
Healthcare Communications: Foundations for Understanding Communications in Healthcare Settings

Part I of this text introduces the foundations for understanding communications in healthcare settings. This introduction is critical to grasping the importance of addressing communications in a textbook on healthcare relationships and why it is essential that communication skills are not only taught but retained. There is much to know about the phenomena of communication. Interpersonal communication is one of the most important of the basic life skills (Gazda, Childers, & Walters, 1982). Effective interpersonal communication skills are said to be the gateway to the development of other important life skills. Successful professional role development depends on our knowledge and understanding of communication concepts, practice, and evidence. In no other professions are interpersonal communication skills more important than in the health professions. As such, they have been studied extensively. Knowing which communications promote health behaviors is basic to provider role development. But, there are principles and concepts of communication that are even more generic and critical to patient–provider relationships.

Chapter 1, *Health Communications and Quality Care*, examines the relationship of communication to desired patient care outcomes. This chapter illustrates what is known about the importance of provider communication and selected outcomes: adherence to treatment, healthcare utilization, trust and satisfaction with healthcare providers, and improvements in health status. The years have passed that we teach and train providers to practice communications solely for the sake of adhering to professional values. While these values are foundational to our professional practice, there is an equally important role for this training and education—to ensure that our patients get safe high-quality patient care. There is a growing body of knowledge that addresses the importance of patient–provider communications in achieving better health outcomes. This knowledge creates not only a professional imperative but a scientific necessity. Chapter 1 presents evidence of the importance of the nature of provider–patient communications and illustrates how these communications have implications for healthcare outcomes.

Chapter 2, *Principles of Human Communication*, addresses the “anatomy” and “physiology” of human communications. The sensory modalities, information processing functions of the brain, and the role of memory and concentration are reviewed. The verbal and nonverbal dimensions of communications; the meta-communicative value of messages; and the basis for deficits in perception, processing, and transmittal of messages are discussed.

Chapter 3, *The Nature of Therapeutic Communications*, addresses the inevitable consequence that provider communications can either be therapeutic or nontherapeutic. How to distinguish between these phenomena, enlisting therapeutic response modes, and resisting nontherapeutic responses are

addressed. Therapeutic and nontherapeutic response modes have either helpful or deleterious outcomes; the rationale behind certain therapeutic response modes is presented.

Chapter 4, Cultural Similarities and Differences and Communication, discusses the process of avoiding cultural blurring and effectively communicating in cross-cultural contexts. In this chapter the importance of cultural competence is stressed. Examples of specific responses are discussed because they carry different interpretations across groups. Communication fluency across groups is presented as a continuum; with cultural incompetent behaviors at the negative end of the spectrum and cultural competence at the valued opposite end of the spectrum.

It is not necessary to deliberate very long about the importance of communication to our roles as providers. What providers generally do not comprehend is that communication is a science as well as an art. It is inconceivable that any text on applied communications would ignore the basic principles and concepts that have been culled from years of study of human communication.

Health Communications and Quality Care

Quality is never an accident; it is always the result of high intentions, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.
—William A. Foster

CHAPTER OBJECTIVES

- Discuss the relationship of communications between patient and provider and the goal to achieve quality patient care.
 - Discuss the Institute of Medicine’s definition of quality care.
 - Identify the aims identified in the *Crossing the Quality Chasm* report.
 - Demonstrate the “teach-back” approach.
 - Using a specific chronic condition and particular standard medication to treat this condition, describe the consequences of treatment nonadherence.
 - Discuss what is meant by “white-coat adherence.”
 - Identify selected communication approaches to improve treatment adherence.
 - Identify selected principles of communication that would facilitate the development of trust in the patient–provider relationship.
 - Discuss communication approaches to assess and monitor symptom severity.
 - Discuss how you would determine factors that influence patient utilization of healthcare services.
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Communication across all sectors of the health arena is critical to quality care. Further, improving the quality of communication is tantamount to improving patient outcomes. Communication between provider and consumers affects every facet on the health continuum—from health promotion and disease prevention to assessment, diagnosis, and treatment. An overriding interest in the area of communicating with patients and their families is the degree to which these communications result in quality care outcomes. Beyond the idea that communication reduces malpractice risk is the notion that it actually does have something to do with quality care. There is evidence that communication between patients and providers, directly or indirectly, determine the extent to which patients:

Experience fewer adverse medical events.
Exhibit higher levels of adherence to their treatment regimens.
Trust their care and their providers.
Are satisfied with their care and their providers.
Practice effective self-management behaviors.

Experience less symptom severity.
Suffer less morbidity and mortality.
Access and utilize available health resources.

This chapter will focus on communication and its relationship to desired healthcare outcomes. This chapter will describe what is known about the importance of provider communication and selected patient and healthcare outcomes: adherence to treatment, healthcare utilization (including retention in care), trust and satisfaction with healthcare providers, and improvements in health (selected documented findings in chronic illness). In each of these sections, what has been found to deter effective communication as well as contribute to effective communication strategies will be highlighted and described. Important linkages will be proposed that document how communication affects quality care. For example, when the provider's communications include listening and involvement in decision making, trust may be higher. If trust is high, patients are more likely to return for treatment and adhere to their treatment regimen.

QUALITY CARE

A landmark report of the issue of quality care in the United States was issued by the Institute of Medicine (IOM) in *The Chasm in Quality: Select Indicators from Recent Reports*. This report identifies clear areas in need of attention if healthcare quality is to be improved. In this report, statistics about health care in the United States are provided, including the number of persons who die from medical errors annually, whether patients receive the recommended care, the prevalence of worse outcomes in the uninsured, the number of patients who die each year from illnesses such as heart attack because preventive care was not adequate, the incidence of death due to medical errors, and the prevalence of mismanagement of patients with select chronic disease. The question raised here is to what extent, and how, problems in patient-provider communication are directly or indirectly related to quality care indicators.

The topic of quality care has been addressed in length. In a recent IOM report, quality care was defined as:

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

(The Chasm in Quality)

Since the development of this work, a series of IOM quality reports have been published and include: *To Err Is Human* (2000), and *Keeping Patients Safe* (2004a). The intention was to identify the scope of the problem of quality of care in selected arenas and propose plans to alleviate these problems over time. In 2001, the Institute of Medicine released the landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. This report concluded that the U.S. healthcare system is in need of fundamental change, and it recommended strategies for achieving substantial improvements in the quality of health care.

The Quality Chasm's framework consisted of six aims:

1. Making health care more safe.
2. Making health care more effective.
3. Implementing a patient-centered approach to health care.
4. Delivering care in a timely manner.
5. Increasing efficiency.
6. Insuring equitable health care for everyone.

In addition to these aims, 10 rules were set forth to guide the redesign of health care:

1. Care based on continuous healing relationships.
2. Customization based on patient needs and values.
3. The patient as the source of control.
4. Shared knowledge and the free flow of information.
5. Evidence-based decision making.
6. Safety as a system property.
7. The need for transparency.
8. Anticipation of needs.
9. Continuous decrease in waste.
10. Cooperation among clinicians.

These recommendations were made in the context of an extensive review of the evidence available that suggested quality needed to be enhanced. Data were categorized as indicators of deficits in quality of care.

For example, *The Chasm in Quality: Select Indicators from Recent Reports* (IOM) indicated that medical errors account for more deaths per year than breast cancer, AIDS, or motor vehicle accidents (citing data from the Institute of Medicine, 2004b; Centers for Disease Control and Prevention, National Center for Health Statistics: Preliminary Data for 1998, 1999). The question that must be raised is to what extent do patient-provider communications contribute to these statistics and others. Otherwise, to what degree, and how, communications are related to quality care outcomes.

OPERATIONAL DEFINITIONS OF QUALITY CARE

Within the IOM framework, which calls for safety, effectiveness, efficiency, patient-centered, timely, and equitable care, are a number of operational definitions of quality care. These definitions have been used as outcome measures to determine the extent to which care is higher in quality. Additionally, these indicators have often been used in clinical trials to provide evidence of quality outcomes. The following discussion highlights studies using these quality indicators.

Adverse Outpatient Drug Events

While much attention has been placed on the problem of inpatient adverse drug events (ADEs), less attention has been given to arenas in which the

patient is self-managing his or her care and communication difficulties result in adverse outpatient drug events. Adverse drug events are serious instances in which errors can lead to morbidity, mortality, or hospitalization. The potential for these errors are great. According to Cherry, Woodell, and Rechtsteiner (2007), reporting on an analysis of data from the 2005 National Ambulatory Medical Care Survey, an estimated 963.6 million outpatient visits to physician offices occurred, with an overall average of 331.0 visits per 100 persons. Medications were provided, prescribed, or continued in 679.2 million visits, accounting for 70.5% of all office visits. At 40.2% of all visits, two to seven drugs were recorded, and at 5.6% of visits, eight or more. With medication therapy being the primary reason for physician visits and at the tune of high numbers, it is not surprising that drug errors and communications surrounding medication taking would be of considerable concern.

Medication errors are harder to assess in the outpatient setting for a variety of reasons. Documenting the incidence of outpatient medication errors is difficult because the problem is somewhat “invisible.” Still there have been attempts to document the prevalence of outpatient medication errors. In the IOM 2006 report *Identifying and Preventing Medication Errors*, it was estimated that about 530,000 medication-related injuries occur annually among Medicare recipients seeking care in outpatient clinics. This does not include outpatients who are not Medicare patients and who are from different age groups. It does not include errors that do not result in an identifiable injury. Altogether, because outpatient errors are more difficult to detect and document, this figure may be more than double that reported.

Once the incidence of outpatient errors is revealed and described, the task is to identify those categories of patients at higher risk for medication errors. At this point, more needs to be known about the factors that place individuals at risk for medication errors. Where and how these problems arise can be summarized to some extent but require a multifaceted perspective. The independent and interactive effects of several variables affect whether certain groups will be at higher risk. Age, disease severity, cognitive deficits, presence of a support system, complexity of the medication regimen, and communications between provider and patient all play a role. Take, for example, the elderly patient who is living alone, has poor nutrition and hydration, has certain comorbid conditions such as impending renal failure. She is taking multiple medications for a variety of conditions received from a number of different specialists who did not communicate well with each other or the patient. These medications were filled at different pharmacies. This scenario is a “prescription” for danger. Now suppose the patient decides to take more medication after becoming aware of increasing but nonspecific symptoms. There are many opportunities for effective communication to improve the situation and protect the patient from drug errors. Table 1–1 depicts several communication strategies to minimize drug errors. Additionally, given that the delivery system had something to do with the resulting problem, the patient needs to be prepared to deal with potential confusions while navigating the system.

What did the patient need to know? Who needed to communicate what and when? How should potential problems be addressed? These are all important questions. The patient is in a position to have an adverse drug event, something that is occurring more often because people are living longer with the

Table 1–1 Communications to Minimize Drug Errors

<i>Principle</i>	<i>Example</i>
Assessing what the patient population will need to know and what might be difficult for them to understand is the first step in organizing an approach to the patient.	“What do you know about this medication/treatment? What is most difficult for you to understand?”
Identifying practical and psychological barriers (poor memory, distraction, cognitive impairment, lack of education, language facility). Instruction will be more effective if cognitive and motivational problems are taken into account.	Assess and plan to address these problems with visual aids, reminders, simple instructions, and use of community caregivers where appropriate.
Using medication lists ^a may help in anticipating difficulties.	Patient medication lists can provide accounts of all medications, schedules, over-the-counter remedies, potential drug interactions, side-effects, prescriber, purpose, what monitoring is required, and date plan should be reviewed.
Encouraging patients to ask questions and give information (using a shame and guiltfree line of inquiry) will more likely provide critical information with which to individualize your approach.	“Many of our patients don’t understand why they are taking this medicine and what will happen if they forget to take it; how about you?”
Anticipating that patients may expect information without specifically asking; check out what they understood you to say and where the confusion lies.	Use “teach-back” approach. “Let’s see how clear I was; can you tell me what you would do if you missed a pill?”
Fears are a basis for not entering into dialogue. Encouraging the expression of fears and concerns will allow for better assessment.	<i>“It is common to have questions now or later . . . we are together in making the treatment work . . . I can help you better if you tell me what you are afraid of or what bothers you about taking your medication.”</i>
Encouraging full disclosure will reveal potential safety issues.	“There are many things that patients do when they can’t make a decision about their medicine . . . they don’t fill their prescription, they don’t refill it, they don’t take the right amount, at the right time, they might stop taking the medicine without telling us, they might take someone else’s medication because they ran out or can’t afford it . . . these decisions can cause problems . . . let’s talk about whether they might happen in your case.” <i>Avoid the use of jargon: “use as directed.” Don’t use abbreviations: use “daily” instead of “QD.” Avoid use of decimals: instead of 0.5 gm, use 500 mg. Use pre-typed prescriptions and instructions.</i>
Communicating clearly and simply about medications will lessen the chance of error.	

^aSee Massachusetts Coalition for the Prevention of Medical Errors; MEDLIST.

chance of having more than one chronic illness. Living longer means more medications. There are more likely to be several different providers and/or specialists involved who may or may not be communicating effectively.

In a paper identifying problems associated with outpatient adverse drug events, Brown, Frost, Ko, and Woosley (2007) identified several psychological and practical barriers patients face in their everyday lives that may result in ADEs. In this study, prescriber–patient miscommunication factors were considered among the most important. They represented 30% of all factors identified by patients. These factors related to how the provider expressed information, elicited information, and the level of exchange. It was noted that 85% of the reported miscommunication factors related to patients' failure to give information or ask questions of the provider.

Lack of motivation to disclose or ask for information and expecting the provider to tell the patients what they needed to know were also important factors that, together with the factors of fear of negative consequences, fear of being rude or inappropriate, and a poor relationship with the physician, made up about 45% of the miscommunication factors. Additionally, 17% of factors related to patients' inability to give pertinent information, including poor memory, being distracted, cognitive impairment, and lack of education or language facility to communicate. Brown and colleagues (2007) proposed a model to account for the many factors patients reported. The model, based on patient self-reports, included psychological and barriers of everyday life, as well as those shown in the literature in the domains of patient, provider, and system of care: literacy of the patient, lack of health information, beliefs and attitudes, multiple drug use, communication skill deficits, limited capacity of provider to track medications, time and technology constraints, provider–patient communication, access to health care, and lack of funds.

Treatment Adherence

As has been commonly posited, communication is more likely to be at the root of the problem than any technical aspects of medical care. Communication is directly associated with treatment adherence. As Travaline, Ruchinskas, and D'Alonzo (2005) state, patients who understand their providers are more likely to fully disclose their problems, understand their treatment and its options, modify their behavior, and follow their medication regimens. While these outcomes are not solely due to the character of the provider–patient communications, the content and manner in which providers communicate is very important.

It is well known and documented that adherence leads to better health outcomes and nonadherence places the patient at risk for poor recovery and disease progression. Nonadherence has been identified as a contributing factor in cases of adverse events. Such is the case for women who do not follow up on abnormal Papanicolaou (Pap) smears who lacked follow-up for two or more years (Khanna & Phillips, 2001). Avoiding follow-up in this case leads to more advanced cancer presentation when presenting for care.

Nonadherence does not always lead to adverse events, but the likelihood that treatment will be compromised is high. Treatment adherence refers not only to medication adherence but compliance with appointment schedules,

diet and exercise regimens, or lifestyle modifications. Irrespective of adverse events, maximal benefits from any treatment plan will not be achieved if individuals discontinue interventions before completion of the treatment. Even if the patient sees the plan through to its completion, less than full adherence to one or more aspects can limit the benefits of the treatment plan, and in some cases, make the patient more susceptible to complications, mortality, and morbidity. Disengaging from treatment or drop out rates are serious and can limit overall effectiveness of the intervention.

Medication adherence refers to the extent that the patient complies with the dosage, schedule, and instructions provided by the provider. Within this context there is room for a great deal of error that may not be immediately recognized by patient, family, or provider.

Drugs don't work in patients that don't take them.
— C. Everett Koop, MD

The exact number of medication errors made by patients receiving outpatient treatment is not fully known, but it can be estimated with figures from studies of outpatient visits in which medications are prescribed. The public's reliance on medications has risen dramatically. The Kaiser Family Foundation (2007) reported an increase in the number of medications purchased from 2.1 billion in 1994 to 3.6 billion in 2006, an increase of 71%. The percentage of the population with a prescription drug expense in 2004 was 59% (for those under age 65) and 92% (for those 65 and older). It was estimated that the average number of retail prescriptions per capita increased from 7.9 in 1994 to 12.4 in 2006 (Kaiser Family Foundation, <http://www.imshealth.com>). Previous studies of patients experiencing a wide range of chronic conditions have reported that medication adherence is problematic and that even in clinical trials adherence might be as low as 43% (Osterberg & Blaschke, 2005).

In the treatment of all major chronic illnesses (arthritis, asthma, hypertension, major psychiatric illness, diabetes, pulmonary disease) adherence to medication regimens is concerning. While the standard of 80% dose adherence (usually taken as the number of pills taken relative to the number prescribed) is sufficient in some cases, this standard is not acceptable in other cases (e.g., HIV/AIDS), where less than 95% adherence may result in health status decline and disease progression. All patients are at risk for poor adherence patterns. Taken as a whole there is a phenomena that has been observed in patients with many types of chronic disease. It has been documented that patients do better just before an office visit (*white-coat adherence*) and worse when they tire of the demands of the regimen. Also, patients pick and choose which medications out of several they might follow more exactly. They do not adhere equally across all medications. These observable phenomena suggests that it is important to find ways to talk about nonadherence patterns and the likelihood medication adherence will wax and wane over time.

Another instance requiring special attention is when patients are prescribed new medications for the first time. Although the provider may describe the medication, the need for it, and how to take it, there may be pitfalls in this encounter. First, the patient may not know the questions to ask the provider about the new medication nor understand the answers given. Second, when

provider and patient enter into a discussion, communications may be ambiguous. Things may be left unclear because neither understands where the other is coming from. Despite the fact that information can be communicated clearly and briefly to increase the patient's understanding and adherence to the medication regimen, this does not always occur. Expecting to eventually understand, the patient and the provider could wait in anticipation for the next cue but nothing tangible surfaces, and both are thus resigned to the situation. The patient might be left with uncertainty and the provider with not knowing what the patient has gathered from the conversation.

To alleviate uncertainty and as time passes, patients are faced with a decision about the uncertainty they experience. Do they decide to take the medication how they remembered the provider telling them? Take the medicine how they *think* the provider would want them to take it? Call the provider's office and wait for a call back? Take a portion of it—some is better than none and probably wouldn't be harmful? Call someone and ask them how they take it? Look the medication up on the computer and take the recommended dose? Ask the pharmacist? Do nothing until seeing the provider at the next visit two weeks from now? Go see another provider and see what they say? Consult a family or folk healer? Maybe do a combination of things?

Identifying the patient's personal circumstances about what they need to know and how they will best receive this information is the patient-centered approach that is advocated within medical circles (Khanna & Phillips, 2001). Recognizing and responding to patients who may be displaying problems with adherence is critical to providers' roles.

Providers are not necessarily proficient in identifying when someone is having a problem with adherence (Osterberg & Blaschke, 2005). In fact, adherence is very difficult to measure. Patients who are more adherent are probably more likely to remember their conversations with providers about adherence. However, providers often overestimate the degree to which patients are following the plan. There are several reasons for this. First, the provider may not know how to ask about adherence. If the provider asks: "Are you taking your medications?" The response is likely to be a short "yes" without further clarifying what problems the patient is having. Posing a close-ended question with the underlying message: "of course you are," yields a simple answer—and one that matches what the patient thinks the provider wants to hear. Additionally, the provider may not know how to explore the possibility of nonadherence without creating shame or guilt. "Remember what I told you last time, you have to take your medications all the time, not just when you can remember to" creates the feeling that if one forgets it is not OK and they are not doing their part in getting better despite the concern and attention of the provider. Osterberg and Blaschke recommend, instead, the approach of presuming non-adherence issues and asking, "How often do you miss taking them?" Table 1-2 summarizes key principles and examples of interventions to improve adherence behaviors.

Trust and Patient Satisfaction

The relationship of trust between patient and provider is built on the effectiveness of their communications. Mutual trust is essential to quality care out-

Table 1–2 Communications to Improve Adherence Behaviors

<i>Principle</i>	<i>Example</i>
Providers are not proficient in identifying patients' problems with adherence.	Make the assumption that there is some problem or some pattern that results in some level of nonadherence and that your assessment of adherence might underestimate the problems the patient is having.
Open-ended questions will elicit clarification and expansion.	"What problems are you having with taking your medication?" or "Since your last visit, what problems have you had taking your medications?" not "Are you having any problems taking your medication?"
Statements and questions that minimize shame and guilt will encourage self-disclosure.	"Many of my patients have trouble taking their medications, how about you?" not "You have to tell me if you are not taking all your medications."
Patients may not know what is incorrect about what they are doing.	Use "teach-back" and return demonstration to pinpoint problems the patient might not recognize by using the medications in their prescription bottle to assess how they are interpreting the directions.
When patients receive a new medication, some degree of passive reluctance may inhibit clear exchange.	"What does taking this medicine mean to you?" "What more could I tell you that would help you to know more about the medication/treatment?"
Everyday life and competing priorities may interfere with following the treatment or medication regimen.	Problem-solve with the patient about what the barriers might be and how each barrier could be minimized in their case. For example, "Knowing that it is difficult to remember to take your medication when you are so busy all the time, what could you do? There are typical things we can do: provide a pill box reminder, refrigerator magnets, help you remember by picking a specific time each day to take your medicine . . . would any of these help?"

comes, particularly to adherence and adaptation of changes required when one is ill or at risk for developing disease or illness. Trust and patient satisfaction are intimately related, but what comes first and what follows is not as clear. One might question how the patient can be satisfied with his or her care if there is not a basis of trust in medical care and the provider(s) that are rendering this care. Likewise, how can the patient trust the healthcare system and provider without a basis of satisfaction with the care received?

Trust in the context of patient care and the relationship between patient and provider refers to the extent that the relationship and partners in this relationship can be relied upon and take the interests of the other in mind. Trust can contribute to the healing forces in the interaction between provider

and patient by contributing to an increased sense of safety and security if not overall well-being (Lee & Lin, 2008; Hall et al., 2002). Providers want patients to trust them and the system. They know that this will get the patient to seek health care earlier rather than later and that positive outcomes are more likely. Most providers agree that trust must be mutual to build a successful working relationship.

Some discussions of the quality of trust in the patient–provider relationship has been likened to religious belief rather than a strong level of confidence that the provider is to be trusted. The idea of “blind trust” translates at the societal level where health providers are trusted in general in their role of “healers.” Trust in a provider leads to a sense of comfort, security, and safety. On the contrary, the reverse, “I can’t trust the healthcare system,” may lead to a sense of anguish and despair—turning individuals away, setting them on a course of finding their different solutions. Rather than a sense of blind trust, which historically has been the case, it can be argued that the public has grown to have a realistic perspective on trusting health providers. The media and wider experiences with health care have increased the public’s awareness that errors do occur and providers are sometimes at fault. Until recently, the vehicle for trust building has been the ongoing relationship of one provider to one patient (Saultz & Albedaiwi, 2004). It has been suggested that by the nature of advances in technology, today it is not so easy to build and sustain a trusting relationship.

Patient satisfaction, a term formerly used to describe satisfaction with inpatient care, is now commonly used to describe the quality and perceptions of outpatient services as well. There is no real consensus about what patient satisfaction is, and the multitude of surveys to measure this phenomena suggest a lack of agreement (Saultz & Albedaiwi, 2004). Although it is thought to be ill-defined, patient satisfaction has frequently been used to mean patients’ perceptions of the affective and technical aspects of the provider’s performance (Meredith, Orlando, Humphrey, Camp, & Shelbourne, 2001). Otherwise, patient satisfaction encompasses perceptions of both the manner in which the patient is addressed (how the provider treats the patient) and the technical competence the patient believes the provider to have (how much the provider really knows what they are doing). Regardless of its measurement, the patient’s level of satisfaction reveals something about the patient’s preferences and expectations of care received within the realities of the care environment. Patient satisfaction stems from the expectations of the patient relative to the experience of care and how well the two match (McKinley, Stevenson, Adams, & Manku-Scott, 2002).

There are key indicators that seem to be associated with patient satisfaction, and these are addressed in multiple patient survey instruments. The following questions/statements are examples of frequently asked questions and give some idea of how communication plays a role in the patient’s valuation of the care received. These survey items are usually presented with the option to reply yes or no, strongly agree to strongly disagree, all the time to not at all, or some variation of these choices.

“How satisfied are you with the information the provider (physician) provided?” (very to not at all)

“Did the provider use language that you could understand?” (yes or no)

“Was your doctor good at explaining the reason for medical tests?” (yes or no)

“Doctors act too unfriendly and disinterested.” (strongly agree to strongly disagree)

“Doctors’ explanations are easy to understand.” (strongly agree to strongly disagree)

“Doctors and the medical staff listen carefully to what I tell them.” (all the time to none of the time)

“Doctors and the medical staff spend enough time listening to me.” (strongly agree to strongly disagree)

“The nurses and doctors sometimes ignore (don’t listen) to what I tell them.” (strongly agree to strongly disagree)

“The doctor/medical staff don’t give me a chance to ask questions.” (agree or disagree)

“The staff treat me with respect and courteously.” (all the time to none of the time)

“The medical staff/physician doesn’t really care about what I think.” (strongly agree to strongly disagree)

One can see that the way the question is worded and the reply options offered can influence the results considerably.

Participatory roles in health care are critical in encounters with health providers to build trust and satisfaction. Essential to advancing participatory provider–patient roles is the underlying importance of mutual trust and patient satisfaction. Basic to this proposition is the acceptance of the principle that patient–provider communications mediate the positive relationship between health orientation and relationship satisfaction (Dutta-Bergman, 2005).

These participatory roles are not easy to come by, depending on the previous experience and fears of some patients. For example, populations that have experienced health disparities may encounter any number of concerns: lack of access to care, inadequate insurance coverage, fears of hospitalization, death, and experimentation by health providers. They may not relate to the system as one that will serve their needs; thus, to enlist them in participatory roles will require discovering and acknowledging these concerns.

In discussions of patient satisfaction and patient–provider communications, several aspects of the communication have been reported as essential: does the provider actively listen, explain the treatment in a manner to address fears and misconceptions, and demonstrate empathy through an understanding of the patient’s experience and concerns? In traditional views, these dimensions of the interactions between provider and patient are best achieved in the ongoing continuity of the patient–provider (or providers) relationship.

There is currently debate as to whether continuity is necessary or, if necessary, if it is practical. Theoretically, with continuity of relationship, there is an increased opportunity for meaningful explanations and teaching. This teaching is likely to be more patient-centered in that the provider hypothetically knows more about the patient, not only about the presenting problem, but about the patient’s fears, beliefs, social resources, and psychological well-being. These are the pieces of data that help tailor the patient’s treatment and take into account factors in the patient’s everyday life that affect responses to treatment and acceptance of the treatment regimen.

Table 1–3 provides a list of principles and practices that help build trust and satisfaction in the provider–patient relationship.

Effective Self-Management

Effective self-management is the extent to which the patient manages disease and illness effectively to elicit healing and promote health. It is estimated that 50% of those with chronic illness are getting appropriate medical intervention. It has also been estimated that 50% are managing their illness and treatment successfully. The Centers for Disease Control and Prevention (CDC)

Table 1–3 Communications to Improve Adherence Behaviors

<i>Principle</i>	<i>Example</i>
Listening to the patient will increase the patient's perception that the provider cares and hears the patient's concerns. Restatement of what the patient says further reinforces that the patient has been listened to and has been heard building trust and satisfaction.	Demonstrating active listening: "I have been listening to you tell me about your fears about taking this medication. Let's talk about them."
Building on the continuity of the relationship will increase the perception that the patient is truly heard and the provider is willing to include the patient as a partner.	Building on continuity and restating: "The last time I saw you you were afraid that the medication would make you feel too drowsy and you would feel 'spacey' . . . tell me how you have been feeling since you started this new medication . . ."
Recognizing the barriers, both everyday stressors, and major constraints that affect the patient's response to utilizing healthcare advice will build an empathetic relationship, which in turn will engender trust and satisfaction.	Examining stressors: "People we take care of have many demands on their time. What demands on your time might prevent you from remembering to get your prescription refilled?"
Trust and satisfaction are related to expectancy; determining what the patient expects from care will help build a working relationship.	Discover and address the patient's expectations: "When you came in, you asked me about if you still needed to take so many medications. I talked about your Lipitor. But let's get back to what you wanted to talk about . . . the many medications you are taking and if you still need to take so many."
In caring for disadvantaged populations, lack of insurance, inadequate access, fears of the medical system, fears of being experimented upon, and fears of hospitalization may influence their trust of health providers and the healthcare system in general.	Acknowledge and address fears and disparities that bring the patient to treatment late: "It must have taken a lot to get you to come for a checkup . . . not easy at all . . . were you afraid that something bad would happen?"

estimates that of all health conditions, chronic diseases are particularly prevalent, costly, and preventable (CDC, <http://www.cdc.gov/nccdphp/overview.htm>). These diseases (primarily heart disease, stroke, cancer, and diabetes) require considerable self-management by those who have them. The CDC estimated that 7 out of 10 Americans who die each year in the United States (more than 1.7 million people) die of a chronic disease.

Self-management is defined as the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions. Self-management support is defined as the systematic provision of education and supportive interventions by healthcare staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support. (IOM/NAS. 2004, ch 5, p 57)

The prolonged course of illness and disability from such chronic diseases as diabetes and arthritis results in extended pain and suffering and decreased quality of life for millions of Americans. Chronic, disabling conditions cause major limitations in activity for more than 1 of every 10 Americans, or 25 million people. More than 90 million Americans live with chronic disease, and 7 of every 10 Americans who die each year, or more than 1.7 million people, die of a chronic disease (CDC, <http://www.cdc.gov/nccdphp/overview.htm>).

The importance of effective self-management as a component of quality health care is quite clear. While the issues of disease self-management have been addressed, the focus has been disease-specific and focused on one condition (e.g., diabetes, arthritis, or asthma). There is reason to believe that self-management strategies can be viewed across chronic diseases. Chronic diseases then would be those illnesses that have in common a prolonged course requiring self-management behaviors by patients and their caregivers. While self-management is not new to chronic disease, the role of the patient and caregiver is becoming a more active participatory one and this requires substantially improved communication between providers and those affected. The role is one of partnership, and the expectation is that a power differential is less important than the patient accepting leadership on behalf of living successfully with a prolonged condition. For example, with increasing potential for home monitoring, there is a greater role for patients to play in adjusting their medications, problem solving and making treatment decisions. New communication strategies that link providers and patients in different ways may be the direction of the future. See Chapter 23 for a more in-depth discussion of electronic and telephonic interventions linking providers and patients.

The realm of supportive self-management in chronic illness is a growing area of research and practice. The chief questions stem from understanding the appropriate mix of supportive relationships and information that will maximize the patient's ability to live as comfortably as possible with a chronic disease. Table 1–4 presents a series of steps that promote communications which enhance effective patient self-management. Provider–patient interactions have been associated with positive self-management and health outcomes.

Table 1–4 Communication and Effective Self-Management: Guides to Supportive Self-Management

- Assess the patient's own views of barriers, beliefs, and fears surrounding the chronic condition.
- Ensure that the patient and family know what is needed and why.
- Assess the patient's motivation for lifestyle changes to support disease management.
- Assess the social support and social network of the patient to determine adequate supportive relationships to achieve management goals.
- Identify the patient-specific strengths and limitations that may affect the patient's self-management practices.
- Identify with the patient and caregivers strategies they have used that worked.
- Focus on setting goals and solving problems, using action plans or personal contracts when appropriate.
- Mobilize and link patient and caregivers to community resources to assist the patient and family to manage the disease and its social, spiritual, psychological, physiological, and quality-of-life issues.
- Provide for seamless, continuous care delivery that promotes effective self-management.
- Provide systematic follow-up with provider phone calls and visits to monitor progress toward the goals.

Caregiving communications and information exchange is also critical to effective self-management. However, it is not clear that strategies that work well with certain groups work equally as well across ages, ethnicities, genders, and persons coming from diverse social/economical communities.

Coleman and Newton (2005) stress the importance of supporting self-management in patients with chronic illness. They add that this kind of support exceeds traditional knowledge-based patient education to include patient problem-solving, self-efficacy, and application of knowledge to real situations that matter to the patient. The important distinction is that information is not enough; what is increasingly clear is that the patient's perceived self-efficacy is important and that this aspect is to be evaluated on an ongoing basis as often as level of knowledge.

Symptom Severity

Symptoms will be identified, monitored, and treated effectively provided the provider and patient address symptoms in depth and the patient can partially, if not fully, describe his or her experiences. The problem here is that the provider and patient use different languages to describe what is happening. It follows that if the patient or caregiver does not discuss symptoms regularly with the provider, the symptoms may persist or go unchecked. Attention must be placed on the quality of dialogue between provider and patient that will elicit this information. The connection between management of symptom severity and patient-provider communication has been made. Donovan, Hartenbach, and Method (2005) reported on a study of 279 women experiencing multiple symptoms associated with active ovarian cancer. They reported an average of 12 concurrent symptoms; however, only 61% of these women had

discussed their most noticed symptom with their healthcare provider in the past month. Only half reported that they had received symptom management recommendations. While it would be nice to believe that symptoms and symptom management is fully addressed in patient visits, this might not be the case.

Why would patients not discuss their symptoms with providers? There may be several potential reasons for this, including patient-specific, patient-provider relationship, and healthcare system factors. It is possible that patients might not know how to describe their experience, and in the absence of bleeding, swelling, or pain, these signs and symptoms are vague phenomena for which the patient has no words. They might talk about symptoms using metaphors:

“Sharp like a needle-stick.”

“Hard like a baseball . . .”

“Itchy.”

“Scratchy.”

“Tickles . . . like a feather.”

Patients’ use of metaphors can be useful. Patients are pleased when the provider matches this language because it is an expression that the provider is engaged in the attempt to find out what is going on, regardless of the difficulty the patient is having providing adequate detail. Otherwise the provider might want to use the same terms as the patient rather than revert to medical jargon (Skelton, 2002). It has also been suggested that it might be best when patients cannot think of words to describe their symptoms that they be encouraged to use metaphors. “When you get that feeling . . . what is it like?” “It’s like bugs are running all over my body.” The provider then has the advantage of using the metaphor to ask further questions: “When you get that feeling that bugs are running all over your body . . . is it hard for you to breathe?” Part of the relief that patients experience in the moment of tension of not knowing how to talk about their experience is that there is someone who cares and is patient enough to help them figure it out. While using patient metaphors initially, it is important to eventually use the medical language with which patients need to become familiar.

Another dimension of the problem of assessing and treating symptoms is the quality of the provider-patient discussion. This involves the provider’s training and expertise, basic assessment and interviewing skills, and interpersonal style. In a National Institutes of Health (NIH) news release in 2002, it was stated that cancer-related pain, fatigue, and depression are undertreated in cancer patients (<http://www.nih.gov/news/pr/jul2002/od-17.htm>). Sometimes providers confine their attention to symptoms most frequently associated with the disease, ignoring important sequelae or co-morbid conditions that interact with symptoms of the presenting condition. It has been reported, for example, that few physicians ask patients about suicidality associated with chronic life-threatening disease when they are significantly prevalent and should be assessed. The National Cancer Institute (<http://www.concer.gov/cancertopics/pdq/supportivecare/depression/HealthProfessional/>) brings attention to the need to carefully assess for suicide in cancer patients, particularly when contributing symptoms (e.g., pain needs to be controlled). An example would be:

“Many patients with cancer at some point think about suicide . . . like doing something if it gets too bad. Have you had any thoughts like these?” Providers’ training needs to include comfort with discussing a wide array of symptoms from those that are easy to discuss, those that might be embarrassing and those that are “taboo.”

Education for an open discussion of symptoms should begin with the health and disease identification process. Symptom discussions should be integrated in all visits and conversations. The repetitive nature of these discussions will improve on patients’ abilities to express themselves and will make the provider more familiar with how the patient experiences symptoms. Emphasis should be placed on the patient’s perception of the symptoms, not just an objective measure of presence/absence or severity of symptoms. Table 1–5 summarizes specific communication strategies to assess and monitor symptom severity.

Morbidity and Mortality

While the data are limited in this area, providers are likely to admit there is some relationship between effective communication and morbidity and mortality. Rather than “Is provider–patient communication associated with morbidity and mortality?”, the question may be, “To what extent and through what pathways are communication and morbidity and mortality related?” *The Chasm in Quality* report emphasized that indicators such as deaths due to medication errors, lack of preventive care, and poor management of patients with major medical illness care are of concern and that progress must be seen on these indicators. Earlier in this chapter, the question was raised about how the connection between such indicators and patient–provider or provider–provider communication provide such alarming results.

More and more, the emphasis on patient self-management skills and patient empowerment to engage in active partnership with providers have been presented as necessary to combat such outcomes of increased morbidity

Table 1–5 Communications to Assess and Monitor Symptom Severity

- Assess and monitor character and severity of the symptoms (intermittent or persistent; mild, moderate, or severe).
- Assess and monitor over time.
 - “Has your coughing been better or worse since your last visit?”
- Assess how symptoms have affected functional status.
 - “In the last two weeks, how often have you had problems with awakening at night because of coughing, problems with symptoms after exercising, etc.?”
 - “How many days from work or your normal activities have you lost since your last visit?”
- Monitor communications with patient:
 - “What questions have you had that you wanted to ask about?”
 - “Has anything interfered with getting your questions answered or with talking to me or the staff?”
 - “How can we help you to improve your management of your care?”
 - “What things have we worked on that have helped you?”

and mortality. If effective delivery of health care depends on efficiency and effectiveness of communication, then it follows that patient–provider communication is associated with outcomes (Teutsch, 2003).

Let's examine one possible connection. Effective communication is associated with adherence to medical regimens, satisfaction, and trust in the provider. Adherence is necessary to prevent the progression of disease and morbidity associated with the disease, such as in diabetes. In certain cases, as with HIV/AIDS, adherence to medication regimens is closely associated with the success of disease progression and even death because of the link between medications and viral suppression. If the communication between patient and provider is effective and efficient, these outcomes are more likely—thus the connection between mortality and morbidity.

In almost every care encounter, providers are pressed for time to address patient needs and relay complex information in an emotionally charged context. Under everyday circumstances, the likelihood that this communication will be adequate and result in patient trust and satisfaction is threatened, and the consequences may result in lack of operational knowledge and/or uncertainty about the “what-fors.” Any or all of the following interact to increase the risk of poor management: errors in carrying out the regimen, misconceptions about the disease or treatment, feeling tired or overburdened with the regimen without telling the provider, inadequate self-management support, lack of awareness of the need to monitor and why, and turning to substitute sources of information that may misguide the patient.

Healthcare Utilization and Retention

Quality health care depends on healthcare utilization patterns and retention in treatment. *Patterns of utilization* refers to both the frequency of utilization and the services that are utilized, suggesting that patients might use services but under- or overuse certain services in inappropriate ways. An example of this is patients' overuse of emergency care when the problem could be addressed in outpatient visits. Healthcare utilization patterns do not provide data on the adequacy of care received. Healthcare utilization refers to a person's behavior in reaching out to and complying with existing available healthcare services.

Race / Ethnicity

It has been estimated that by 2050 one in every two Americans will be African American, Hispanic, Asian American, Pacific Islander, or Native American (Modlin, 2003). There are clear and significant disparities in health and treatment of ethnic and minority populations, suggesting that more attention must be given to providing culturally competent care. The disparities that do exist are due in part to the level of cultural competence of the clinician. Some of the suboptimal care received is due to these deficits in competence. Care and care providers that are neither trustworthy nor satisfying to patients are likely to turn potential recipients away and or cause them to discontinue care prematurely. Cultural beliefs and health practices play a significant role in utilizing health services and remaining in the healthcare system. One needs to consider how treatment and approach are consistent or inconsistent with

previously held beliefs or conceptions of disease and treatment. Without sufficient appreciation or attention to the beliefs of the patient one cannot expect adherence or retention in care.

In an important piece of research focused on Latino satisfaction with communications with health providers, it was reported that Latino Spanish-speaking respondents were significantly more dissatisfied with provider communication than either Latino English-speaking or white respondents (Morales, Cunningham, Liu, Brown, & Hays, 1999). The investigators conclude that these individuals may be at increased risk of lower quality of care and poor treatment outcomes, and even dis-enrollment.

Gender

Gender, communication, and what keeps people coming back has been addressed in the literature in a number of ways. First, studies have examined the difference in character of communication when the provider is female. Weisman (1986) studied patients' responses to female physicians. Both the behavior of female physicians and responses to them differ from the case of male physicians, pointing out that female physicians might be better communicators and more empathetic. A number of studies have focused on the concordance in the dyad; that is, female patients and female physicians versus female patients and male providers. The effect of the provider's gender on the satisfaction of services received is inherently important in the utilization of healthcare services and recidivism. Further, Weisman concludes that physician-patient dyads, where both parties are of the same sex, might be important in cases where sex-specific conditions are the focus, the condition is highly sensitive; or in the treatment of chronic conditions over protracted periods of time, when a long-term relationship is required.

Age

The warning: "Don't go back. . . . you'll just get sicker (it will be worse)" might be a function of several patient characteristics. But it has relevance to the age of the patient for many reasons. Adolescents and young adults might feel and express such sentiments. For example, youth who are prescribed an antidepressant may not like coping with the side-effects of their medication: "I feel different." Young people may also be concerned about peer perceptions. Who wants to carry an inhaler in football practice? In studies of youth, the following disease frustration issues were observed: not wanting to take the medication at school, feeling that it gets in the way of their activities, not wanting other people to know they are taking medication, not liking what the medication does to their appearance, feeling tired and forgetting to take it, and feeling tired of living with the medical condition (Simmons & Blount, 2007). If youth and providers do not discuss these issues, they may passively dis-enroll.

In the elderly, health literacy, cognitive decline, and worsening illness affect patients' abilities and willingness to seek treatment and continue care over time. Problems with transportation can affect attendance at follow-up appointments and, if these problems are not discussed with providers, might lead to disengaging when in fact they should be seen frequently. The lack of accessible and affordable transportation is a major barrier to health care. It is an issue of availability as well as affordability. Of particular vulnerability are

the elderly who may not be able to drive. (Compared with all other age groups, people 75 and older have the most medical visits. It is unknown whether this group has a significant dis-enrollment issue that is a function not only of age but of many other sociodemographic factors.)

Illness

Illness affects utilization of care in complex ways. Communication abilities affect how well an individual can describe his or her need for care. Persons with communicative disabilities primary or secondary to their condition require special attention. Most obviously, medical conditions affecting speech, vision, reception, and interpretation of data are extremely important to communication effectiveness. Disorders of this kind would include speech impairment, visual impairment, deafness, and cognitive disabilities and/or mental disorders. These conditions are often referred to as *disabilities*. The problem of communication and keeping patients with disabilities in the loop for basic health promotion and health care has been acknowledged, and attention to altering services has received ongoing attention.

People with disabilities include a large and growing population that needs access to services. It has been noted that while more than 54 million Americans may have been identified as “disabled,” the actual number of people living with a disability in the United States today is unknown. However, many people with disabilities do not seek out or receive the quality of care they need. Consequently, they may only access care for emergencies, thereby reducing important contributions of health promotion and disease prevention. There are many reasons people with disabilities do not seek healthcare services early on: provider ineptness and lack of resources, patient embarrassment and fear of losing more independence, and staff and patient experience of frustration in communicating.

In the important document entitled “People First: Communicating with and about People with Disabilities” (<http://www.health.state.ny.us/nysdoh/promo/people.htm>), principles and practices for communicating with people with disabilities were identified. They include (1) treating all with respect; (2) making sure an offer of assistance is accepted before continuing; (3) speaking directly to the person without using an interpreter, until the patient requests that you use one; (4) always identifying yourself before speaking; (5) listening attentively when talking to someone who has difficulty speaking; (6) getting the attention of someone who is deaf using touch; and (7) relaxing about responding inappropriately (there is the chance that you will be understood and accepted for what you say). Further, there are words or expressions that are preferred (e.g., using *person who is blind*, not *blind man*). Other terms (e.g., spastic, retard, gimp, and cripple) are hurtful and should be avoided when talking to or about patients.

In a brief report by Berren, Santiago, Zent, and Carbone (1999) focusing on healthcare utilization by persons with severe and persistent mental illness, mental patients were more likely to use urgent care settings than counterparts without mental disorders. Additionally, among typically frequent urgent care users, patients with severe and persistent mental illness used urgent care to higher degrees. The investigators point to the necessity of mainstreaming these patients in routine outpatient services. There are many reasons

these patients use urgent care, including system, patient, and provider factors. When providers are not skilled to work with this population, do not like working with this population, and where the psychiatric patient's symptoms interfere with clear and unambiguous communications about symptoms and history, urgent care might be perceived to be the only answer. Indeed, as Berren and colleagues point out, the use of urgent care under the existing circumstances may be adaptive, especially when the patient's support system is weak or nonexistent. This pattern of utilization would be categorized as inappropriate, but the inappropriate use of care services is perhaps more the result of the system and provider deficits.

CONCLUSION

Clear healthcare communication is the foundation of healthcare delivery. It affects every aspect of the health–illness continuum from prevention and health promotion, to assessment and diagnosis of disease and illness, to the adequacy of treatment and the continued self-management of chronic or life-threatening diseases. The question raised here is to what extent and how problems in patient–provider communication are directly or indirectly related to quality care indicators.

The purpose of effective communication is to bring both the patient and health providers to a level of understanding that will aid the provider in delivering patient-centered care and the patient to management of health and illness over time. Quality of care is seen through the patient's eyes and measured professionally through the lens of best practice procedures. Quality has been defined in many ways and recent IOM documents released the landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. This report concluded that the U.S. healthcare system is in need of fundamental change and proceeded to identify key indicators that serve to guide the assessment of our current and future healthcare systems: making health care more safe, making health care more effective, implementing a patient-centered approach to health care, delivering care in a timely manner, increasing efficiency, and ensuring equitable health care for everyone. In the context of these goals several indicators measure the likelihood that we will reach these aims. The degree to which change must be made to ensure a meaningful level of success is unknown, but what is clear is that providers' communications are directly or indirectly important in addressing any deficits that are present.

In this chapter, the link between quality and communications was described using available literature that, while mixed, supports the premise that with better patient–provider communication comes quality care.