician-patient relationships is ineffective and detrimental to optimal patient care. The chronic nature of many disease processes, constraints on health care resources, and complex ethical issues associated with developments in high-technology medical care require patients to become partners with their physicians in decision making about their health care management. At a very basic level, the loss of decision-making power is a very heavy blow to the morale of patients who, because of illness, already may have lost control over their bodies. When patients try to regain power by not adhering to treatment regimens, they waste costly medical care resources and

even may jeopardize their health. Furthermore, when physicians fail to communicate and collaborate effectively with their patients, they foster patient dissatisfaction and increased risk of malpractice litigation. On the other hand, a physician-patient relationship based on open information exchange, mutual respect, collaboration, negotiation, and the resolution of conflict can be expected to foster more satisfying and effective interchange, more positive health care outcomes, and a higher quality of health care for patients.

Key words: communication; physician-patient relations; quality of health care

7. Donabedian, A. 1988. The quality of care: How can it be assessed? *Journal of the American Medical Association* 260 (12):1743–48.

   Before assessment can begin, it must be decided how to define quality. That depends on whether one assesses only the performance of practitioners or the contributions of patients and the health care system also, on how broadly health and responsibility for health are defined, and on whether individual or social preferences define the optimum. We also need detailed information about the causal linkages among the structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care. Specifying the components or outcomes of care to be sampled, formulating the appropriate criteria and standards, and obtaining the necessary information are the steps that follow. Though we know much about assessing quality, much remains to be learned.

   Key words: quality; outcomes; standards

8. Evans, B. et al. 1992. Communication skills training and patients' satisfaction. *Health Communication* 4 (2):155–70.

   Effective physician-patient encounters require the doctor to have consulting skills that facilitate communication flow. When adequate communication does not occur, patients express dissatisfaction with their medical interactions.

   Many medical students show interview behaviors that may not contribute to patients' satisfaction. Poor communication skills reduce the reliability of elicited medical information and lead to reduced satisfaction for both patients and students.

In the present study, a communication skills training course was evaluated, using rating of students' videotaped history-taking interviews with patients and patients' satisfaction rating.

Trained students showed significantly improved consultation skills and techniques compared with a group of control students who displayed few changes in behavior over the course of the study. The satisfaction rating given by patients of trained students improved significantly, whereas ratings given by patients of control-group students decreased over the same period.

Key words: patient satisfaction; training; communication; physician-patient interaction

9. Fallowfield, L. et al. 1998. Teaching senior oncologists communication skills: Results from Phase I of a comprehensive longitudinal program in the United Kingdom. *Journal of Clinical Oncology* 16 (5):1961–68.

This study was done to determine the communication difficulties experienced by clinicians in cancer medicine and to develop, implement, and evaluate communication skills training courses. One hundred seventy-eight senior clinicians attended one-and-one-half- or three-day residential courses designed to enhance skills development, knowledge acquisition, and personal awareness. Course content included structured feedback, video review of interviews, interactive group demonstrations, and discussion in groups of four led by trained facilitators. The main outcomes were self-rated confidence in key aspects of communication, attitudinal shift toward more patient-centered interviewing, perceived changes in personal practice, and initiation of teaching programs for junior staff. Fewer than 35 percent of the participants had received any previous communications training. Time, experience, and seniority had not improved skills: Before the course, oncologists expressed difficulty with 998 different communication issues. Primary problems concerned giving complex information, obtaining informed consent, and handling ethnic and cultural differences. Confidence ratings for key communication areas were improved significantly postcourse ($p < .01$). Three months postcourse, 95 percent of the physicians reported significant changes in their practice of medicine. Seventy-five percent had started new teaching initiatives in communication for junior clinicians. Clinicians showed positive shifts in attitude toward patients' psychosocial needs ($p = .0002$) and were more patient centered (p

=.03). The courses were highly rated, and 97 percent would definitely recommend them to colleagues. Subjective improvements reported immediately postcourse were maintained at three months.

Key words: communication; education, medical, continuing; medical oncology; education; Great Britain; physician-patient relations

Figueroa, M.E. et al. 1998. "Does Quality of Care in Rural Peru Matter as Much in Reproductive Health as in Family Planning?" (Paper submitted to MCH)

A growing body of research and program experience relates adoption of family planning methods, effective use, and continuation to the quality of client-provider interactions. Unlike family planning, however, where the main issue of quality of care is informed choice, in other areas of reproductive health and child care consultations, the client plays a minor role in the decision-making process. Does the quality of the interaction matter for the client and/or for the provider? How important is the interaction in promoting good health behavior? This study draws from the family planning experience of quality of care and expands into the field of maternal and child care and reproductive health. The purposes of the study are to assess 1) the importance of providers' interpersonal communication skills on clients' participation during the consultation, and 2) how clients' perceptions of the providers' actions relate to the clients' information needs. Data consists of client-provider interactions in public-sector facilities at 10 rural sites in Peru. Additional sources were client exit interviews, focus groups with clients, and interviews with providers. Results of the quantitative analysis show client participation is, in general, low compared to that of the provider, regardless of the type of consultation. The results also show higher levels of provider interpersonal communication skills are strongly associated with higher and significant participation by the client. The results also show clients are highly perceptive and can recall clearly even the most basic or subtle of interactions— or lacks thereof—during the consultation. Results from the qualitative analysis confirm the quantitative findings that the client in rural Peru is a reflective and emotional individual who values warmth and attention from the provider and is motivated to participate by that type of behavior. These findings suggest even in health care services where the participation of the client in the decision-making process is not as relevant as it is in family planning behavior, provider communication skills can make a difference in clients'

participation and possibly can be conducive, over time, to self-adopted good health behaviors and use of health care services.

Key words: reproductive health; Peru; interpersonal communication; maternal-child health; quality of care

10. Hall, J. et al. 1988. Meta-analysis of correlates of provider behavior in medical encounters. *Medical Care* 26 (7):657–75.

    This article summarizes the results of 41 independent studies containing correlates of objectively measured provider behaviors in medical encounters. Provider behaviors were grouped *a priori* into the process categories of information giving, questions, competence, partnership building, and socioemotional behavior. Total amount of communication was also included. All correlations between variables within these categories and external variables (patient outcome variables or patient and provider background variables) were extracted. The most frequently occurring outcome variables were satisfaction, recall, and compliance, and the most frequently occurring background variables were the patient's gender, age, and social class. Average correlations and combined significance levels were calculated for each combination of process category and external variable. Results showed significant relations of small to moderate average magnitude between these external variables and almost all of the provider behavior categories. A theory of provider-patient reciprocation is proposed to account for the pattern of results.

    Key words: meta-analysis; provider-patient communication; interpersonal processes; satisfaction; compliance; recall

11. Henbest, R.J. and Stewart, M. 1990. Patient-centeredness in the consultation: Does it really make a difference? *Family Practice* 7 (1):28–33.

    The major purpose of this study was to test the hypothesis that patient-centeredness in the consultation was associated with improved patient outcomes. Patient-centered care was defined as care in which the doctor responded to the patient in such a way as to allow the patient to express all of his or her reasons for coming, including symptoms, thoughts, feelings, and expectations. The study took place in the offices of six family doctors. All consultations were audiotaped, and the patients completed a questionnaire and two structured interviews with the investigator: One was held immediately following the

consultation and the other took place two weeks later. Patient-centeredness was found to be associated with the doctor having ascertained the patient's reasons for coming and with the resolution of the patient's concerns. It was associated also with the patient's feeling of being understood and resolution of the patient's symptoms until confounding variables were controlled. The results of the multivariate analysis suggested the impact of a patient-centered approach might be part of a package of care, consisting of a doctor whose overall practice allows for the development of personal relationships through continuity of care with patients over time.

Key words: patient-centeredness; treatment outcomes; patient satisfaction

12. Huntington, D. et al. 1990. User's perspective of counseling training in Ghana: The mystery client trial. *Studies in Family Planning* 21 (3):171–77.

    Evaluating counseling training programs from the client's perspective has posed a methodological challenge for family planning researchers. This report describes an evaluation method that combines clinic observation with an exit interview methodology. Eighteen women posing as clients were requested to visit three clinics with trained and three clinics with untrained family planning counselors. These clients (called "mystery clients" in Ghana) were interviewed later to uncover any perceived differences among the consultations. The effect of training was evident. Trained counselors consistently provided more complete information about all available contraceptives. However, both trained and untrained counselors often treated younger clients with disrespect or refused to give them the information they requested. This behavior indicated the need to strengthen the values clarification section of the counselors' training sessions, which now has been done.

    Key words: family planning and methods; program evaluation; sex counseling and education; professional-patient relations

13. Kim, Y.M. et al. 1999. Client participation and provider communication in family planning counseling: transcript analysis in Kenya. *In Press: Health Communication* 11 (1).

    To examine how much and in what ways clients participate in family planning consultations and how providers influence their behavior, investigators analyzed transcripts of 178 counseling

sessions with female clients in Kenya and developed coding guides that focus on client participation. The results show providers dominate most counseling sessions, and clients rarely take an active role. The most common way for clients to participate is by volunteering additional information when they respond to providers' questions. Providers may encourage clients to play a more active role by building a sense of rapport, by relating contraceptive information specific to each client's personal situation, and by rewarding clients' attempts to participate.

Key words: communication; Kenya; counseling; family planning

14. Kopp, Z. et al. 1989. "Implementing a Counseling Training Program to Enhance Quality of Care in Family Planning Programs in Ecuador." (American Public Health Association presentation)

    During 1988 and 1989, a counseling training program was developed for all staff members of APROFE (Asociación por Bienestar de la Familia Ecuatoriana). The program was developed jointly by International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) and APROFE, which is an Ecuadorian family planning organization affiliated with IPPF/WHR. A baseline client survey was carried out to determine levels of client satisfaction and contraceptive knowledge at six clinic sites. The quality of client-provider interaction also was assessed by direct observation. Seven training workshops were provided for the over 100 staff members of APROFE who interact with clients: secretaries, receptionists, physicians, nurses, motivators, educators, counselors, and nurse-midwives. The impact of the program was assessed by pre- and postworkshop knowledge, attitude, and practice (KAP) tests and by subsequent observations of client-provider interactions.

    Key words: evaluation; counseling; family planning; Ecuador

15. Larsen, K. and Smith, C.K. 1981. Assessment of nonverbal communication in the patient-physician interview. *The Journal of Family Practice* 12 (3):481–88.

    The interview portion of 34 patient-physician visits at a family medical center was videotaped. Two judges in two major nonverbal categories, immediacy and relaxation, screened videotapes. Physician and patient were scored separately at 40-second intervals for 11 component parameters of the two major

categories. These scores were correlated with patient satisfaction and understanding ascertained by a postinterview questionnaire. For analytical purposes, patients were assigned to low- or high-satisfaction groups and low- or high-understanding groups.

Statistically significant differences between low- and high-satisfaction groups were demonstrated with respect to overall physician immediacy, five individual physician nonverbal parameters, and two individual patient nonverbal parameters. Similar statistical results were obtained for understanding groups.

The preliminary investigation suggests nonverbal behavior of the physician in the patient-physician interview is important in determining patient satisfaction and understanding.

Key words: nonverbal communication; patient satisfaction; understanding

16. Levinson, W. and Roter, D. 1995. Physicians' psychosocial beliefs correlate with their patient communication skills. *Journal of General Internal Medicine* 10 (7):375–79.

    To assess the relationship between physicians' beliefs about the psychosocial aspects of patient care and their routine communication with patients, 50 community primary care physicians participated in a continuing medical education program with 473 of their patients in Portland, Oregon. Routine office visits were audiotaped and analyzed for communication behaviors and emotional tone, using the Roter Interactional Analysis System (RIAS). Physicians' beliefs about psychosocial aspects of care were measured, using a self-report questionnaire with a five-point Likert scale. Attitudes were correlated with communication behaviors, using the Pearson correlation coefficient. Physicians' attitudes toward psychosocial aspects of care were associated with both physician and patient dialogue in visits. The physicians who had positive attitudes used more statements of emotion (i.e., empathy, reassurance) ($p < 0.05$) and fewer closed-ended questions ($p < 0.01$) than did their colleagues who had less positive attitudes. The patients of the physicians who had positive attitudes participated more actively in care (i.e., expressing opinions, asking questions), and these physicians provided relatively more psychosocial and less biomedical information ($p < 0.05$). Physicians' beliefs about psychosocial aspects of patient care are associated with their communication with patients in routine office visits. Patients of physicians with more positive attitudes have more psychosocial discussions in

visits than do patients of physicians with less positive attitudes. They also appear more involved as partners in their care. These findings have implications for medical educators, teachers, and practicing physicians.

Key words: attitude of health personnel; communication; physician-patient relations

17. Ley, P. et al. 1973. A method for increasing patients' recall of information presented by doctors. *Psychological Medicine* 3:217–20.

    Within minutes of leaving the consulting room, patients are frequently unable to recall what their doctor has told them. This paper describes a simple, practical method for increasing recall by organizing medical information into labeled categories. The success of this technique was demonstrated first in a laboratory experiment with volunteer subjects and then in a naturalistic setting with general practice patients.

    Key words: patient recall; family practice; doctor-patient communication

18. Ley, P. and Spelman, M. S. 1965. Communications in an outpatient setting. *British Journal of Social and Clinical Psychology* 4:116–18.

    A sampling of 47 new attendees at a medical outpatient clinic were interviewed shortly after they had been seen by the consultant to see how much they remembered of what the consultant had told them. Patients' accounts were taken down and compared with the verbatim records made by the consultant at the time he had interviewed the patients. Patients retained proportionately less of the information the more they were told. Older patients tended to remember more of what they were told than younger patients. Recall was related to the nature of the information given. Of all statements made by doctors, instructions are the most likely to be forgotten.

    Key words: information retention; communication; doctor-patient interaction

19. Loevinsohn, B.P. 1990. Health education interventions in developing countries: A methodological review of published articles. *International Journal of Epidemiology* 19 (4):788–94.

Some 67 journal articles describing and evaluating health education programs in developing countries were read by two independent reviewers, who examined the methodology used in the studies. Of the articles, 47 percent provided a sufficiently detailed description of the educational intervention to allow replication, and 40 percent described the educational level of the intended audience. Only 21 percent were controlled studies employing sample sizes greater than 60 individuals of two clusters, although six studies used randomized or quasi-randomized designs. Of the studies, 33 percent looked at changes in health status, while another 33 percent used observable changes in health behavior as an endpoint. There was good agreement among the reviews on whether these characteristics were present.

Only three of the articles contained all four methodological attributes described above. The results of these articles suggest successful health education depends on using a few messages of proven benefit repeatedly and in many forums.

It is important to improve the methodological quality of health education research. This can be done by using controlled, preferably randomized, designs; ensuring adequate samples sizes; examining only objective changes in behavior; or, better yet, changes in morbidity or mortality. Research reports should describe in detail the educational intervention employed and the target audience.

Key words: health education; developing countries; outcomes

20. McKerrow, W. 1997. Improving patient care and reducing risk through effective communication. *Health Law Can* 18 (1):30–32.

    Effective communication with patients results in better treatment outcomes and may be the best tool in managing risk. Providers must appreciate the barriers to effective communication, identify what and how information is to be communicated, and develop the necessary skills.

    Key words: communication; professional-patient relations; education; patient education

21. Meryn, S. 1998. Improving doctor-patient communication: Not an option but a necessity. *British Medical Journal* 316 (7149):1922.

This editorial discusses the importance of teaching communication skills in all levels of medical education. Previous studies and literature are cited that have found significant positive associations between doctors' communication skills and patients' satisfaction. Special emphasis is given to patient perceptions and expectations in the doctor-patient interaction.

Key words: communication; physician-patient relations; education; patient satisfaction

22. Mechanic, D. 1998. Public trust and initiatives for new health care partnerships. *Milbank Quarterly* 76 (2):281–302.

Effective communication between doctor and patient is a critical component of high-quality care. The physician's credibility has a significant effect on treatment outcomes. Because changes in medicine and larger cultural trends challenge the ability of clinicians to engage their patients' trust, new kinds of partnerships must be created. To do this effectively, physicians have to sharpen their communication skills and devise strategies for assuring their patients become informed allies in their own treatment. A number of innovations are helping to build these alliances: training in communication skills, creative uses of the Internet and videotape technologies, improved customer service programs, critical pathways for patients, and special educational aids. All these tools promise to be useful, but they require careful development and evaluation.

Key words: communication; patient participation; physician-patient relations; interpersonal relations; patient education, methods

23. Nicholas, D. et al. 1991. The quality assurance project: Introducing quality improvement to primary health care in less-developed countries. *Quality Assurance in Health Care* 3 (3): 147–65.

Persistently excessive morbidity and mortality rates in less-developed countries (LDCs) served by primary health care systems suggest the quality of services is inadequate. The PRICOR project, sponsored by the United States Agency for International Development, has designed and implemented methods for quality assessment and problem solving in LDC health systems. After developing comprehensive lists of essential activities and tasks, similar to practice parameters, for seven child-survival interventions, PRICOR supported comprehensive

quality assessment studies in 12 LDC countries. The studies, yielding over 6,000 observations of health worker-client encounters, indicated highly prevalent, serious program deficiencies in areas, including diagnosis, treatment, patient education, and supervision. To facilitate corrective action, PRICOR assisted managers in conducting operations research to resolve priority problems revealed by the assessments. The recently initiated Quality Assurance Project is building on PRICOR techniques in designing and implementing sustainable, continuous quality improvement programs for LDC health systems.

Key words: child welfare; developing countries; quality assurance; acute disease

24. Novack, D.H. et al. 1997. Calibrating the physician. Personal awareness and effective patient care. (Working group on promoting physical personal awareness, American Academy on Physician and Patient.) *Journal of the American Medical Association* 278 (6):502–09.

Physicians' personal characteristics, their past experiences, values, attitudes, and biases can have important effects on communication with patients; being aware of these characteristics can enhance communication. Because medical training and continuing education programs rarely undertake an organized approach to promoting personal awareness, we propose a "curriculum" of four core topics for reflection and discussion. The topics are physicians' beliefs and attitudes, physicians' feelings and emotional responses in patient care, challenging clinical situations, and physician self-care. We present examples of organized activities that can promote physician personal awareness, such as support groups, Balint groups, and discussions of meaningful experiences in medicine. Experience with these activities suggests through enhancing personal awareness, physicians can improve their clinical care and increase satisfaction with work, relationships, and themselves.

Key words: attitude of health personnel; curriculum; physician-patient relations; communication

25. Ong, L.M. et al. 1995. Doctor-patient communication: A review of the literature. *Social Science and Medicine* 40 (7):903–18.

Communication can be seen as the main ingredient in medical care. In reviewing doctor-patient communication, the following

topics are addressed: 1) different purposes of medical communication, 2) analysis of doctor-patient communication, 3) specific communicative behaviors, 4) the influence of communicative behaviors on patient outcomes, and 5) concluding remarks. Three different purposes of communication are identified: creating a good interpersonal relationship, exchanging information, and making treatment-related decisions. Communication during medical encounters can be analyzed by using different interaction analysis systems (IAS). These systems differ with regard to their clinical relevance, observational strategy, reliability and validity, and channels of communicative behavior. Several communicative behaviors that occur in consultations are discussed: instrumental (cure-oriented) vs. affective (care-oriented) behavior, verbal vs. nonverbal behavior, privacy behavior, high vs. low controlling behavior, and medical vs. everyday language vocabularies. Consequences of specific physician behaviors on certain patient outcomes are described: satisfaction; compliance and adherence to treatment, recall, and understanding of information; and health status and psychiatric morbidity. Finally, a framework relating background, process, and outcome variables is presented.

Key words: communication; physician-patient relations; patient education; treatment outcome

26. PRICOR 1990. Operations research improves home treatment of malaria in children. *PRICOR Child Survival Report: Results From Systems Analysis* (Study 1 only).

    Two problems existed relative to the treatment of malaria with chloroquine in Zaïre. One problem only 30 to 50 percent of mothers used chloroquine when it was necessary; the other is over half of those who used it did so in a dose too low to be effective. In order to strengthen the capacity of the health center nurses to educate mothers regarding malaria treatment, the nurses were trained in treatment and in health education techniques. Educational materials and messages were developed. Pre- and posttest information was used to determine the extent of mothers' proper treatment of malaria and their knowledge of the correct dosage.

    Key words: health education; malaria; children; Zaïre

27. Putnam, S. et al. 1985. Patient exposition and physician explanation in initial medical interviews and outcomes of clinic visits. *Medical Care* 23 (1):74–83.

Visits to a medicine walk-in clinic were tape-recorded, transcribed, and coded according to the verbal response mode (VRM) system. Questionnaires (given before and after the clinic visit) and telephone interviews (one week and four weeks after the visit) were used to measure patient satisfaction, compliance, and change in symptoms. Two verbal exchanges were examined: in the medical history, the patient exposition exchange, which was measured as the frequency with which patients make statements about their illnesses in their own words; and in the conclusion, the physician explanation exchange, which was measured as the percentage of physicians' statements that are factual. These verbal indexes showed correlations with patient satisfaction but no correlations with patient compliance.

Key words: patient exposition; physician explanation; medical interviews; clinic visits; compliance; satisfaction; health outcomes

28. Razavi, D. and Delvaux, N. 1997. Communication skills and psychological training in oncology. *European Journal of Cancer* 33, Suppl. 6:S15–21.

    Preserving the best possible quality of life for cancer patients and their families has become a major goal in cancer care. However, the cumulative effect of stressors related to cancer care, many of which involve communicating with patients and relatives, may lead to the development of burnout in staff. Many health care professionals lack the psychosocial knowledge and communications skills needed to identify patients' problems because general professional training focuses on technical care. Teaching strategies known as psychological training programs (PTP) are being developed to help improve health care professionals' sensitivity to communication problems with patients and relatives. Cognitive (e.g., theoretical information), experiential (e.g., case history discussions), behavioral (e.g., role-playing exercise), and supportive (e.g., stressor identification) training techniques are used to teach the essential skills of good communication (i.e., listening, empathy, response to cues, and appropriate use of reassurance). PTP range from one-day courses and residential workshops to full-time, one- or two-year curricula. However, one of the main obstacles to implementing PTP is skepticism among health care professionals about its usefulness. Research on training effectiveness, therefore, should be developed to assess the impact of communication skills on quality of care and patients' quality of life.

Key words: communication; medical oncology, education; education, continuing; physician-patient relations

29. Rinehart, M.A. et al. 1998. *GATHER Guide to Counseling. Population Reports J (48).* Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program.

    Counseling is one person helping another as they talk person-to-person. When you help a client make a decision or solve a problem, you are counseling. Through counseling, you help clients make choices that fit their own needs. For example, some clients are choosing a family planning method. Other clients are deciding how to avoid sexually transmitted diseases. Young clients may be choosing whether to delay sexual activity. All these clients can make better decisions with your help.

    Key words: family planning; counseling; provider-patient communication

30. Robinson, E.J. and Whitfield, M. J. 1985. Improving the efficiency of patients' comprehension monitoring: A way of increasing patients' participation in general practice consultations. *Social Science and Medicine* 21 (8):915–19.

    The aim of the reported investigations was to examine the effects of helping patients to check their understanding of instructions and advice given during their consultations with general practitioners. Three groups of patients were both tape-recorded during their consultation and interviewed immediately afterwards. The groups differed in the written information they were given prior to their consultations. The "normal" group was informed the researcher was interested only in how well doctors and patients understand each other. The "permission" group was invited explicitly to raise queries with the doctor during their consultation. The "guidance' group was asked to use two specified strategies to check their understanding of instructions and advice given by the doctor. We coded the frequency of questions and comments about treatment which patients produced during their consultations and the accuracy and completeness of their subsequent accounts of the recommended treatment. The "normal" and "permission" groups did not differ in either respect. The "guidance" group produced significantly more questions and comments than the "normal" group and gave more complete and accurate accounts of the recommended treatment. A partial replication in a different practice produced

consistent results.

Key words: family practice; patient education, methods; patient participation; referral and consultation; physician-patient relations

31. Ross, C. and Duff, R. 1982. Returning to the doctor: The effects of client characteristics, type of practice, and experiences with care. *Journal of Health and Social Behavior* 23 (June): 119–31.

Although a number of policymakers have suggested previous experiences with medical care affect subsequent use of physician services, few researchers have examined the issue empirically. We divided the determinants of revisiting the doctor in pediatric practice into three categories: client characteristics, organizational characteristics, and characteristics of the doctor-client interaction, and we developed a causal model. Although race, income, and education have no direct effects on the frequency of returning to the doctor, they have indirect effects, through the organization of health care and experiences within the health care system. Clients who are poorly educated tend to have consistently negative experiences with the health care delivery system. These experiences affect subsequent use of services. Positive experiences with the interpersonal, psychosocial aspects of the doctor-client interaction increase a client's proclivity to return to the doctor, while negative doctor-client interactions decrease the probability of returning to the doctor.

Key words: physician-patient relations; referral and consultation; adolescence

32. Rost, K. et al. 1990. Physician-patient familiarity and patient recall of medication changes. The collaborative study group of the SGIM Task Force on the doctor and patient. *Family Medicine* 22 (6):453–57.

Although patients regularly see the same physician for medical care, little is known about the effects of physician-patient familiarity on important visit outcomes. In a study of visits made to 79 physicians in 11 primary care settings, investigators sought to determine: 1) whether patient recall of prescription medication changes improved as physician-patient familiarity increased, and 2) whether characteristics which predicted recall for newer patients also predicted recall for intermediate and established patients. Sixty-six percent of patients recalled all medication changes recommended during the visit. While recall did not

improve as physician-patient familiarity increased, predictors of recall did differ. Generally, the more drug information the physician gave during the concluding segment of the visit, the fewer drug changes the patient remembered. However, this relationship reversed as physician-patient familiarity increased. Elderly patients demonstrated diminished recall regardless of the number of previous visits. The findings suggest the lengthy provision of drug information actually succeeds in heightening medication recall only when the physician and patient have a well-established relationship. In earlier stages, asking patients to restate recommendations may be a more effective strategy to enhance patient recall.

Key words: physician-patient relations; recall; age factors; communication; patient education

33. Rost, K. et al. 1989. Introduction of information during the initial medical visit: Consequences for patient follow-through with physician recommendations for medication. *Social Science and Medicine* 28 (4):315–21.

While negotiation of treatment decisions in the medical visit long has been recognized as an important interviewing skill, limited work has been done to investigate how doctors and patients negotiate what information is relevant in understanding the patient's problem. In this research, we tested how the introduction of information reflecting both the patient's and physician's perspective is related to the patient's adherence to the physician's recommendations for medication. Introduction of information was defined as bidirectional if patients independently offered information or behavior as frequently as they provided the information or exhibited behavior physicians requested. Thirty random samples of audiotaped dialogue were used to construct estimates of introduction of information during the history, examination, and consultation phases of initial ambulatory care visits of 45 older male patients. The data demonstrate bidirectional introduction of information during the examination segment explains more than half of the variance in patient adherence to physician recommendations for new medication. These findings support the idea that physicians' willingness to allow patients' input may contribute to the partnership's arrival at treatment decisions that have meaning for both.

Key words: patient compliance; patient education, methods; physician-patient relations

34. Roter, D.L. et al. 1998. Effectiveness of interventions to improve patient compliance: A meta-analysis. *Medical Care* 36 (8):1138–61.

This article summarizes the results of 153 studies published between 1977 and 1994 that evaluated the effectiveness of interventions to improve patient compliance with medical regimens. The compliance interventions were classified by theoretical focus into educational, behavioral, and affective categories, within which specific intervention strategies were further distinguished. The compliance indicators broadly represent five classes of compliance-related assessments: 1) health outcomes, e.g., blood pressure and hospitalization; 2) direct indicators, e.g., urine and blood tracers and weight change; 3) indirect indicators, e.g., pill count and refill records; 4) subjective report, e.g., patients' or others' reports; and 5) utilization, e.g., appointment making and keeping and use of preventive services. No single strategy or programmatic focus showed any clear advantage compared with another. Comprehensive interventions combining cognitive, behavioral, and affective components were more effective than single-focus interventions.

Key words: patient compliance; meta-analysis; adherence; compliance interventions

35. Roter, D. et al. 1998. The effects of a continuing medical education program in interpersonal communication skills on doctor practice and patient satisfaction in Trinidad and Tobago. *Medical Education* 32:181–89.

This study investigates the effects of a brief training program on the communication skills of doctors in ambulatory care settings in Trinidad and Tobago. Evaluation of doctor performance is based on analysis of audiotapes of doctors with their patients during routine clinic visits and on patient satisfaction ratings. A pretest and posttest, quasi-experimental study design was used to evaluate the effects of exposure to the training program. Doctors were assigned to groups based on voluntary participation in the program. Audiotapes of the 15 participating doctors (nine trained and six control), with 75 patients at baseline and 71 patients at the posttraining assessment, were used in their analysis. The audiotapes were content coded, using the Roter Interaction Analysis System (RIAS). Doctors trained in communication skills used significantly more target skills posttraining than their untrained colleagues. Trained doctors used more facilitators in their visits and more open-ended questions than other doctors.

There was also a trend towards more emotional talk and more closed-ended questions. Patients of trained doctors talked more overall, gave more information to their doctors, and tended to use more positive talk compared to other patients. Trained doctors were judged as sounding more interested and friendly, while patients of trained doctors were judged as sounding more dominant, responsive, and friendly than patients of untrained doctors. Consistent with these communication differences, patient satisfaction tended to be higher in visits to trained doctors.

Key words: clinical competence; communication; education, medical, graduate; family practice, education; physician-patient relationship; Trinidad and Tobago

36. Roter, D.L. and Hall, J.A. 1991. Health education theory: An application to the process of patient-provider communication. *Health Education Research* 6 (2):185–93.

Although the medical visit is widely acknowledged as an important event presenting unique opportunities for the modification of health beliefs and behaviors, health education theory has provided few explanatory mechanisms for understanding its communication process. The purpose of this paper is to explore a theoretical model, loosely derived from social exchange and reciprocity theory, for viewing the dynamics and consequences of patient-provider interaction during the medical encounter. We have elaborated this notion of reciprocity to suggest provider behaviors within both the technical and socioemotional realm inspire parallel patient behaviors. For instance, a physician who is very informative may expect a patient to remember his instructions and comply with his recommendations. Further, a physician who is warm and friendly will inspire parallel patient attitudes in the socioemotional domain, such as friendliness and satisfaction. However, we believe the reciprocity principle is only partially operative between domains. While an informative physician may be perceived as concerned and caring, merely being nice or caring, in the absence of indications of task performance (such as information giving), does not supply the evidence on competence that patients need to decide to attend to information or adhere to a therapeutic regimen. Our theory of reciprocal exchange in the medical visit is consistent with a consumerist perspective of patient-provider relations and with the activated patient philosophy of health education.

Key words: health education; patient-provider interactions;

reciprocity

37. Roter, D. and Stewart, M. 1989. *Communicating With Medical Patients: Sage Series in Interpersonal Communication, v.9.* Newbury Park, CA: Sage Publications.

38. Roter, D. and Hall, J. 1987. Physicians' interviewing styles and medical information obtained from patients. *Journal of General Internal Medicine* 2 (5):325–29.

    This paper investigates the association between physicians' interviewing styles and medical information obtained during simulated patient encounters. The sources of data are audiotapes and transcripts of two standardized patient cases presented by trained patient simulators to 43 primary care practitioners. Transcripts were scored for physician proficiency, using expert-generated criteria, and were content analyzed to assess the process of communication and information content. Relevant patient disclosure also was scored from the transcripts, based on expert-generated criteria. Findings were: 1) On the whole, physicians elicited only slightly more than 50 percent of the medical information considered important according to expert consensus, with a range from 9 percent to 85 percent. 2) Both open and closed questions were substantially related to patient disclosure of medical information to the physician, but open questions were substantially more so (Pearson correlations of 0.37 and 0.72, respectively). 3) Patient education, particularly information regarding prognosis, cause, and prevention, was substantially related to patient disclosure of medical information to the physician (Pearson correlations of 0.44, 0.36, and 0.34, respectively). 4) Finally, clinical expertise was only weakly associated with patient disclosure of medical information to the physician (Pearson correlation of 0.16).

    Key words: interviews, methods; medical history taking; physician-patient relations

39. Roter, D. et al. 1987. Relations between physicians' behaviors and analogue patients' satisfaction, recall, and impressions. *Medical Care* 25 (5):437–51.

    This paper investigates associations between physicians' task-oriented and socioemotional behaviors on the one hand and analogue patients' satisfaction, recall of information, and global impression on the other. The study is based on role-playing subjects' responses to interactions between physicians and simulated patients. Audiotapes of two standardized patient cases,

presented by trained patient simulators to 43 primary care physicians, were rated for vocal effect by 37 independent judges. Content analysis was made of the visits' transcripts to assess interaction process and to identify all medical information communicated. Findings revealed role-playing patients clearly distinguished tasks from socioemotional behaviors of the physicians. Within the task domain, patient-centered skills (i.e., giving information and counseling) were consistently related to patient effects in a positive direction, whereas physician-centered behaviors (i.e., giving directions and asking questions) demonstrated the opposite relationship. A negative pattern of association was also evident between physicians' socioemotional behaviors and patient effects.

Key words: physician-patient communication; physician-ask behavior; physician socioemotional behavior; patient satisfaction; patient recall; analogue study; simulated patients; physician performance

40. Roter, D. 1977. Patient participation in the patient-provider interaction: The effects of patient question asking on the quality of interaction, satisfaction, and compliance. *Health Education Monographs* 5 (4):281–315.

The purpose of this study was to investigate the effectiveness, dynamics, and consequences of a health education intervention designed to increase patient question asking during the patient's medical visit. Data were collected at a Baltimore family and community health center, which provides outpatient services to a low-income, predominantly black and female population. The majority of the study participants were, in addition, elderly and chronically ill. A total of 294 patients and three providers took part in the study. The study design included random assignment of patients to experimental and placebo groups with two nonequivalent (nonrandomized) control groups. Findings included: 1) The experimental group patients asked more direct questions and fewer indirect questions than did placebo group patients; 2) the experimental group patient-provider interaction was characterized by negative affect, anxiety, and anger, while the placebo group patient-provider interaction was characterized as mutually sympathetic; 3) the experimental group patients were less satisfied with care received in the clinic on the day of their visit than were placebo patients; and 4) the experimental group patients demonstrated higher appointment-keeping ratios (an average number of appointments kept divided by an average number of appointments made) during a four-month prospective

monitoring period.

Key words: patient compliance; professional-patient relations; consumer satisfaction; outpatient clinics; hospital

41. Stewart, M.A. 1995. Effective physician-patient communication and health outcomes: A review. *CMAJ* 152 (9):1423–33.

To ascertain whether the quality of physician-patient communication makes a significant difference to patient health outcomes, the MEDLINE database was searched for articles published from 1983 to 1993, using "physician-patient relations" as the primary medical subject heading. Several bibliographies and conference proceedings also were reviewed. Randomized controlled trials (RCTs) and analytic studies of physician-patient communication in which patient health was an outcome variable were studied. The following information was recorded about each study: sample size, patient characteristics, clinical setting, elements of communication assessed, patient outcomes measured, and direction and significance of any association found between aspects of communication and patient outcomes. Of the 21 studies meeting the final criteria for review, 16 reported positive results, four reported negative (i.e., nonsignificant) results, and one was inconclusive. The quality of communication, both in the history-taking segment of the visit and during discussion of the management plan, was found to influence patient health outcomes. The outcomes affected were, in descending order of frequency: emotional health, symptom resolution, function, physiologic measures (e.g., blood pressure and blood sugar level), and pain control. Most of the studies reviewed demonstrated a correlation between effective physician-patient communication and improved patient health outcomes. The components of effective communication identified by these studies can be used as the basis both for curriculum development in medical education and for patient education programs. Future research should focus on evaluating such educational programs.

Key words: communication; outcome assessment, health care; physician-patient relations

42. Video:

Buckman, R. et al. 1998. A Practical Guide to Communication Skills in Clinical Practice. Medical Audiovisual Communications, Inc.