



COMMUNICATION SKILLS FOR PATIENT-CENTERED CARE

RESEARCH-BASED, EASILY LEARNED TECHNIQUES FOR MEDICAL INTERVIEWS THAT BENEFIT ORTHOPAEDIC SURGEONS AND THEIR PATIENTS

BY JOHN R. TONGUE, MD, HOWARD R. EPPS, MD, AND LAURA L. FORESE, MD

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Better physician-patient communication is linked to increased patient satisfaction and patient adherence to medication and treatment regimens as well as to improved clinical outcomes¹⁻⁴. Practicing orthopaedic surgeons have received limited formal education in the communication skills necessary for patient-centered care; yet, we perform over 100,000 medical interviews during our careers⁵. Patient-centered care involves treating patients as partners, involving them in decision-making, and enlisting their sense of responsibility for their care while respecting their individual values and concerns^{6,7}. We have tended to focus mainly on the technical aspects of our care-giving⁸.

We do not seem to be very good communicators^{9,10}. In 1998, the American Academy of Orthopaedic Surgeons (AAOS) conducted an extensive national survey to which 807 patients and 700 orthopaedic surgeons responded¹¹. The patients and surgeons were asked to rate orthopaedic surgeons with use of the same categories. Patients rated technical skills as important (“high-tech”) but valued communication skills equally (“high-touch”)¹² (Table I). According to this survey, 75% of the orthopaedic surgeons believed that they communicated satisfactorily with their

patients, but only 21% of the orthopaedic patients reported satisfactory communication with their physicians. This gap was most evident in categories such as listening and caring and time spent with the patient⁹. Our most common deficiency in our daily interviews with patients remains a failure to demonstrate an empathic response¹³.

We can all learn to communicate better. During the past twenty years, effective tools for teaching and assessing physician communication skills have been developed. Communication skills are being taught in medical schools and residency programs^{2,8,14-16}. Beginning with the class of 2005, the United States Medical Licensing Examination will require medical students to pass a clinical skills-assessment examination by interviewing standardized patients at designated national testing centers¹⁷. Furthermore, the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties now link assessment of communication skills to accreditation of residency programs and to maintenance of certification for practicing physicians, respectively^{18,19}. Busy orthopaedic surgeons must continue to build communication skills to deal with the challenges of shifting patient expectations,

language and cultural barriers, increasingly complex medical treatments, and constraints from managed care.

Good communication skills improve medical care and reduce lawsuits²⁰. Skillful interviews improve diagnostic accuracy by gathering a superior quantity and quality of data². Physicians with adept communication skills establish rapport with their patients and consequentially improve the patients’ compliance with treatment. Effective interviews also improve patient outcomes, reduce medical errors, and make the specialty of orthopaedic surgery more enjoyable^{15,21,22}.

Malpractice suits often are the results of differences in expectations between the patient and the physician. Beckman et al. reviewed depositions from sixty-seven malpractice claims and reported both the preponderance and the types of communication problems described in these depositions²³ (Table II). Good communication helps physicians to understand patient expectations, thereby reducing liability exposure.

Improving Our Communication Skills Educational Programs

Improving communication skills, like improving operating skills, is best done

TABLE I Discrepancies Between AAOS Members' Self-Assessment and Patients' Perceptions of Orthopaedic Care¹²

	Physician's Perception: I Believe Patients View Me As:	Patient's Perception
Highly trained	70%	64%
Having successful results	64%	53%
Being caring and compassionate	71%	37%
Spending time with patients	71%	36%
Providing valuable service	65%	35%

with an organized educational program. Although written material is useful in improving patient-physician communication, behavioral change is more likely to occur in a workshop⁹. The AAOS partnered with the Bayer Institute for Health Care Communication (BIHCC) in 2001 to form the AAOS Communication Skills Mentors Program (CSMP)²⁴. This initiative combines a successful educational model, the "4Es" (engage, empathize, educate, enlist), with jointly developed orthopaedic-specific video vignettes (Fig. 1). Twenty-five orthopaedic surgeons trained as mentors teach interactive workshops as part of the CSMP. Written comments and follow-up questionnaires confirm the workshop participant's interest and ability to successfully incorporate new communication skills techniques.

The Bayer educational model, or the "4Es," defines the critical communication tasks—to engage, empathize, educate, and enlist the patient—which are considered to be of equal importance to the biomedical tasks, or the "2Fs," of finding the problem (diagnosis) and fixing the problem (treatment). The BIHCC has fifteen years of experience teaching the science behind the art of medicine and has trained more than 90,000 clinician participants²⁵⁻²⁷. Engagement establishes an interpersonal connection that sets the stage for the patient-physician interaction. Engagement draws the patient in. Empathy demonstrates the physician's understanding of and concern about the patient's thoughts and feelings. The patient is seen, heard, and understood by the physician. Education delivers in-

formation to the patient. The patient learns something. Enlistment extends an offer to the patient to actively participate in decision-making. Enlistment acknowledges that the patient controls much of what can happen in his or her health-care treatment plan²⁸.

Techniques for Patient-Centered Interviews

First impressions are important^{29,30}. You should be neatly dressed and well groomed. You should clear your thoughts and smile to provide a pleasant introduction for the patient. After knocking, enter the room with a deliberate but not rushed pace. Smile, make eye contact, and speak in a calm, pleasant, consistent tone of voice. All attention should be on the patient. When introducing yourself, start with a salutation (good morning/afternoon/evening). The patient should be addressed as Mr., Ms., Madame, Señorita, etc. Check the pronunciation of the patient's name, if necessary. Even in an emergency, introductions are important.

You should be cautious about asking patients "How are you today?" Although this is more of a greeting than a question in the United States, it can

put ill or injured patients in the awkward position of responding that they are "fine" just before relating their story and/or medical problem. With the initial introduction, say "Welcome" or "Good to see you" while maintaining eye contact and offering a handshake, when such a greeting is culturally appropriate. You should sit approximately 2 to 4 ft (0.6 to 1.2 m) from the patient. If the patient continues to look you over in an attempt to estimate your pace and the warmth of the initial greeting, you should try a normalizing statement such as "How do you like this hot/cold/wet weather?" You should not stand while the patient is seated during the medical interview.

Ask: "How can I help you today?" Six simple, powerful words. Open-ended questions allow the patient the opportunity to define the conversation. Although it is hard to do, you should wait until the patient finishes speaking. It takes most patients two minutes to tell their story and explain why they are seeing you; however, the average physician interrupts the patient within eighteen to twenty-three seconds. Avoid this pitfall. If you listen for two minutes the patient will tell you 80% of what you need to know². Nodding, reflective facial expressions, and continued eye contact all signal your attention to and concern for the patient. Physicians should look at the patient while listening; notes should be written during pauses in the conversation.

When the patient says, for example, "I'm here because my shoulder hurts," you should respond by saying "Fine, tell me all about it" with an uplifting, pleasant tone of voice indicating interest and concern. If you say, "Tell

TABLE II Contribution of Communication Breakdowns to Malpractice Risks *²³

Patient mentioning poor relationship as reason for claim	71%
Patient felt deserted	32%
Patient felt devalued	29%
Patient felt information was delivered poorly	26%
Patient felt there was a lack of understanding by the clinician	13%

*The decision to litigate is most often associated with perceived lack of caring and/or collaboration in health care delivery.

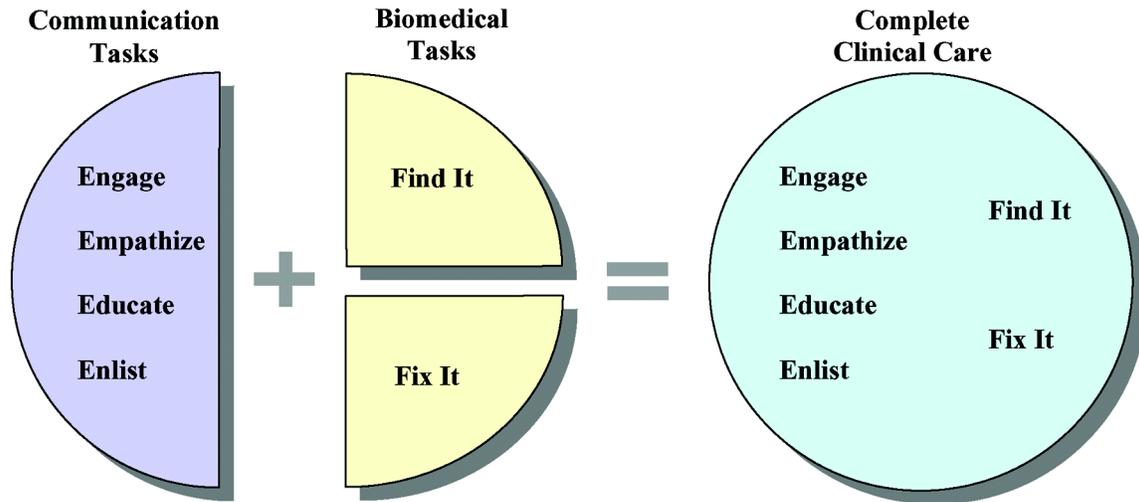


Fig. 1

The “4Es” define the communication tasks, combined with traditionally taught biomedical tasks, that are necessary for complete clinical care²⁵.

me about your shoulder pain,” you risk conveying the impression that you are interested only in a body part and that only that one complaint can be considered. Continue to avoid a transition to closed questions of what/how/when/where to gather more information. Instead, the next few questions should flesh out the patient’s story, not the interpretation of the orthopaedic condition. Helpful statements might include “I’m curious about . . .” or “Tell me more about . . .”

A source of frustration frequently mentioned by participants during CSMP workshops is the unmentioned problem that arises at the end of the visit. These “hidden agendas” may force the physician to extend the visit and disrupt the schedule or risk angering the patient by leaving the problem unaddressed³¹. Because orthopaedic patients often have multiple complaints, it is very important to identify them and, if necessary, to prioritize them (“Is there anything else?”). When secondary concerns cannot be adequately addressed during an office visit, the physician should explain in terms that are centered on the patient’s best interests (“We did not schedule enough time to adequately address these other problems today, but we can schedule another appointment for you.”). Familiarizing the patient with the pro-

cess and the need for additional information and/or tests also reduces the patient’s anxiety and expresses your respect for the patient. Humor can be an important method of presenting a physician’s style and confidence as well as of lightening and refreshing an otherwise overly serious conversation. However, humor can cause misunderstandings and possibly result in patients judging physician behavior as being patronizing or arrogant.

Acknowledging the patient’s emotions and values demonstrates that you recognize their individuality. Statements such as: “That must have been (painful/frightening/frustrating)” are crucial to establish rapport. Orthopaedic surgeons rarely use empathetic statements. We tend to be uncomfortable relating to our patients’ emotions. Remember that a little human kindness could make that patient your best advocate. As Terry Canale said in his AAOS Vice-Presidential Address: “The patient will never care how much you know, until they know how much you care.”³²

You should reflect your understanding of the patient’s story by summarizing what you heard. Some of the patient’s words should be repeated. Feelings should be normalized (for example, “Many people feel that way.”). It may help to briefly share a story from your own life that relates to the patient’s

condition as long as the attention remains focused on the patient.

After completing the history and physical examination, say, “Tell me what you understand about this problem” or “So what have you been thinking about this condition?” This saves time because physician-dominated visits often include information that does not address what is on the patient’s mind^{3,31}.

You should explain your thoughts with clear direct words, avoiding jargon and reflecting the patient’s style and values. Pause to check for comprehension during what might otherwise become misunderstood as a physician monologue, even when patients are nodding and appear to be following every word. Patients normally forget half of what is said within minutes of leaving our offices. Pamphlets and informational brochures can supplement, but not replace, effective communication. Asking questions, in an uplifting tone of voice, such as: “What questions do you have?” and “Is there something else you’ve been wondering about?” encourages patient responses, while authoritative voice tones may be perceived by patients as indicating the end of an interrogation.

After assessing the patient’s understanding of the possible diagnosis and treatments, you should always ask, “How does this fit with what you’ve been

thinking?” This one question can avoid misunderstandings and may reveal that the patient has a different agenda that he or she has been hesitant to share. Treatment options should be discussed to explain benefits, anticipate potential obstacles and risks, and offer a specific time-frame for reevaluation and results. You should offer goals tied to future results that put the patient in control; it is often helpful to write them down.

Scheduled follow-up examinations help to motivate and monitor progress. Patients should have ownership of their treatment program, which should include feedback measures to help keep them motivated. Ask the patient: “How important do you think it is to do these things?” and “How confident are you that you can do these things?” These two questions often uncover unknown barriers or motivators and provide opportunities to tailor the treatment plan. An effective tool for improving future follow-up communication is to say: “When you return, I’ll ask you if you are better. And if you are better, I’ll ask you how much better—10%, 50%, 90%? So be thinking about this until I see you then.” This suggestion invites patients to actively monitor and prepare to discuss their progress and to demonstrate their level of adherence at their follow-up visit³³.

You should conclude each interview by reviewing the diagnosis, treatment, and prognosis. With a sincere, uplifting tone, physicians should say good-bye and, while shaking hands and maintaining eye contact, deliberately state the expectation of a positive outcome. Expressing hope leaves the patient with a lasting positive impression.

Communicating Adverse Outcomes

When a patient has had an adverse outcome or has sustained an injury as a result of a medical error, the physician’s reaction is often defensive, resulting in the patient not being fully informed. There are, however, persuasive arguments for complete disclosure³⁴. Informing patients allows them to make appropriate plans for subsequent treatment³⁵. An uninformed patient may not cooperate with necessary cor-

rective measures. Disclosure also prevents the patient from worrying about the etiology of an event. For example, a patient who is informed that unexpected bleeding is due to anticoagulants will not worry that he or she has a gastrointestinal tumor³⁶.

Patients prefer full disclosure of errors. In a study of 1500 randomly selected members of a large health maintenance organization, patients who had received full disclosure were less likely to change physicians and had greater satisfaction³⁷. Trust in their physician increased, and they had a more positive emotional response. In some cases, disclosure decreased the risk of legal action. A positive response was not guaranteed, however; it was dependent on the clinical outcome and the details of the error³⁸.

In another study, investigators assessed the attitudes of 149 randomly chosen adults about medical errors³⁹. Patients were more likely to commence litigation following moderate and severe errors if there had been no disclosure.

The Ethics Committees of the American Academy of Orthopaedic Surgeons, the American College of Surgeons, and the American Medical Association believe that the physician has a duty to inform the patient about any adverse event or error. Also, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires physicians in accredited hospitals to inform a patient when results of treatment differ substantially from the anticipated outcomes⁴⁰.

There are specific techniques that are useful in communicating adverse events⁴¹. Discussing the incident with members of the patient’s health-care team and other staff members can ease the burden and help to prepare an appropriate response⁴². Consider who should be present and who should break the news. Patients and their families may suffer not only from an adverse incident, but also when the incident is handled insensitively or inadequately. Conversely, when staff members acknowledge the damage and take corrective actions, the overall im-

pact on patients can be greatly reduced⁴³. Include important family members and try to have both parents present if the patient is a minor. Eliminate possible interruptions like pagers and cellular phones. The exact content of the disclosure and the order in which facts will be given should be carefully considered. All pertinent data and test results should be readily available⁴⁴⁻⁴⁷.

Use a quiet room with privacy. Avoid barriers like desks and tables between you and the patient. A substantial portion of communication is nonverbal. Make eye contact, and speak with an even tone of voice. The discussion should not appear hurried, and you should try to remain calm.

Provide ample time. The discussion should not occur between surgical cases or five minutes before office hours. Reschedule other commitments in order to properly organize and address the communication needs related to the unexpected event in the same way that you would prepare for emergency surgery. The content of the initial discussion may be less important than the circumstances of the delivery. Some suggest that touching the patient by holding hands or providing a hug can be very reassuring to carefully selected patients. However, such gestures are not appropriate in every situation, and the physician should judge each situation carefully⁴⁵⁻⁴⁸.

Direct, clear statements are important, as are their delivery, particularly the tone of voice. You may want to start by saying, “I am afraid I have some bad news.” Communicate in a manner that is open, compassionate, and timely. Give an accurate, clear-cut statement with nondefensive explanations of what has happened. Speak in short statements, frequently stopping to inquire whether the patient or family members understand. Avoid slipping into the comfort zone of technical descriptions and medical jargon.

Do not assign blame, and avoid offering initial beliefs or subjective opinions of possible causes of the event. The cause of the error may not be understood or apparent until a thorough investigation has been completed. Many

medical errors result from poor communication among team members. Criticisms of the health-care team may detract from caring for the patient.

Disclosure of an adverse event causes stress for the patient and the family. Expect and acknowledge emotional responses. Complex, even severe reactions of fear, anger, mistrust, and hopelessness are common. An apology without assigning blame is acceptable and does not denote an admission of liability. "We are sorry that this happened to you" demonstrates concern without blame. The focus should remain on the disease, not the health-care provider⁴⁹.

Prepare to receive the patient's emotional outpouring of fear, anger, disappointment, and mistrust. Tolerate silence as emotions are gradually understood and then expressed. Reflect and acknowledge emotions that you see as well as those that are stated. Listen for concerns that can be clarified and values that can be confirmed. Offer to listen to family members who could not participate in the initial disclosure.

At the end of the discussion, you should summarize an explicit, proactive plan for the care and support of the patient. The patient's understanding and acceptance of the plan should be evaluated and improved if necessary. Writing down a list of instructions for the patient can be helpful. Document thoroughly the details of the discussion. Adverse events and bad outcomes profoundly affect the physician as well as the patient⁴². After the discussion, the physician should take time to regroup before moving on to the next task. Follow-up after the discussion is critical. Subsequent tests and consultations should be completed expeditiously. The progress of the care plan should be reviewed directly with the patient. As care continues, the patient's emotions may shift, and such changes should be acknowledged and respected. You should remain hopeful for the patient and the family.

Culturally Diverse Populations

Nearly twenty years ago, in *The Silent World of Doctor and Patient*, Jay Katz first articulated his premise that effective communication between physi-

cians and patients builds essential mutual trust and facilitates medical decision-making¹⁴. Yet even Katz could not anticipate the magnitude of language and cultural barriers that challenge efforts to improve effective communication. More than twenty million people living in the United States are not proficient in English. Linguistic minorities report worse care than ethnic or racial minorities⁵⁰. At the same time, cultural conflicts often lead to misunderstandings and distrust, which adversely affect patient outcomes^{16,51}.

The Language Divide

English is not the primary language of a growing number of patients in the United States. The number of immigrants has nearly tripled since 1970, increasing from 9.6 to twenty-six million⁵². These patients have been described as having limited English proficiency. The scope of the language divide is qualitative as well as quantitative. When an interpreter is necessary, introduce the interpreter to the patient. During the medical interview, you should relate to the patient, not the interpreter. Speak to the patient as if they understand. Make certain that the patient is responding to your questions through the interpreter, and do not allow the interpreter to answer without the patient's response. Any effort by the physician to speak even a few words of the patient's language will be appreciated⁵³. Patients using interpreters require more physician time than do those who are proficient in English⁵⁰. They also require more visits⁵⁴. Decision-making may be more cautious and expensive when non-English-speaking patients are treated in the absence of a bilingual physician or a professional interpreter⁵⁵.

The Office of Civil Rights (OCR) of the United States Department of Health and Human Services has issued a final "policy guidance" (i.e., regulation) that requires physicians who receive reimbursement from Medicaid or State Children's Health Insurance Programs to provide competent translation services when they are requested by patients who claim limited English

proficiency⁵⁶. According to the regulation, any reimbursement for medical services provided to Medicaid patients (and, if applicable, patients covered by Medicare Part A) constitutes "federal financial assistance" to the physician under provisions of Title VI of the Civil Rights Act of 1964.

Physicians can comply by retaining employees who are fluent in English and a second language to perform the translation services, by using the telephonic services offered by MultiLing (www.multiling.com, accessed 1/20/05), or by contracting with professional translators. In some communities, volunteer translators for certain languages may be an alternative. The OCR strongly suggests that it is inappropriate for family members to play the role of translator between the patient and physician and other medical office staff for reasons of confidentiality. The practice is acceptable if the patient offers or agrees to use a family member or friend to translate but not when the patient requests an independent translator. The rule also specifically bars physicians from discriminating against patients with limited English proficiency by refusing to see them or discharging them from their practices.

Because these regulations make no provision to pay the considerable cost of translators, several specialty medical associations and nearly forty states have signed letters in opposition, recommending that physicians be exempted from these OCR regulations and that translators be allowed to directly bill third-party carriers or patients for their services. There is also the concern that these costs will reduce patient access to physicians.

The Cultural Divide

The American Medical Association's *Cultural Competence Compendium* defines a culture as "any group of people who share experiences, language, and values that permit them to communicate knowledge not shared by those outside the culture."⁵⁷ Medical cultural competence refers to the effective communication of a diagnosis and treatment plans in a manner that is

TABLE III Six Realities of “Cultural Programming”*

Culture is not obvious
We all feel our own culture is best
We misinterpret the actions of others if we do not understand their interpretations of their own observations
We may not know when we are offending others
Awareness of differences and possible barriers improves our chances for successful interactions
Understanding our own “software” or value system is a crucial step in providing culturally competent care

*Adapted, with permission, from: Gardenswartz L, Rowe A. Managing diversity in health care manual: proven tools and activities for leaders and trainers. San Francisco: Jossey-Bass; 1999.

acceptable to patients from different cultural backgrounds⁵⁸.

Each of us reflects individual cultural values as well as the culture of medicine. We need to be aware of our own culture, belief systems, and values because they affect our interactions with patients⁵⁹. Cross-cultural communication is a critical skill for physicians and other health-care workers if we are to reduce disparities in both access and outcomes of medical care. To avoid misunderstandings, Gardenswartz and Rowe recommended that physicians consider six “realities of cultural programming”⁶⁰ (Table III). Problem areas arising from misunderstandings in cross-cultural communication include those related to authority, physical contact, communication styles, gender, sexuality, and family⁶¹.

We can reduce these misunderstandings by being more aware of possible cultural barriers⁶². For example, in cultures where status is inherited rather than earned, the position of other decision-makers in the family must be acknowledged. Also, values related to privacy, including feelings of

modesty and shame, could make it more difficult to obtain necessary information even after initial efforts to build a trusting relationship.

Ethnicity-specific information for use in the treatment of several different disease states is available from a series of booklets entitled *A Provider’s Handbook on Culturally Competent Care* from Kaiser Permanente⁶³. Sections in each of these handbooks are devoted to major diseases and areas of special clinical focus. There are no specific references to musculoskeletal conditions.

Overview

Good communication between physicians and patients is the bedrock of quality medical care. Essential communications cannot be delegated^{28,64}. The importance of communication skills education has recently been fully recognized, leading to requirements of documented teaching in orthopaedic residency programs as well as assessments within the proposed maintenance-of-certification process^{65,66}.

We can all improve our performance of the most common procedure

in orthopaedic surgery—the medical interview. Recognizing communication skills as a new focus of medical education, the AAOS has successfully developed and implemented a Communication Skills Mentoring Program, which includes interactive, highly rated workshops. This AAOS program provides residents and practicing orthopaedic surgeons with easily learned techniques that sharpen their professional communication skills. More information, including the CSMP mentors and workshop schedules, is available at www.aaos.org.

John R. Tongue, MD
Orthopedic and Fracture Surgery,
6485 S.W. Borland Road, Suite A, Tualatin,
OR 97062. E-mail address for J.R. Tongue:
jtongue.md@verizon.net

Howard R. Epps, MD
Fondren Orthopedic Group, 7401 South Main
Street, Houston, TX 77030

Laura L. Forese, MD
New York-Presbyterian Hospital, 161 Fort
Washington Avenue, New York, NY 10032

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