REMAPPING DEBATE
Asking "Why" and "Why Not"

How hard is it for doctors to listen and to care?

Original Reporting | By Margaret Moslander | Education, Health care

Oct. 19, 2011 — Last month, the Pritzker School of Medicine at the University of Chicago received a substantial gift — $42 million — to establish the Bucksbaum Institute, intended to "improve doctor-patient communication and clinical decision-making." The Institute is the latest of a series of initiatives that have been started by medical schools in recent years in response to widespread complaints that doctors often fail to communicate effectively with their patients and, perhaps even more fundamentally, fail to empathize with them.

Remapping Debate's examination of the issues of doctors failing to communicate and empathize reveals that, despite innovative efforts at a number of medical schools, the medical community as a whole still has far to go to remedy these problems.

Indeed, some of those most closely involved in trying to reshape medical education to bring communication and compassion to the forefront candidly admit that there are currently profound structural barriers in the organization of medical care that limit the effectiveness of the most well-intentioned training interventions.

Furthermore, a longstanding culture within medicine resistant to taking issues of communication and compassion as seriously as other aspects of medical practice has meant that the change that is occurring generally has begun only in the last several years.

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A status quo not centered on the patient

According to a 2006 Commonwealth Fund report based on a survey of patients from Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States, "on most measures of quality of care," particularly regarding "measures of equity, patient perceptions of safety…[and] patient-centeredness," the United States "ranked last or second-to-last."

The same report noted "nearly one in four U.S. respondents" reported "leaving the doctor's office without having all of their important questions answered," and "50 percent of sicker adults in the U.S.

reported that their regular doctor sometimes, rarely or never tells them about care options or asks for their opinions." The report concluded that seen through the lens of the patient, "the U.S. health care system is not the 'fairest of them all,' at least from the viewpoint of those who use it to stay healthy, get better, or manage their chronic illnesses."

Dr. Robert Arnold, director of the University of Pittsburgh's Institute on Doctor-Patient Communication, said that patient communication suffered because of an excessive focus on the technologies of medicine.

"We need really good science and really good communication, because good communication is crucial in terms of patient adherence to treatment plans, patient satisfaction with their care experience, and whether they come back." Arnold believes that many doctors still see effective communication as a "soft topic," one not on par with the scientific knowledge required to be a successful physician.

Navigating increasingly complex systems

Dr. Matthew Sorrentino, a faculty member at the Pritzker School of Medicine at the University of Chicago, identified the increasing reliance on technology within the medical community as having a tendency to erode good doctor-patient communication.

> "Doctor-patient communication is more important than ever but is also one of the first things to go." — Dr. Matthew Sorrentino, University of Chicago

"As medicine has become more technology-based, as procedures and medical therapies have become more sophisticated, as times in the hospital have become more fast-paced and confusing, doctor-patient communication is more important than ever but is also one of the first things to go."

Dr. Jeffrey Gold, a member of the American Medical Association's Council on Medical Education, said, "A typical hospitalization may involve as many as 200 different professionals interacting with a patient. Between changes in nursing shifts, physicians rotating call, and the other social services and occupational therapists that may be involved, there are many different opportunities for patients to get lost in the shuffle."

Do doctors have an obligation to help patients navigate this bureaucracy? Arnold said they do.

"Doctors should play an important role. There need to be more systems where all of a given patient's doctors see that patient together, and then they all talk, so the patient doesn't have to run from place to place."

Dr. Calvin Chou, a professor at University of California, San Francisco and a member of the American Academy for Communication in Healthcare (AACH), agreed. He cited approvingly a patient-centered "medical home" model. That model is team-based and "provides continuous and coordinated care throughout a patient's lifetime," he said.

The model essentially keeps patients within a specific practice and attended to by a specific team, rather than shuttling them around to different physicians all the time. Chou said there were several benefits to this model. There are "more people who are on the team, more eyes to catch things that an individual might not be able to catch," he said.

But this approach is not the reality in most hospitals across the country, Chou said. On the contrary, "teams mainly function to support the hectic routines of the physicians rather than accommodating the diverse needs of patients."

Movement towards change

Among the medical schools that have implemented programs designed to help medical students learn to communicate effectively with future patients, the Stanford University School of Medicine has adopted a program called Educators-4-Care. That program matches every medical student with a faculty mentor who, according to the program's web site, is charged with helping students "acquire and refine patient communication skills, physical examination skills, clinical reasoning, and professionalism." The mentor meets with his or her mentees once a week during the first two years, and then during the clerkship years, "continues to provide guidance for students' bedside clinical skills and professionalism" through semi-monthly meetings.

Dr. Lars Osterberg, director of the program, emphasized that these faculty mentors are given "20 percent paid, protected time to teach doctor-patient communication. Traditional medical school faculty members usually do not [get compensated] for teaching core values."

Osterberg spoke frankly about the difficulties of maintaining a focus on good communication skills. "The clinical years are where we struggle," he said, adding that, "In many ways, students are treated as a third wheel on a rotation, and are seen as getting in the way of productivity." The rotation system "doesn't lend itself particularly well to teaching effective communication," he observed.

Osterberg's concerns echo those of a study done by the AACH. That study found that "a hostile clinical learning climate [in medical schools] and a lack of importance attributed to teaching caring attitudes [in clinics] were significant barriers" to medical students' ability to learn effective communication skills.

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The Stanford program attempts to overcome these challenges by incorporating a "360 degree evaluation" in which "nurses, peers, residents, doctors and patients" are all asked to fill out evaluations on their interactions with students, and then using those evaluations to assess and grade students.

At the University of Pittsburgh, the Doctor-Patient Institute has implemented mandatory courses on effective communication for first- and second-year students, and has attempted to remedy the loss of control of the student experience during the clinical years by instituting several day-long assessments of students' communication skills during the third and fourth years.

Robert Arnold, the Institute's director, said, "While most schools have courses in first year or second year, we've tried to build our courses on each other so that there's teaching of communication in each of the rotations that students are in. We've also extended the program beyond medical school and have spent a lot of energy making sure our residents practice communication skills as well, giving them several days when they're just supposed to be learning about how to communicate."

UCSF: following the patient, not the specialty

An innovative program at the University of California, San Francisco, attempts to remedy the fact that students have little long-term exposure to patient care in a course entitled "Foundations of Patient Care."

In this course, patients are assigned to a specific clinic, rather rotating through different specialties. While at the clinic, students interact with the patients who attend that clinic on a regular basis and learn to communicate with those patients on a long-term basis.

The idea behind the program is that longitudinal experience with patients, rather than short-term exposure to different specialties, allows medical students to understand what it means to work within a team to provide care to patients over a long period of time.

Dr. Anna Chang, director of the Foundations of Patient Care course, described the course as "complex," stating that it runs over 18 months, starting the first week of medical school and running through the end of the second year. The program, according to Chang, "focuses on getting students in touch with patients, practicing clinical skills, learning how to communicate with patients. They are out in the community with real practicing physicians interacting with real patients."

"The idea, she said, "is that under supervision they have a real setting to put everything else that they're learning together." This program avoids the problem of the medical student being seen as the "third wheel" — the person in the way — because the student is integrated into the long-term life of the clinic.

For patients, the medical student often becomes a familiar face, one whose main focus is on communicating with them.

Varied levels of commitment

In 2007, the Association of American Medical Colleges identified significant gaps in physician preparation, among them "a loss of altruism and qualities of caring as [students] proceed through training and enter the practice environment," an inability to "communicate with patients about difficult issues," and a lack of skills in "cultural competence and awareness and [inability] to recognize that some patients may have health literacy issues." The AACH found "inconsistent implementation of [communication] values in admissions, teaching, assessment and faculty development processes"; medical students reported that "professionalism and compassion" were "role modeled" less than 12 percent of the time by the doctors who served as their mentors during their clinical years.

THE MULTIPLE MINI INTERVIEW

A report of the 2011 annual meeting of the AMA's Council on Medical Education found that "tools to assess personal qualities are limited," and "the tools now used by many admissions committees to assess applicants' personal qualities…are insufficient with regard to validity and reliability."

Medical schools seem unable, or unwilling, to inject the application process with something other than numbers; while students' grades and MCAT scores are under the microscope, other personal characteristics that are important to becoming a good doctor are left untested.

At Stanford, the medical school has started to experiment with the "Multiple Mini Interview" (MMI) in the hope that it will help schools better gauge students' interpersonal and communication skills. Osterberg explained that the MMI replaces the traditional one-hour medical school interview with several eight- to ten-minute interviews with various members of the medical community, including former patients, nurses, and medical school faculty.

According to one published report, at least eight U.S. medical schools are employing the MMI as part of the admissions process.

Since 2004, communications skills have been among those tested by the National Board of Medical Examiners during the exam that doctors take to be licensed to practice. As a result, Jeffrey Gold of the AMA's Council on Higher Education believes that just about every medical school in the country has instituted some sort of communication training.

The rigor of the training varies, however. "For some schools, it's very important," he said. "For others, it's less so." A report by the AACH found that while "most [respondents] believed that their medical schools' curricula strongly emphasized caring attitudes, one third disagreed that they were emphasized as much as scientific knowledge."

While the report found that "patients define quality of care in terms of the quality of communication with members of their health care team, " Chou of UCSF and the AACH said that, "The penetration of the message is variable. Some people have gotten it, others haven't."

One factor that contributes to stymieing progress, Chou said, is the "myth that doctors know how to communicate."

There also remains a problem that admissions procedures for most medical schools do not have effective means of evaluating applicants' ability to foster "caring attitudes" or effective communication skills. This gap in medical school admissions procedures is particularly significant when, as discovered by the AACH, "most [medical school deans] expressed pessimism about fostering caring attitudes in students who do not already possess them." Furthermore, while "three quarters of medical schools ask admissions interviewers to assess caring attitudes in medical school applicants," only "25 percent of those schools train them to do so." (See sidebar on previous page)

The key structural obstacle: there's just no time

Every doctor Remapping Debate spoke with identified a lack of time to spend with patients as a significant obstacle.

"There has been a push to see more patients in a quicker period of time," Sorrentino said. "The 10 minute patient visit in an outpatient clinic has become common, but it's hard to have good communication, an opportunity to educate your patient, and a good rapport with your patient in 10 minutes. It takes a fair amount of time to educate a patient about their disease in words they understand."

Osterberg noted that "in a traditional doctor-patient relationship, you had time to spend with the patient. Now we're pushed and pushed to see more patients, in less time, and we haven't thought about the consequences of that. The actual communication part gets pushed by the wayside."

Gold reiterated this concern, noting the importance of doctors learning what it means to be in the position of a patient.

"What doctors learn when they are in the patient role is that when you're under stress or delivering or receiving bad news, your ability to focus and concentrate on hearing full story sometimes gets lost," he stated. "Doctors need time with patients to make sure they understand, to be sure that they're getting 100 percent of the story. That doesn't always happen the first time you give someone news. You need time to repeat yourself, and doctors don't have that."

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Despite the clearly harmful impact of the time crunch, most doctors and institutions are not pushing for structural change. Instead, they are attempting to teach medical school students how to deal with the constraints the system imposes.

Sorrentino emphasized his belief that "there is no question that physicians can work within constraints and do extremely well, and have wonderful relationships in the 10-minute encounter they have to work with. We need to teach students to imitate those doctors." But he added a caveat: "Personally, I

feel that physicians are too rushed. If they had more time to sit and talk with the patient, I think we'd see higher patient satisfaction and possibly better outcomes."

Why weren't these issues confronted sooner?

The failure to test communications skills until recently is widely agreed to have contributed to the slow pace of change in the medical profession.

It is also true, doctors said, that communication is not as easily assessed as other elements of medical knowledge.

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"How do you put a number on compassion?" Osterberg asked rhetorically. "It really is a softer science."

The AMA also noted that medical schools tend to have difficulty figuring out how to assess students' communication skills, stating in a 2007 report, "While schools are using a variety of teaching and assessment methods, there is an apparent lack of structure to these activities."

Moreover, there is little support or funding available for established physicians who were not taught communication in medical school and want to improve their skills.

According to Chou, "For those doctors who graduated 25 or more years ago, there's really no continuing education in something like communication. Some specialties have some sort of 'reboarding' process, but those are largely medical knowledge-based exams, and don't take communication skills into account."

"There's no impetus to change; people feel like they have [communication] skills already, and if they figure out that they don't, it's training that's generally not financially supported and less valued than other, easier ways to help the patient, like prescribing medication," Chou added.

Finally, much of medical culture continues to value scientific knowledge over effective communication; not everyone agrees with putting time and resources into improving the communication skills of doctors of all ages.

"Most people think that it's just talking, that anybody can talk," Arnold noted. "But this is a kind of talking that most of us don't do."

An ongoing challenge

Despite efforts to teach doctors how to communicate and a growing understanding that communication is an important piece of medical knowledge, progress in this area remains slow and some difficulties are not easily dealt with.

Reflecting on whether doctors themselves believe that patients are entitled to good communication with their doctors, Osterberg said that they do.

“I believe there is a sense from the medical community that patients deserve effective communication and compassion from their doctor. There are just lots of barriers: time, productivity pressures, interruptions.”

The systemic obstacles are most apparent in the time crunch, but also are reflected in the impact they have on physicians themselves, including fatigue, stress, and burnout, Osterberg said.

This content originally appeared at http://remappingdebate.org/article/how-hard-it-doctors-listen-and-care