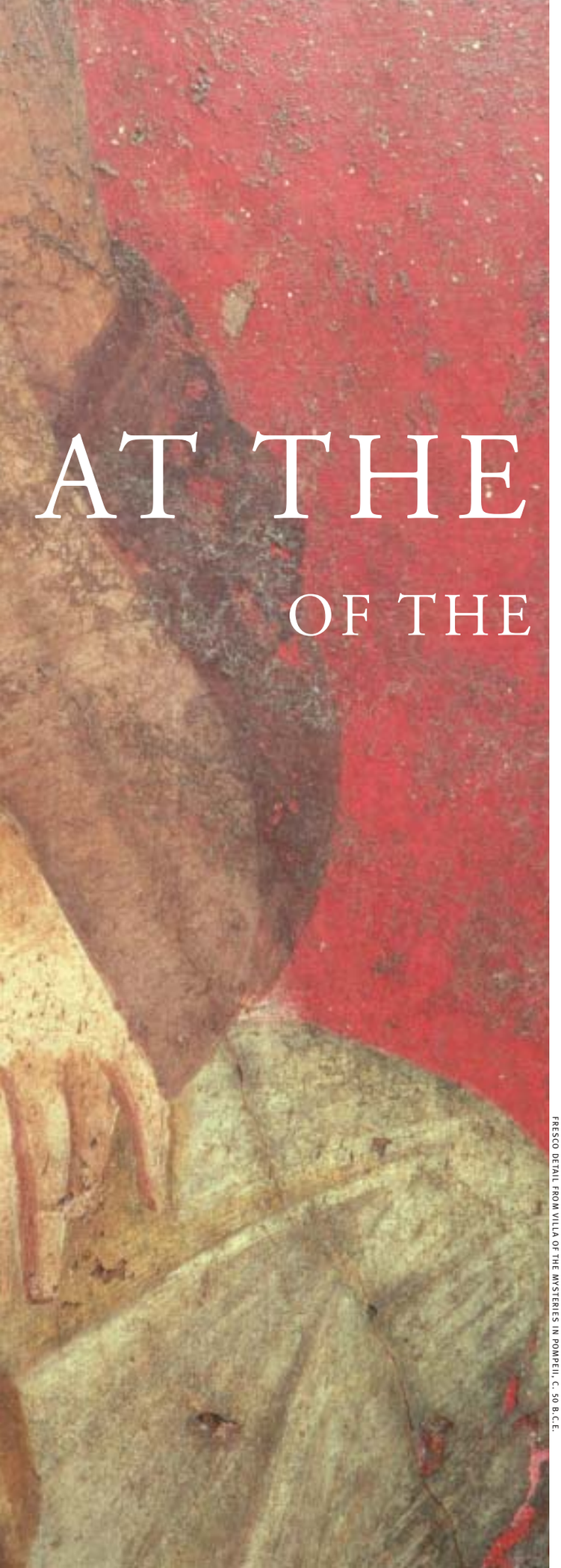


We know that if we can improve communication between doctors and patients, patients will do better. A new institute at Pitt is dedicated to the subtler elements of the clinical encounter.



FRESCO DETAIL FROM VILLA OF THE MYSTERIES IN POMPEII, C. 50 B.C.E.

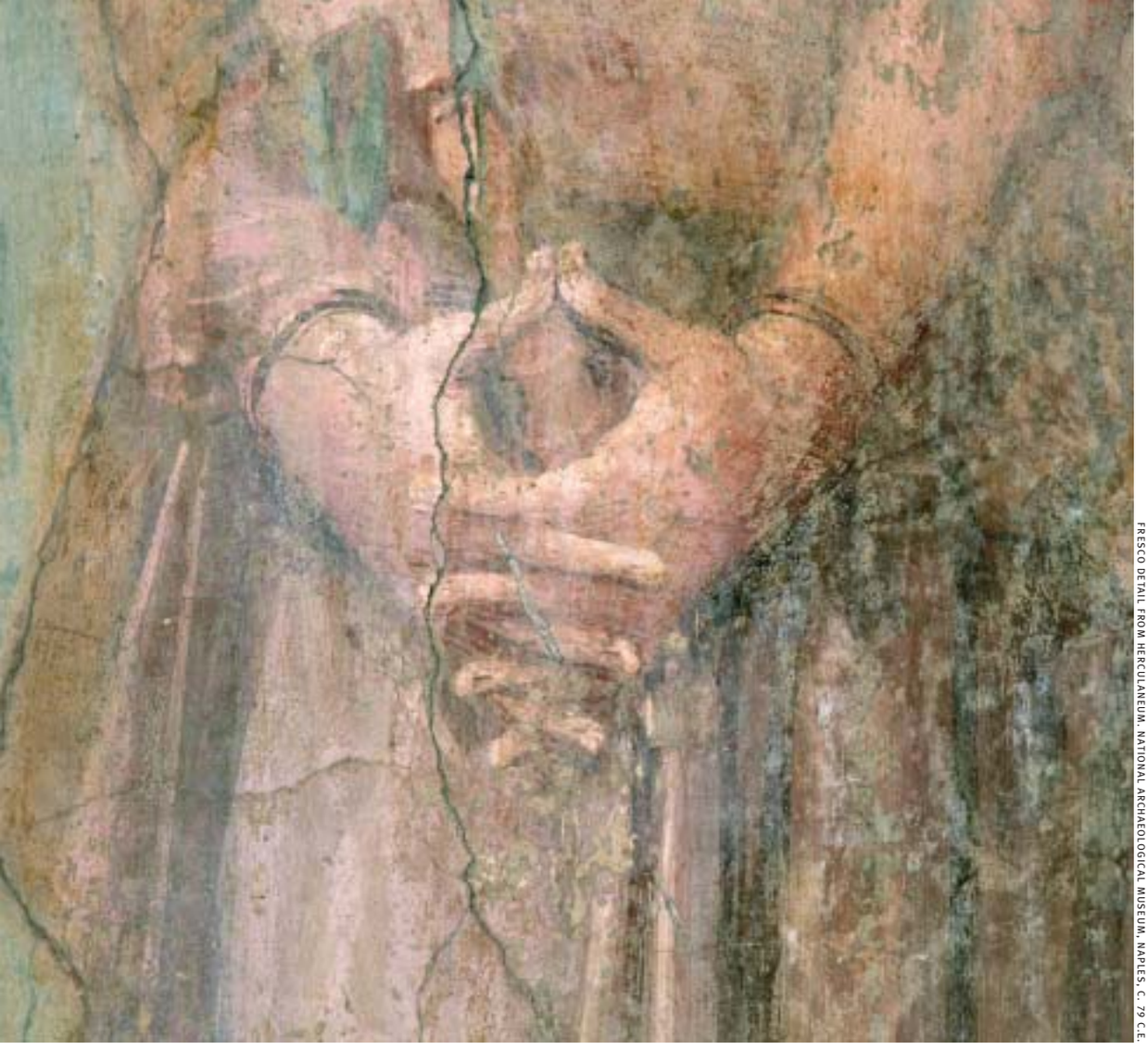
WHAT'S SAID, WHAT'S NOT SAID, WHAT SHOULD BE SAID | BY DOTTIE HORN

AT THE HEART OF THE CLINICAL ENCOUNTER

Chemotherapy had done little to help John Colby (not his real name), a 23-year-old with leukemia. Doctors recommended a bone marrow transplant and began preparations, which would take three or four weeks, for the procedure.

Then, suddenly, Colby came down with pneumonia. Because his immune system had been destroyed by the leukemia, he had no defenses against the infection. Hitendra Patel, a University of Pittsburgh Cancer Institute hematology and oncology fellow, admitted Colby to the hospital and gave him the most powerful antibiotics known. Even so, within a week, Colby's lungs failed. He was placed on a ventilator, which meant that he had to be sedated and was unconscious. His parents,

PHOTOGRAPHY | MIMMO JODICE, CORBIS



FRESCO DETAIL FROM HERCULANEUM. NATIONAL ARCHAEOLOGICAL MUSEUM, NAPLES. C. 79 C.E.

always by his side, were optimistic—the pneumonia had come out of the blue, and they hoped that the transplant would be successful. Every day, Patel updated them about changes he was making to their son's antibiotics (new drug-resistant microorganisms were often found in Colby's lung secretions). But there were other issues to discuss, and Patel struggled to find the words.

The parents were so devoted to their son and so hopeful. How could he help them understand that this would likely be the end of their son's life? When should they give up hope of any recovery and take him off the ventilator?

Patel spoke to the parents every day, explaining the gravity of the situation. Eventually, the parents made the decision to take Colby off the ventilator. The day after they removed the ventilator, Colby died.

Patel wanted to be better prepared for conversations like the ones with the Colby family, which he'd always found difficult and uncomfortable. When he saw a notice about a program to help oncology fellows improve their communication skills, he decided to apply.

Patel was accepted to the program and, in April 2002, traveled to Colorado to participate. Every day during the weeklong workshop, Patel would practice his skills with several other fellows: In front of the entire group, he would go through a clinical interaction with a "simulated patient"—a trained actor. One day, his job was to tell a patient that she had liver cancer and to negotiate a treatment plan. The next day, he would see the same patient to tell her that the treatment wasn't working—there was nothing more doctors could do to stop or slow the progress of her disease. During each daily role-playing session, Patel received comments from the group about what he did well and what he might change. "That's when I realized that I can handle things differently," says Patel.

Since completing the training, Patel has incorporated many of its techniques into his conversations with patients and their families. He has learned, for example, how to handle emotions and nonmedical concerns. Say a patient is worried about what will happen to his wife after he dies. Patel lets the patient know that he recognizes and understands the concern; he has discovered that very simple gestures, like saying, *I see that you are concerned about your wife*, can open the door for the patient to talk further. He tries to present options. *We can talk to our social worker about that,* he might say. Or, *People sometimes discuss those kinds of issues in our support group.* Offering an outlet for patients to express their feelings or worries makes the medical encounter more fulfilling and helps them cope with painful emotions, Patel has learned.

Research suggests that doctors of all kinds may want to look at their communication skills. A recent study surveyed 755 "sicker" adult Americans—those who either rated their health as fair or poor or who'd faced serious medical problems within the past two years. Half reported that their regular doctors do not ask for their ideas and opinions about treatment and care. Half indicated that, over the past two years, the doctor had not discussed with them the emotional burden of coping with the condition. A third said they had left the doctor's office without getting important questions answered. (Researchers have been studying patient-physician communication since the early 80s—though Arthur S. Levine, Pitt's senior vice chancellor for health sciences and School of Medicine dean, was ahead of the times. He published a 1973 article in *The New England Journal of Medicine* that looked at the effectiveness of a weekly teaching seminar to help oncology fellows cope with their reactions to dying patients.)

The training Patel attended in Colorado was part of a National Cancer Institute–funded research project for which Robert Arnold, professor of medicine at the University of Pittsburgh School of Medicine, serves as coprincipal investigator. Throughout the next five years, Arnold and his collaborators will train 180 oncology fellows; their goal is to see whether the course actually improves the fellows' ability to talk to patients and families about end-of-life issues. Fellows are evaluated at the

beginning and at the end of the weeklong course to measure changes in their interactions. (It is still too early to draw any conclusions from the data.)

The oncology fellows project is part of a larger effort by Arnold, and by the University of Pittsburgh, to study what happens at the heart of the clinical encounter: i.e., what's said, what's not said, and what should be said between a doctor and a patient. Researchers in scattered medical school departments have been studying such issues—but now, Pitt's recently formed Institute for Doctor-Patient Communication offers a supportive forum where interested researchers can meet monthly to discuss projects and share ideas. In addition, the institute will sponsor symposia and conferences; it will also reach out to medical students (see "Patient Interrupted").

"We know that if we can improve the interactions between doctors and patients, patients will do better," says Arnold.

He cites one study, in which researchers enrolled patients with diabetes who were placed randomly into two groups. Each study participant met with a research assistant for 20 minutes just prior to two regularly scheduled physician office visits. In the control group, the assistant provided standard education about diabetes; in the experimental group, the assistant taught the patients ways to become more involved in medical decision making. At the third visit, the experimental group showed better diabetes control (lower blood glucose levels) and fewer functional limitations than the control group. A similar study has shown that training hypertensive patients to communicate with their doctors can also lead to lower hypertension.

Such evidence suggests that better communication may equal better health—yet the doctor-patient interaction is fraught with the potential to become "chaos," says Bruce Ling, a Pitt assistant professor of medicine and codirector for research at the institute.

He describes the relationship as one that can break down at any number of points. Consider a typical office visit: "Mrs. Smith" comes in with an agenda and discusses her concerns. "Dr. Jones" takes in that information and begins to develop a treatment plan. At the same time, the doctor may come to the visit with certain goals—perhaps wanting to discuss health maintenance issues, like losing weight or stopping smoking. Dr. Jones must broach those issues and offer suggestions; Mrs. Smith must digest that information and respond. All in 15 minutes or less.

"If there is a misunderstanding anywhere in that exchange," says Ling, "that can really impact what happens after the visit—what the patient does and what the doctor does as well, in terms of ordering tests, using medicines, addressing needs."

And that's just what happens in a standard interaction. Consider a situation that requires more finesse. Imagine a patient who has spent hours researching obscure Internet sites and has learned of a new wonder drug for arthritis available from a nutritional supplement provider. The patient is adamant that this drug will be a cure-all. If the doctor does not agree with the patient's thinking, the relationship can quickly become adversarial, notes Ling: "It takes some very good communication skills to be able to address the [patient's] information without making it look like you're just blowing it off and without offending the patient."

To add to the challenge, there is, of course, often conflicting evidence within medicine and uncertainty among physicians about how to manage some conditions. This ambiguity can complicate the doctor's role. First, the doctor must highlight what the controversies are in a time-efficient manner *and* in a way that the patient can understand. The doctor then needs to let the patient form and express an opinion and to work with the patient to develop a treatment plan. "That can be very difficult," says Ling.

He remembers a clinical encounter in which he wanted a patient to be screened for colon cancer. There are several different tests that can be used for the screening. "Current recommendations are that we speak with the patient, go over each of the options, and work with the patient to come up with the option that the patient accepts, prefers, and that we feel would be appropriate," says Ling. In this case, however, the patient didn't understand much of what Ling was saying. "I spent 20 minutes going over this," he says, "and I think afterwards the patient was more confused about

PATIENT INTERRUPTED

The third-year med student is eager to practice taking a history. He enters an exam room and greets the patient inside. She came to the doctor, he learns, because of two weeks of sharp shoulder pain. He asks about her living situation; she is married and has two toddler sons. He decides to ask some screening questions.

"Have you ever been physically abused by your partner?" he asks. She looks up at him.

"Yes."

The student is speechless. No patient has ever before answered yes when he asked that question.

"It's pretty intimidating to the student the first time that happens," says Melissa McNeil, professor of medicine. In the Clinical Skills course for second-year students, McNeil teaches students how to handle such a situation. "We give them some statements that will help them move to the next part of the encounter, so they're not left feeling uncomfortable, nor is the patient," says McNeil.

In her course, McNeil teaches students how to talk with patients about other potentially sensitive issues, including sexuality, alcohol, and drug abuse. Once the course is over, students move on to third-year clinical rotations. Depending on their priorities, clinical faculty members may or may not reinforce the communication skills students have learned.

The medical school's new Institute for Doctor-Patient Communication has an eye on ensuring that Pitt med students have the training and practice opportunities they need to become capable communicators. The just-formed institute is mapping out a strategy, guided by Laurel Milberg, adjunct clinical associate professor of family medicine and institute codirector for education.

"We want to provide resources and support to improve education in doctor-patient communication skills across all four years of the medical school curriculum," says Milberg.

She is first canvassing to see which courses and clinical rotations currently include instruction on relating to patients. Eventually, the institute will partner with professors who want to incorporate communication—or more of it—into their courses or rotations and will develop ways to support those professors.

Institute organizers would also like to see med students be more extensively tested on their patient one-on-ones during simulated clinical settings.

Studies show that when a doctor initiates discussion with a patient (usually by asking why the patient came in), the doctor listens to the patient's opening statement for an average of just 11 to 18 seconds before interrupting. Research also tells us that patients usually don't share their most significant concern first, but initially talk about less important issues. If physicians interrupt, they may never hear what's really on the patient's mind, says Milberg. She intends to help future Pitt med grads get the whole story. —*DH*

what colon cancer screening is all about." He fears he put up a new barrier for the patient and made it less likely the screening would ever take place.

Situations like this led Ling to wonder about the best way to approach the topic. "Maybe I shouldn't expect the patient to be able to grasp these very complex issues and make that decision right then and there," says Ling. "Maybe it's that you send written material and prime the pump and prepare the patient for such a discussion." Now, with the support of a Career Development Award from the National Cancer Institute, Ling plans to identify successful techniques for relaying colon cancer screening information. He'll also identify common pitfalls.

The doctor-patient interaction is fraught with the potential to become "chaos." The relationship can break down at any number of points.

Ling is hoping to find answers to some burning questions: Are there certain things that are either said or done that predict whether one ends up getting screened? What might a physician say or do that results in increased trust and satisfaction? And if trust and satisfaction are high, does that make a difference in whether the patient decides to get the screening?

Asking such questions could save lives. Research shows that only 40 percent of Americans are up to date with their colon cancer screening. "We are hoping to change [that statistic]," says Ling, "so that we have a majority of the population who are up to date, so that they can benefit maximally from the technology that is out there."

The patient was fidgeting and looked like she was about to burst into tears. She had received a card in the mail telling her that her Pap test was abnormal—and that she might have cancerous or precancerous cells. Judy Chang, then an undergraduate who volunteered at a clinic, spoke with the woman when she came in for further evaluation. Chang explained what the abnormal Pap test meant and what to expect during the exam. As she spoke, the woman's face relaxed and she stopped fidgeting. It was a scenario Chang witnessed repeatedly.

"Just providing that information seemed to change their entire outlook on the procedure and maybe even on how much control they felt like they had over their health," says Chang, looking back. "It was striking how that interaction, though it was very short, could actually be very powerful." The undergraduate liberal arts major decided to become an MD—and eventually she decided to study how doctors communicate with patients.

Chang has studied interactions physicians have with patients who've experienced domestic abuse. Now, as an assistant professor of obstetrics, gynecology, and reproductive sciences at Pitt, she is planning a broader study. Chang will look at how physicians talk with patients during obstetric visits about factors that can negatively affect health—such as drug and alcohol use, smoking, multiple sex partners, and domestic violence. Like many others who study physician communication, she will tape-record and analyze the conversation between the doctor and the patient. Yet, as she plans the project, she faces many challenges inherent in this type of research.

First, doctors—as well as patients—have to agree to participate in the study and to have their interactions audiotaped (some researchers even use videotapes, so that they can observe nonverbal communication). Researchers wonder whether the self-selected group that elects to take part is representative. "Are they better communicators in the first place, or at least more confident about their communication skills, so that they're willing to participate in the project?" asks Chang. She also worries that doctors, conscious of being in the spotlight, may change the way they interact with patients when they know they're being recorded—bringing up the old research quandary of potentially changing something just by watching it. "You don't know really if it reflects reality when you're audiotaping," says Chang.

Once she has taped the conversations, Chang will have to decide how to analyze them. Some researchers boil the conversations down to sets of phrases or sentences: What's being said? Is it medical information or psychosocial talk? Is the doctor or patient speaking? Other researchers focus more on the back and forth. Who starts the conversation and how? Do the two parties take turns? Are there lots of interruptions? Do people pick up on each other's cues—or do they not pick up on cues?

Still others focus on the tone of the conversation. They take an audiotape and blur the words, so that a listener cannot discern the content of the conversation but can still hear the cadence and volume of the speech. Then they'll have a group of people (who have no connection to the conversations) listen to the tapes and categorize the general tone of the healthcare provider—was it aggressive, for example, or soothing?

As she refines the methodology of her project, Chang is looking forward to the opportunities offered by the new institute: "For me as a junior investigator, someone who's just starting out in this field, I'll now have a resource to learn from other people's experience as well as a forum. I can bounce my ideas and plans off of people who are also thinking about the same issues."

But there are a few big "what ifs" involved in such efforts. What if Patel, who sought out help, is an exception? What if, after researchers carefully plot out ways to enhance clinical encounters, Arnold and his colleagues find physicians aren't motivated to learn new techniques? What if the attitude is, "Who has the time for this?" It's not just a matter of teaching old dogs new tricks to ask physicians with notoriously busy schedules to spend time bettering their one-on-one encounters.

"It's hard for physicians to take two to five days and go someplace and spend eight hours a day focusing on their communication skills," says Arnold. "A lot of physicians won't do it."

So the mountain may come to them. Arnold is looking into less time-consuming and simpler ways for doctors to get feedback. With his collaborators at Duke University, he will experiment with giving feedback on a CD to oncologists who send in tapes of patient sessions. Then the researchers will have the oncologists tape their visits again.

Arnold believes that, as new communication techniques and teaching methods are developed, more and more doctors will invest the time to improve their skills.

"In my experience, practicing physicians are *very* interested in doctor-patient communication," he says.

"They're interested in what they're having problems with. They get stuck and they're not sure what to do." ■