The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

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Committee on Patient Safety and Quality Improvement
Committee on Health Care for Underserved Women

This document reflects emerging concepts on patient safety and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Effective Patient–Physician Communication

ABSTRACT: Physicians' ability to effectively and compassionately communicate information is key to a successful patient–physician relationship. The current health care environment demands increasing clinical productivity and affords less time with each patient, which can impede effective patient–physician communication. The use of patient-centered interviewing, caring communication skills, and shared decision making improves patient–physician communication. Involving advanced practice nurses or physician assistants may improve the patient's experience and understanding of her visit. Electronic communication with established patients also can enhance the patient experience in select situations.

Physicians' ability to effectively and compassionately communicate information is key to a successful patient–physician relationship. The Accreditation Council for Graduate Medical Education identified interpersonal and communication skills as one of six areas in which physicians-in-training need to demonstrate competence (1). This Committee Opinion reviews interviewing techniques to help the busy obstetrician–gynecologist effectively obtain a complete medical history, and discusses communication skills to assist in effectively relaying treatment plans.

Patient outcomes depend on successful communication. The physician who encourages open communication may obtain more complete information, enhance the prospect of a more accurate diagnosis, and facilitate appropriate counseling, thus potentially improving adherence to treatment plans that benefits long-term health. This type of communication, which may be referred to as the partnership model, increases patient involvement in their health care through negotiation and consensus-building between the patient and physician (2, 3). In the partnership model, physicians use a participatory style of conversation, where physicians and patients spend an equal amount of time talking (3). The partnership model is one of several communication models that improves patient care and reduces the likelihood of litigation. Another communication tool, AIDET, developed by Studer Group, is gaining popularity among a number of hospitals. The fundamentals of AIDET are Acknowledge, Introduce, Duration, Explanation, and Thank you (see Box 1) (4). The RESPECT model, which is widely used to promote physicians' awareness of their own cultural biases and to develop physicians' rapport with patients from different cultural backgrounds, includes seven core elements: 1) rapport, 2) empathy, 3) support, 4) partnership, 5) explanations, 6) cultural competence, and 7) trust (see Box 2) (5).

Box 1. AIDET® Five Fundamentals of Patient Communication ⇦

Acknowledge	Being attentive and greeting the patient in a positive manner
Introduce	Giving your name, your role, and your skill set
Duration	Giving a reasonable time expectation
Explanation	Making sure the patient is knowledgeable and informed
Thank you	Showing appreciation to the patient for her cooperation

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Box 2. The RESPECT Model ⇦

Rapport

- Connect on a social level.
- See the patient's point of view.
- Consciously attempt to suspend judgement.
- Recognize and avoid making assumptions.

Empathy

- Remember that the patient has come to you for help.
- Seek out and understand the patient's rationale for her behaviors or illness.
- Verbally acknowledge and legitimize the patient's feelings.

Support

- Ask about and try to understand barriers to care and compliance.
- Help the patient overcome barriers.
- Involve family members if appropriate.
- Reassure the patient you are and will be available to help.

Partnership

- Be flexible with regard to issues of control.
- Negotiate roles when necessary.
- Stress that you will be working together to address medical problems.

Explanations

- Check often for understanding.
- Use verbal clarification techniques.

Cultural Competence

- Respect the patient and her culture and beliefs.
- Understand that the patient's view of you may be defined by ethnic or cultural stereotypes.
- Be aware of your own biases and preconceptions.
- Know your limitations in addressing medical issues across cultures.
- Understand your personal style and recognize when it may not be working with a given patient.

Trust

- Self-disclosure may be an issue for some patients who are not accustomed to Western medical approaches.
- Take the necessary time and consciously work to establish trust.

Reprinted from Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies by permission of the Center for Health Professions, University of California, San Francisco, 2002.

Inequality in Patient Communication

In 2003, the Institute of Medicine issued a report detailing the importance of patient-centered care and cross-cultural communication as a means of improving health care quality across patient groups (6). Differences between physicians and patients, including culture, gender, race, and religion, can introduce bias into patient–physician communication. Two seminal studies have documented differences in how race and gender can affect care. Cooper and colleagues found that African American patients were substantially less likely to report equal speaking time (ie, participatory decision making) compared with white patients (7). Schulman and colleagues reported gender and racial differences in how physicians communicated about cardiac catheterization (8).

Developing Effective Communication

Developing effective patient–physician communication requires skill in conducting patient-centered interviews; conversing in a caring, communicative fashion; and engaging in shared decision making with patients (9). Physicians may consider five steps for effective patient-centered interviewing as shown in Table 1 (10). The following four qualities are important components of caring, effective communication skills: 1) comfort, 2) acceptance, 3) responsiveness, and 4) empathy (11). Comfort and acceptance refer to the physician's ability to discuss difficult topics without displaying uneasiness, and the ability to accept the patient's attitudes without showing irritation or intolerance. Responsiveness and empathy refer to the ability to react positively to indirect messages expressed by a patient. These skills allow the physician to understand the patient's point of view and incorporate it into treatment (12). The four qualities may be applied to the following scenarios:

> Scenario 1: An adolescent girl, accompanied by her mother, comes to you to discuss birth control options. During the discussion, the mother continues to express disagreement with her daughter's decision to become sexually active and proceeds to the door in order to leave the examination room.
>
> Effective response: You ask the mother to remain in the room briefly so that you can explain to her and her daughter what will take place during this visit. After obtaining a general medical history from both mother and daughter, the physician requests that the mother allow private time for discussion with her daughter. Later, a member of the office staff escorts the mother back to the examination room. The physician encourages open communication between the mother and daughter and answers any further questions.
>
> Scenario 2: A physician enters the examination room and greets a long-term patient and notices that she is tearful. She states, "I'm just having a bad day." The

Table 1. Five Step Patient-Centered Interviewing ⇦

Step 1. Set the stage for the interview (30–60 s)	1. Welcome the patient
	2. Use the patient's name
	3. Introduce yourself and identify specific role
	4. Ensure patient readiness and privacy
	5. Remove barriers to communication (sit down)
	6. Ensure comfort and put the patient at ease
Step 2. Elicit chief concern and set an agenda (1–2 min)	7. Indicate time available
	8. Forecast what you would like to have happen in the interview
	9. Obtain a list of *all* issues the patient wants to discuss
	10. Summarize and finalize the agenda
Step 3. Begin the interview with non-focusing skills that help the patient to express herself (30–60 s)	11. Start with open-ended request/question
	12. Use nonfocusing open-ended skills (attentive listening)
	13. Obtain additional data from nonverbal sources
Step 4. Use focusing skills to learn 3 things: Symptom Story, Personal Context, and Emotional Context (3–10 min)	14. Elicit symptom story
	15. Elicit personal context
	16. Elicit emotional context
	17. Respond to feelings/emotions
	18. Expand the story
Step 5. Transition to middle of the interview (clinician-centered phase) (30–60 s)	19. Brief summary
	20. Check accuracy
	21. Indicate that both content and style of inquiry will change if the patient is ready

Reprinted with permission. Fortin AH 6th, Dwamena FC, Frankel RM, Smith RC. Smith's patient-centered interviewing: an evidence-based method. 3rd ed. New York (NY): McGraw Hill Medical; 2012.

physician completes the routine medical history and examination without further discussion of her affect.

Effective response: The physician shakes the patient's hand, stating, "I'm sorry you're having a hard time. Perhaps it will help to talk about it." The patient proceeds to discuss recent events that have led to her sadness. The history is consistent with depression, and the physician may offer or refer her for treatment.

An extension of the partnership model is the concept of *shared decision making*, which is defined as a process where both patients and physicians share information, express treatment preferences, and agree on a treatment plan (13). The process is applicable if two or more reasonable medical options exist (14). The physician shares with the patient the relevant risk and benefit information on all reasonable treatment alternatives and the patient shares with the physician all relevant personal information that might make one treatment more or less tolerable than others (15). This paradigm of communication may be a marked departure from the traditional doctor-centered model. An example of shared decision making is that of the National Institutes of Health Consensus Panel on vaginal birth after cesarean delivery (16). The Consensus Panel recommended that the decision for vaginal birth after cesarean delivery or repeat cesarean delivery should occur only after a conversation between the patient and her physician, incorporating the risks and benefits and the patient's preferences. Shared decision making can increase patient engagement and reduce risk with resultant improved outcomes, satisfaction, and treatment adherence (17).

Communication and Information Technology

The use of information technology has been identified by the Institute of Medicine as one of the critical forces necessary to improve the quality of health care in the United States. An increasing number of physicians are using electronic health records and web messaging to communicate with their patients. Health information technology systems should be compatible with the requirements of the Health Insurance Portability and Accountability Act and flexible enough to accommodate state privacy laws (18).

It is important to use appropriate safeguards when communicating electronically with patients. The Health Insurance Portability and Accountability Act Privacy

Rule allows covered health care providers to communicate electronically, provided they apply reasonable safeguards when doing so. Further, while the Privacy Rule does not prohibit the use of unencrypted e-mail for treatment-related communication between health care providers and patients, other safeguards should be applied to reasonably protect privacy, such as limiting the amount or type of information disclosed through unencrypted e-mail (19). The physician time spent answering and managing e-mail should be acknowledged, and efforts should be made to advocate for compensation for additional time spent by physicians and staff to provide this service. When the patient has a complicated question or issues or has questions regarding symptoms, face-to-face contact between the physician and the patient may be preferable.

Recommendations for the Obstetrician–Gynecologist

The competing demands of clinical productivity (20), increasing paperwork, the rigidity of using electronic medical records that encourage providers to only complete the check boxes on the screen and not engage the patient in conversation, and the delivery of care to multiple patients, often with complex diagnoses (21, 22), can inhibit effective communication. Developing effective patient–physician communication requires a substantial commitment in an increasingly challenging environment with declining clinical reimbursements and increasing expenses. It may well be that, in the long term, effective communication skills save time by increasing patient adherence to treatment, thereby reducing the need for follow-up calls and visits. The obstetrician–gynecologist can take the following steps to improve communication:

- Use patient-centered interviewing and caring communication skills in daily practice.
- Encourage patients to write down their questions in preparation for appointments. A form for writing down questions can be given to patients on their arrival at the office. An organized list of questions can facilitate conversation on topics important to the patient.
- Consider arranging for a communications consultant to conduct a workshop on cultural and gender sensitivity for physicians and office staff based on the needs of an individual practice. The National Culturally and Linguistically Appropriate Services Standards in Health and Health Care, developed by the Office of Minority Health of the U.S. Department of Health and Human Services, are intended to advance health equity, improve quality, and help eliminate health care disparities (23). Obstetrician–gynecologists may wish to consider review of these voluntary standards.
- Consider hiring nonphysician health care providers, such as advanced practice nurses or physician assistants, with patient-centered interviewing skills to assist with established patients.
- Advocate for sustainable practice models that increase the duration of visits to provide the opportunity to address multiple patient concerns. Increased time for visits is crucial in efforts to improve patient-centered interviewing, shared decision making, and improved patient–physician communication.

American College of Obstetricians and Gynecologists' Resources

Cultural sensitivity and awareness in the delivery of health care. Committee Opinion No. 493. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011; 117:1258–61.

Health literacy. Committee Opinion No. 585. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:380–3.

Partnering with patients to improve safety. Committee Opinion No. 490. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:1247–9.

Other Resources

The following resources are for information purposes only. Referral to these sources and web sites does not imply the endorsement of the American College of Obstetricians and Gynecologists. These resources are not meant to be comprehensive. The exclusion of a source or web site does not reflect the quality of that source or web site. Please note that web sites are subject to change without notice.

Institute for Healthcare Communication, Inc.
171 Orange Street, 2nd Floor, 2R
New Haven, CT 06510
(800) 800-5907
http://healthcarecomm.org

Institute for Patient- and Family-Centered Care
6917 Arlington Road, Suite 309
Bethesda, MD 20814
(301) 652-0281
http://www.ipfcc.org/index.html

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