

CRITICAL REVIEW**PATIENT CENTERED COMMUNICATION: A SYNOPTIC REVIEW OF THE STATE OF THE ART**Amanuel Gebru, PhD^{1*}

“The good physician treats the disease; the great physician treats the patient who has the disease”
William Osler (1849-1919)

ABSTRACT

With rising awareness of the importance of effective communication in health care and the need for patient-centeredness, a transition is taking place from a clinician-centered biomedical to a humanistic biosychosocial approach that centers much of the medical communication on the patient. The transition has led to significant evidence validating numerous patient reported outcomes that include better adherence to therapy and illness self-management. This narrative review synthesizes the evidence base on patient centered communication, its distinguishing characteristics, and key strategies, chief among which are the modalities of the Patient Interview, Shared Decision Making and Patient Decision Aids as well as the Six-Step Protocol for Delivering Bad News. On the basis of the relevant gaps identified in medical training, a case is made for the inclusion of communication competency in the Ethiopian medical curriculum that underpins key physician communication skills based on international models and the best practices evidence base.

Key words: Communication, patient-centred, interview, measurement, competency, ethics

Conceptual, definitional and substantive landscape

The adoption of the biopsychosocial model in health care has had multiple ramifications (1,2) placing the patient at the center of a galaxy of actors and parameters that impact the wellbeing of the individual pointing to the import of a whole person approach (3). The patient centered approach acknowledges patient voice as central to the healing experience and wellness states. Patient empowerment through self-care means overturning the biomedical model that puts the disease and the provider in the center to one that locates the patient in the center of the medical encounter. The shift in perspective and review of older models means there is now a more negotiated interactional space with the controlling and hierarchical bent giving way to more horizontal, less scripted conversation. The patient comes to have more self-knowledge, self-direction and autonomy over outcomes and prognosis. Rightly patient-centered medicine stipulates that patients need to be active, responsible participants in their healthcare and clinical decisions and choices. Incrementally collaborative exchanges lead to patient development and sensitivity requiring less direction and more autonomy.

The Institute of Medicine (IOM) defines patient-centered care as: “Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care” (4). From a more impersonal perspective defined as “as right care in the right way at the right time” quality of care has been reconceptualized as “providing care that the patient needs in the manner the patient desires at the time the patient desires”(5).

Quality of care is at the center of what is now considered patient centered healthcare. According to the Institute of Medicine’s definition of the dimensions, patient-centered care encompasses:

- Compassion, empathy and responsiveness to needs, values and expressed preferences
- Co-ordination and integration Information, communication and education
- Physical comfort
- Emotional support, relieving fear and anxiety
- Involvement of family and friends (6)

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Clearly, the dimensions of the construct of patient centered care are in the main relationship and communication issues. Compassion is about emphatic communication that a patient in distress needs. Compassionate communication may be exemplified by information that can empower or sooth the patient as yet another ingredient of the construct to which one may add affective support that relieves the patient of anxieties arising from a medical event or related concerns. The family and friends dimension also contributes towards the agenda of putting the patient in the center and using communication and relationship strategies towards assisting patients as they pass through a difficult psychosomatic period.

However, it is impliedly important to note that it may be necessary to ponder over what is communication especially as it relates to healthcare settings. Reducing it to information transfer or interchange would seriously undermine the considerable semantic load carried by the construct –which may be broken down, albeit at the cost of reductionism, to information communication and relationship communication using appropriate verbal and nonverbal codes. All codes radiate toward the patient as the center who is the subject of the extraordinarily important curative function.

Indeed the popular construct of patient centered communication (PCC) is at the center of modern health care that values the humanity of the patient beyond and above other considerations. Yet definitional imprecision and lack of theoretical clarity have characterized the catchphrase. Thus it has been synonymously described as patient-centeredness, or patient-centered care highlighting the absence of a definitive semantic settlement. However patient-centeredness does imply communicative focus on and relational closeness to the patient. The elements of patient-centeredness manifest themselves in considerations of the patients' receptive and expressive needs, perspectives of their illness experience, and their inputs into the doctor-patient partnership. The partnership while dyadic in the main, nonetheless, involves or subsumes other modalities that are functional and relational. The whole communication complex includes interprofessional communication (inclusive of nursing and other staff), family members and the patient (7). Core definitional elements of patient-Centered Communication subsume "(1) eliciting and understanding patient perspectives (2) understanding the patient within his or her unique psychosocial and cultural contexts, and (3) reaching a shared understanding of patient problems and the treatments that are concordant with patient values" (8).

The evidence base supporting patient centered communication

The patient-centered communicative system aids in health outcomes including survival, recovery, affective wellness, pain reduction, as well as better functioning owing to the vital psychosocial power associated with therapeutic communication. More specifically, six outcomes pertain to communication, namely uncertainty management, management of emotions, information interchange, decision-making, patient empowerment for self-management, and cultivation of curative relationships (20).

A large body of scholarship has found PCC to be an asset in medical practice (21). While it may be axiomatic that good communication that is dialogical in character may have desired yields, more specific benefits have been borne out by audits of medical communication. First among these is that the patient feels an encounter with an amicable physician was fruitful because s/he was partners in a valuable communication with a knowledgeable figure. Patients report general satisfaction as well as more specific information/communication satisfaction because of the symmetry in the communication and their centrality in the process (22). Patient adherence and compliance have also been linked to patient-centered communication (23).

A sense of inclusion and ownership leads patients to take the driver's seat when it comes to managing their own health course. Efficiency has also been an outcome suggesting that when communication is patient-centered and as a result of information richness, patients' request for expensive tests decreases as word of mouth explanatory detail helps them make correct choices. Better health outcomes, lower relapse and readmission rates have also been reported in settings practicing patient centered communication (24). Patient-focused communication is also related to lower litigation and legal costs to medical establishments as the probability of patients suing them for lack of correct and adequate information about procedures and dispensary becomes less (25). Further a communicative- curative alliance can be considered an epitome of good patient-centered communication and the beneficial outcomes extend to family relief and ease of anxiety.

Barriers to patient centered communication

A number of factors adversely impact the implementation of patient-centered communication. All too often physicians seem to believe the practice is unproductively time-taking (9). Indeed time may be spent trying to describe, explain, clarify and predict. While the conversational time does add value to both the patient and physician, many physicians seem to perceive it as inefficient. But studies seem to show that patients take no more than 3 minutes to air their narrative. If time spent conversing with a patient is unduly short, the therapeutic role of the communication may be lost as patients are able to take home with them the barest essential information which consequently compromises their self-management. Conversational interruption is also common costing the patient much as it disrupts the evidence communication the doctor needs (10). Further the self-disclosure that is so much important is ignored owing to standard focus on biomedical data.

The standardization of medical practice could mean that the individuality and uniqueness of every patient is sidelined. Whilst different patients respond differently to the same course, standard instructions about standard symptoms, regimen and prognosis rule out the need for individualized patient-centered communication. As is typical with many in the helping professions physicians may have burnout levels that deny them the needed fuel for human communication leading them to treat patients in a formal, aloof and impersonal or even cold style.

There may also be factors that relate to patient health literacy levels that can impact a physician's approach to patient-centered communication. The literacy levels can make conversation drag on for longer than is normal in an attempt to send a message across through simplification of medical linguistics and health education. Patient-physician congruence is also a factor that may shorten or help to make optimum the conversational duration. Factors in this category may include personality match, age, gender and other demographic details including disability such as hearing dysfunction. There may also be a caseload that frustrates patient-centered communication and in especially private practice this may be an important factor discouraging communication satisfaction from an optimal interchange.

However, considered against the litigation and patient dissatisfaction that can be damaging, the time taken in patient-centered discourse would be worth making a normal practice and a standard policy. The evidence that patients may fail to remember or incorrectly recall more than half of critical medical information makes patient-centered communication even more important as outcomes are dependent on effective communication which involves retention (11).

Evidence based communication strategies:

Four Habits Model

Medicine uses as a data line the best conversational technology called the medical interview. The four habits model is one of several models with graded and sequenced communication events that unfold in a standard medical encounter. Consistent with the principle of patient-centered communication, the model addresses the psychology of communication by first helping establish a relational foundation of trust vital for a mutually satisfying communication experience.

The Four Habits are: Invest in the Beginning, Elicit the Patient's Perspective, Demonstrate Empathy, and Invest in the End. In Habit 1: Invest in the Beginning; the interview establishes much needed rapport for a productive communication. This stage is followed by Elicit the patient's perspective i.e. finding out from the patient their take on their experience, and their medical situation expressed in their own ways. Then comes demonstration of sympathy i.e. understanding the patient's state and emotionally sharing their situation. Invest in the end subsumes providing medical-diagnostic information, educating, involving the patient and rounding up the visit (12).

The Calgary-Cambridge guide

Another model of patient-centered communication is the widely used Calgary-Cambridge guide taught as a crucial component of medical communication across universities (13) and structured in the following sequence

- Initiating the session
- Gathering information
- Providing structure
- Building relationship

- Explanation and planning
- Closing the session
- Options in explanation and planning

Built around 71 communication skills and behaviors (14.) the guide is more meticulous than the four habits model but shares much in terms of the desiderata of good communication in modern medicine that places the patient in the center. For instance at stage one, the rapport stage, the physician welcomes the patient and conveys a nonverbal message that he is there to listen and help.

While PCC is an important innovation, it appears to lack qualities suitable to women's situations. It seems that women are less likely recipients of PCC –suggesting they may also be communicationally or informationally less satisfied in view of the evidence that women's communication styles and preferences are different from men's (15). Back in 1995, the United Nations Fourth World Conference on Women made recommendations that there is an unmet need to tailor services to women's conditions- a point further strengthened by the WHO in later years in Women and Health (16). Calls for a woman-centered approach and women-relevant innovations such as Humanised Midwifery Health Services have implicit implications for patient-centered communication relevant to women (17).

Another important model is the management of communication in difficult medical circumstances that are uncomfortable to both physician and patient but more so to the patient. This emotionally distressing and demanding communication may relate to how bad news is communicated in a patient centered communication context. Subject to cultural norms and context the SPIKES model has been in use across a wide range of health services and settings. The model sequences six communication tasks (18) that culminate in the revelation of bad news to a patient that recognizes and respects the humanity of the patient. Defined as “any information which adversely and seriously affects an individual's view of his or her future” (19) it is able to come as a complete and devastating shock while its reception may differ interpersonally.

SPIKES - The Six-Step Protocol for Delivering Bad News-is structured as follows:

- STEP 1: SETTING UP the Interview
- STEP 2: Assessing the Patient's PERCEPTION
- STEP 3: Obtaining the Patient's INVITATION
- STEP 4: Giving KNOWLEDGE and Information to the Patient
- STEP 5: Addressing the Patient's EMOTIONS with empathic responses
- STEP 6: Strategy and Summary

Shared Decision Making and Patient Decision Aids

In regard to communication for optimal patient outcomes, evidence may come from scientific literature, clinical practice, informed patients, and clinical experience. These together serve to guide a clinical decision on offer. These nonetheless are patient decision aids serving as important inputs. Called patient decision aids, they help patients participate in decisions made regarding their healthcare needs. Their importance lies in their informative power in regard to patients who are made aware of clinical options available to address their medical/surgical needs. The set includes clarification of values and preferences in relation to options available.

The totality of the communication as pertains shared decision making (SDM) 1) includes choice discourse which addresses imperatives of decision making and weighing patient options 2) option discourse (extended discussion involving reference to decision aids as outlined). This category of discourse includes delineation of patient-relevant risk-benefit analysis followed by a relevant discussion of values and preferences vis-à-vis options available.

The deliberation phase follows, which takes a more diagnostic evaluation of the totality of the medical options, which is followed by a final decision phase of the shared decision making encounter as a patient centered communication phase (26).

The effectiveness of the model has been extensively demonstrated (27).

- Gains in patient medical understanding

- Enhanced patient-physician communication
- More participatory experience of patient in decision-making of important clinical issues
- Raising patient communication and service satisfaction
- Enhancing patient decision satisfaction by reducing decision ambiguity
- Raising figure of patients who make decisions

International Patient Aids Standards (28) highlight and recommend additional merits of aids which include.

- Information adequacy made available to patient in regard to options
- Detailing of options that includes the option of taking no action
- Provision of both positive (eg cost) and negative features (eg. risks) of options objectively
- Discussion of statistical chances of options and associated adverse events

Overall, ISDAs help in clarifying and encouraging that a decision needs to be reached, in informing patients about existing options, in helping them make a decision based on what matters to them most and experiencing higher satisfaction levels.

Patient centered communication ethics

Grounded in the ethics of care, patient centred communication ethics puts the patient in the center of the health care system, shares decision making (“nothing about me, without me”) and unconditionally shows respect for persons (29)

The evidence base for outcomes and correlates of patient-centered communication

Measurement of Patient centered communication

Lack of complete consensus on what constitutes patient centered communication continues to plague the conceptual literature. However researchers have identified six constructs forming patient centered communication that included exchanging information, fostering healing relationships, recognizing and responding to emotions, managing uncertainty, making decisions, and enabling patient self-management representing an attempt to facilitate operationalization and measurement (30).

Other measures of patient centered communication include the Euro-communication scale (31), Measure of patient-centered communication (32), Roter interaction analysis system patient centeredness subscale (33), Consultation care measure (34), Patient perceived involvement in care scale(PICS) (35), Patient-perceived patient-centeredness scale (PPP) (36), and Measure of Patient-Centered Communication in Health Promotion Clinic Visits with Youth (37). There are other ways of conceiving patient centered communication or aspects thereof as in medical interviewing. These suggest the measurement literature needs to move toward and result in refinement and further development as extant tools are limited.

The further operationalization and refinement of PCC has far reaching implications for programs in communication programs in medical schools, as well as independent certification programs and institutions engaged in communication certifying (38). There is also the need to take advantage of psychometric advances in instrument validation which seem to have been paid little attention in the area of patient centered communication. It is also important that mixed methods can be employed that capture the full gamut of patient data in regard to perceiving medical communication which can then be used for further scale development and validation.

Implications for communication education

Evidence regarding communication skills interventions

Communication is complex and the complexity requires knowledge of its characteristics and the desiderata of effective communication especially in health care settings. In medical settings communication occurs as a central element of interpersonal, inter-professional and small group processes. There are also cross-gender, cross-cultural and intergenerational communications that warrant attention. Because medical care is a communication intensive practice an understanding of the nuances and techniques of communication is vital for optimal health outcomes.

The intricate character of communication suggests it is necessary that medical education include a communication competency component. Because the biomedical component is insufficient training has to include human and medical communication.

Studies have addressed the place of communication in the medical curriculum in several academic settings and the training offered in others. In some studies, communication training led to beneficial outcomes that included the competency to handle emotional issues among patients (39,40) interviewing skills (41) with a focus on the Four Habits identified as important clinical communication skills (42). Another evidence comes from a five day communication course intervention that had a significant effect on doctor-patient communication satisfaction (43). Training does appear to make a difference in communication competence and performance in medical settings (44). Communication training also led to more focused competencies clarification of patient concerns, discussing treatment options, rapport communication, and favorable patient impression of health care provider (45).

Statistically significant improvement was reported in a two-day communication training offered to medical doctors as demonstrated by higher patient satisfaction. With a specialized communication training in breaking bad news a tailored training led to significant self-perceived communication competence gains (40) Further evidence showed communication training of physicians led to significant rise in patient satisfaction (46). Empirical evidence also points to the value of communication training as demonstrated in improved patient outcomes, functioning, life quality, psychological adjustment, and clinical outcomes (47). On the whole the communication training surveyed had general and more specific features that improved physicians' quality of interaction with their patients as well as their own satisfaction (48).

In the Ethiopian medical school setting, students do not take training in specialized medical communication. In consequence both physicians and patients may not reap the benefits of a productive and mutually satisfying communication encounter. Since training does often make a difference, it is necessary that Ethiopian medical education include a professional communication component that many medical universities have put in place for quite long. Learning their relevant best practices would take the Ethiopian healthcare system to even greater heights. Given the lower levels of general education and the attendant health literacy standards in Ethiopia, medical communication training has to offer even more benefits than in contexts of more advanced countries where doctor-patient communication may be a lot easier.

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