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Communication Matters

Taking time to save time—and lives!

For many clinicians, the pace of work feels out of control, which leads to feelings of dissatisfaction and frustration. The prospect of developing enhanced communication skills may sound like a way to worsen the time pressures, not relieve them. In fact, IHC's long experience and sizable research evidence demonstrate far-reaching benefits when clinicians take the time to hear their patients' stories. While achieving better outcomes for your patients and yourself does not have to make for longer visits, it does take an openness and commitment to learn and practice effective communication tools.

As always, thanks for your time!

Warm regards,

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It's a paradox: taking time can save time. How can that be?

In medicine, where ambiguities and complexities are common, there is the ever-present risk of misdiagnosis. Research shows that an estimated 10 to 15 percent of diagnoses are incorrect (Groopman, 2008), citing (Higgs,1995). Many factors-individual and systemic-boost the risk of diagnostic error. Time pressures are frequently cited as key contributors.

Fortunately, there are evidence-based interventions to help clinicians interact more effectively-and efficiently-with patients.

PRESSURES ABOUND

Clinicians, pressed to see high volumes of patients and bombarded with information, may not always use their time with patients optimally to elicit all the information necessary to diagnose a problem. Language and cultural barriers and hesitancy around sensitive topics further conspire to create opportunities for erroneous or delayed diagnoses.

RESEARCH EVIDENCE

For more than 30 years, there has been a growing recognition of the role clinician communication behavior plays in the collection of medically relevant information during patient interviews. Beckman and Frankel (1984) analyzed audio tapes of interviews with patients, and concluded that "Physician-directed interviewing at the beginning of a visit may eliminate the expression of patient concerns and questions." This is significant, because when patients do not express their concerns, important diagnostic data may be overlooked. A recent study, published in the March 25 issue of *JAMA Internal Medicine* (Singh, 2013) and described in *amednews.com* (O'Reilly, 2013), found significant potential harm as a result of diagnostic errors: 73 percent of errors posed risk of considerable or serious harm and 14 percent were potentially fatal. The study involved analysis of diagnostic errors in an outpatient primary care setting, examining the conditions that were misdiagnosed, the potential for harm resulting from the misdiagnoses and the root causes of those errors.

Lead author Hardeep Singh, MD, MPH and colleagues found that the overwhelming majority of diagnostic errors (78.9 percent) were related to issues in the patient encounter and more than half of patient-practitioner encounter breakdowns (56.3 percent) were primarily related to problems with history-taking.

Dr. Singh noted, "That so many diagnostic mistakes involved the bread-and-butter of the office visit-how patients and physicians communicate, how doctors conduct exams and take histories-shows how the time squeeze takes its toll on ordinary practice." (O'Reilly, 2013) Commenting on the research results, David Newman-Toker, MD, PhD, a neurologist at Johns Hopkins Hospital and a board member of the Society to Improve Diagnosis in Medicine, acknowledged that briefer primary care visits contribute to the incidence of diagnostic error.

SUGGESTIONS

Experts have weighed in with some suggestions to address the problem. Dr. Newman-Toker suggested physicians "seek systematic information about patient outcomes as a way to measure their diagnostic acumen." (O'Reilly, 2013) Gordon D. Schiff, MD, associate director of the Center for Patient Safety Research and Practice at Brigham and Women's Hospital, Boston, urges "situational awareness" of the potential for diagnostic errors. Other suggestions include enlisting patients' shared responsibility and taking advantage of new technologies such as decision support.

COMMUNICATION SKILLS

More specifically, **IHC provides training in the fundamental-and readily acquired-communication skills that can ensure that patients share their stories fully with clinicians using the E4 communication model (Engage, Empathize, Educate and Enlist).** There are many models for setting up a strong foundation for productive and engaged patient interviews; all focus on key skills to establish a relationship of trust and ensure a thorough exchange of critical information. Kaiser Permanente, a leading innovator in medical care quality and organization and a long-time partner with IHC, has adopted the Four Habits Model. The first habit, **invest in the beginning**, is not just a vague exhortation: it outlines specific behavioral skills and techniques that will be very familiar to IHC-trained faculty and workshop participants: **create rapport quickly, elicit the patient's concerns** and **plan the visit** with the patient.

IHC clinician-patient communication training emphasizes three key skills to help to build a strong foundation for an effective patient interview. **Refraining from interrupting** sounds like an obvious rule. Unfortunately, research shows it is honored more in the breach than in practice. On average, physicians interrupt patients' opening monologues after 18 seconds. **Uninterrupted, patients take 30-90 seconds to state the reasons for their visits**. (Rabinowitz, 2004)

Asking open-ended questions draws on the expertise of the person in the room who knows most about the patient's symptoms and concerns: the patient! A simple inquiry, "Is there something else you want to address in the visit today?" reduces the chances that something important is missed. (Heritage, 2007)

Active listening skills such as **reflecting back the patient's words** not only demonstrate caring, but they offer opportunities to ensure full and accurate understanding of the patient's meaning. The axiom "Message sent is not the same as message received" highlights common causes of confusion and consternation in everyday life; in medical history-taking, there can be life-threatening consequences.

DOESN'T ALL THIS TALK MAKE FOR LONGER VISITS?

These are just a few of the specific skills that can contribute to more effective clinician-patient communication. One may wonder, **"*Doesn't all this talk make for longer visits*?"** Clinicians may fear that they will lose control altogether of their visit time if they ask open-ended questions and elicit patients' perspectives on their conditions. That fear is not supported by the evidence in the literature or learners in IHC's patient-centered communication skill-building courses.

IHC surveys workshop participants to learn about the real-world impact of our communication skills training. While the results are not scientifically valid, learners report making "more accurate diagnoses" as a result of the Clinician-Patient Communication program. A comment from a learner is typical:

> *"When I allow patients to talk and I listen for at least two minutes without interrupting, I am able to gather more information within a shorter amount of time."*

RESEARCH EVIDENCE ON VISIT LENGTH AND PATIENT-CENTERED COMMUNICATION

A study published in 2011 examined patient-centered behaviors and whether they contributed to longer visits. Laws *et al* measured a slight increase in visit length for more patient-centered encounters, but discovered that some of the longest visits included talk about things not related to care! The authors concluded "Patient centeredness is weakly related to visit length, but may reflect inefficient use of time in long encounters." (Laws, 2011)

Another 2011 study, by Brock and co-authors, examined some process measures and outcomes of training in upfront collaborative agenda-setting. Significantly, there was **no observed increase in visit length** as a result of the shift in physicians' communications to elicit more information from patients. (Brock, 2011)

The evidence is clear: the medical history is frequently the most critical diagnostic tool in the clinician's armamentarium. (Peterson, 1992) With focused attention, patient-centered intention and practice, it can be highly efficient and effective.

THE GIFT OF TIME IN PRACTICE

In his *New York Times* bestseller *How Doctors Think*, Jerome Groopman relates the story of a young woman's 15-year ordeal with undiagnosed celiac disease. (Groopman, 2008) Erroneous diagnoses of irritable bowel syndrome, anorexia and bulimia were treated for years, without positive results. "...After a myriad of tests and procedures, it was her words that led [the consulting gastroenterologist] to correctly diagnose her illness and save her life." The physician was warm and welcoming, he employed active listening techniques and he took time to hear her story through. He approached the patient with curiosity and without judgment, and asked open-ended questions. Much of Groopman's book focuses on different types of cognitive errors that confound medical diagnoses. He recognizes time limits as important factors for making correct diagnoses. For the patient in this story, taking time was instrumental in two important ways: the physician

spent **time listening to the patient**, ensuring she did not feel rushed, and assuring that he heard the whole story; and he took **time to investigate and think** about the clinical picture before him.

Whether medical visits are for routine complaints or confounding and intractable problems, there is significant value to investing the time and attention to allow patients to tell their stories fully. The pressures on clinicians to maintain high patient volumes, make accurate diagnoses and build strong relationships with patients might, at first blush, appear to be mutually exclusive. In fact, all of these goals are supported by effective communication. Since its founding in 1987, IHC has been advocating for the importance of communication as an essential aspect of healthcare.

For information about IHC clinician training programs, visit our website or contact us at info@healthcarecomm.org.

NOTES

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IHC programs and services

Clinician-Patient Communication to Enhance Health Outcomes **--**IHC's flagship program for clinicians. It helps **clinicians** at every state of their careers enhance their effectiveness and boost their job satisfaction.
Upcoming open enrollment CPC train-the-trainer faculty development course: Sept. 24-27, 2013, Germantown, WI. Application

Additional **upcoming courses** are listed on the IHC website.

IHC is nationally accredited to provide continuing medical education and continuing nursing education by three major accreditation agencies (ACCME, AAFP, and ANCC). IHC takes responsibility for the content, quality, and scientific integrity of all its CME/CE activities.

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