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# Communication—

## THE KEY TO EFFECTIVE

# Teaching

*The quality of patient instruction vastly improves compliance and outcomes, and mastering a few communication concepts can help you master the teaching moment.*

**BY CHRISTINE A. HINZ**

When Janet Vittone, MD, sees women at Mayo Clinic, there's one topic she's sure to address. It doesn't matter if her patient is young or old, she asks, "Do you do a breast self exam?" If the answer is "No," she follows quickly with, "Can you help me understand why you don't?" Vittone has more than just an objective interest in hearing, "I don't know what I'm doing." As someone who found her own cancerous lump at age 38, and whose mother and sister were diagnosed the same year, this internist wants to guarantee that patients can confidently examine their own breasts.

Educating and motivating patients to do breast self exam, exercise, or quit smoking is easier said than done. Regardless of whether you can—or are inclined to—share a personal

health experience, finding your teaching rhythm is vitally important, no matter what specialty you pursue.

Put aside for the moment that it's just good business. It's always better to have satisfied customers, especially when the going gets rough and someone might sue, but the reason for being the best-ever teacher is that you want the best possible patient outcomes. Experts suggest that better interactions lead to improved diagnostic accuracy for physicians and better compliance and a greater decision-making stake for patients.

"Communication is really very important," says Frederic Platt, MD, a consultant for the New Haven, Connecticut-based Bayer Institute for Health Communication and a Denver internist. "It's not a trivial thing that can be left to someone else. It has many side effects. With better communication, clinical outcomes improve, mostly because patients are more likely to follow their doctors' recommendations."

Not all encounters lead to follow through, however. Research shows that patient adherence to prescriptions, med-

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ical regimens, and other physician orders varies widely, from 30 to 90 percent. At the same time, other studies suggest patients want more guidance in their medical affairs. Yet how do you motivate people when you're being squeezed by every bureaucratic and economic fact of medical life? You can restructure how you conduct a patient visit

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**Janet Vittone, MD, an internist at Mayo Clinic, wants to connect with patients right off the bat. "People come in with suitcases full of outside materials that they think will be helpful, but I usually start by saying, 'You know, I think the most important source of information is you. I'm going to set this aside now, and I want you to tell me your story.'"**

## Take On Bad Habits

Smoking is a killer. Obesity is an epidemic. So what strategy can you use to motivate people to make lifestyle changes that might prevent diabetes, hypertension, or cardiac disease? The 5 "As"—ask, advise, assess, assist, and arrange—is a communication construct that helps you lead patients to realize that it's in their self-interest to eliminate bad habits and follow your plan. By asking a series of questions, you move this person from thinking (or not thinking) about an issue to taking action.

You begin by getting permission: "I'd like to ask you about your smoking, would that be OK?" Then you let the patient direct you to leave the conversation or query further. If you get the nod to continue, you elicit this person's interest in actually quitting: "Have you been thinking about doing it?" If the answer is "yes," you can go directly to final two "As" of the process—"assist" and "arrange" a plan. But if your patient is stuck in neutral, you focus on a series of questions, leading with: "Can you think of good things that might happen if you stop smoking?" Obviously, you go where the conversation leads you but the idea is get people to think exhaustively about positive consequences until they eventually turn the corner and ask you for help.

"None of us knows at what point patients will say, 'I have to change,'" says Lorish about plant-ing the seeds in just minutes. "But that's what fundamentally has to happen. They have to know what to do—but they have to decide first to do it." ■

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## THE TEACHING MOMENT

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**Kristene Whitmore, MD depends on her nurse practitioners to help her educate patients. The arrangement works because she found people with her brand of commitment. “I’m very compulsive about how I practice and how much energy I give to patients,” she says. “I want colleagues who are well-trained and enthusiastic. I’ve had wonderful experience.”**

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so education doesn’t fall through the cracks. “The idea that you’re being oppressed by time isn’t new,” says Platt. “We just blame it on different things now, but that doesn’t solve the problem since the issue is how you use that time effectively and efficiently.”

### **No one is born a good teacher**

The good news is that you don’t have to be a natural communicator to master a teaching moment. You can acquire techniques even if your personal skills and education aren’t up to par. The truth is, physicians routinely complain they were shortchanged in training about talking to and teaching patients. Perhaps you had a lone lecture on the topic. More than like-

ly you fumbled on your own.

Even today, doctors-in-training are so hot on the disease trail that taking time for these skills is just diversion. Or they pick up fundamentals in the classroom with little reinforcement in the field. The end product: very intelligent professionals, enormously knowledgeable and technically competent but with rudimentary skills in dealing with the people wrapped around the disease.

Whatever deficiencies, by 2004 all 125 medical schools had reported to the Association of American Medical Colleges (AAMC) that in some way, shape, or form, the institution has some requirement that addresses communication. While a variety of skills fall under

this umbrella, health education and primary prevention are addressed in 98 percent of them. Similarly, interpersonal skills and communication are one of the six core competencies required of residency programs by the Accreditation Council for Graduate Medical Education (ACGME).

The standard model folds teaching skills into broader curriculum offerings that focus on the patient’s point of view. Obviously there are variations on the theme, but many programs, particularly in general medicine, are moving toward solidifying these skills from the get-go. At the University of Alabama School of Medicine, for instance, third-year students practice interviewing skills with simulated patients. The goal is to apply the 5 “As”—ask, advise, assess, assist, and arrange, a protocol originally developed by the Surgeon General for smoking cessation—to other habits. “It’s beginning to sink in with medical schools,” says Christopher Lorish, PhD, an associate professor of education in medicine at the University of Alabama School of Medicine, “that you can’t leave the training to random experiences and expect students to develop high-level capabilities. You have to institute a structure whereby they can practice and get feedback.”

A red-hot topic in general medicine, communication is getting attention in other disciplines, too. The American Academy of Orthopaedic Surgeons (AAOS) is the first specialty society to develop a comprehensive national curricula targeting surgeons-in-training concerning their teaching and communication skills. Working with the Bayer Institute, AAOS uses veteran surgeons, formally trained as mentors, to instruct residents in the 4 “Es,” Bayer’s clinically-proven communications model. It’s

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based on the idea that by breaking down encounters to engage, empathize, educate, and enlist, anyone can motivate a patient to participate, comply, or change. The AAOS initiative is in response to the group's own research giving orthopaedic surgeons high marks for technical skills but not-so-high marks for communication. Based on that wake-up call, the group has initiated a three-year project to train 3,000 residents in 150 programs as well as other members.

"You always have to have the patient's perspective in mind," says Stuart Weinstein, MD, the AAOS president and an Iowa City, Iowa, scoliosis and spinal-deformity surgeon. "You want to say to yourself, 'What would I expect from an encounter with a doctor?' If you never lose sight of that, you'll go a long way in enhancing your own skills."

### **Filtering through the ad chatter**

You want your patients to understand the diagnosis, agree to the therapy, and be realistic about the outcome, but given the health news and ad chatter today, you may have to work harder at your coaching. Obviously, there's a plus to taking care of people who can talk about bodies, wellness, and disease, but with few filters on the information superhighway, doctors are chasing down a lot of erroneous stuff.

Kristene Whitmore, MD, enjoys it when patients in her Philadelphia female urology practice know something about their bladder, bowel, and genitalia, rather than just pointing and saying, "I have a problem down there." However, when they tap Web sites and chat rooms for info on herbal and other remedies, she has to kick her teaching skills into high gear.

After learning what they know about the products, which is sometimes con-

### **Nix Non-Compliance**

How do you increase your patient's adherence to treatment? Writing in the May/June 1998 issue of the *Journal of Clinical Outcomes Management*, J. Gregory Carroll PhD, and Frederic W. Platt, MD, suggest several techniques:

- **Simplify the regimen.** Patients are more likely to adhere to their medication if it's a once or twice daily regimen than three to four times per day.
- **Address one problem at a time.** Focusing on too many changes can frustrate you and your patient.
- **Tailor regimens to individual habits.** Identify points in your patient's daily routine that can be a segue to treatment; isolate any obstacles and ways to overcome them.
- **Write (or have your patient write) down information that's important to remember.** Being able to recall instructions enhances adherence, but patients typically forget a third of what they hear by the time they reach home. To facilitate recollections, issue instructions on letterhead to emphasize your investment. Also,

personalize and highlight handouts and encourage patients to display the materials in a prominent place.

- **Describe potential results of treatment.** Tell your patients what they will feel initially and when the drug finally takes effect. If the regimen, like an antibiotic, must be completed to be fully effective, emphasize sticking with it even after they feel results.
- **Review common side effects.** Patients who know what to expect will likely continue on, despite experiencing them. Mention the top two or three and explain what to do about them.
- **Involve significant others in planning.** Since another party may remember more of the interaction, ask your patients if they want someone else to listen in. ■

siderable, she reminds them that these products aren't always well-studied or understood. The challenge comes when her patient is taking multiple remedies to "cure" everything from depression to detoxification. If a woman mentions that the preparations aren't working—as usually happens—Whitmore's message is: Proceed with caution. Try one from each category and see how you do. "If they're willing to go there, great. If they're not, then I might say, 'I'm sorry, but I don't have the expertise on some of these agents. Perhaps you should see a naturo-

pathic doctor.'"

With research yielding new regimens by the score, doctors are now the front-line salesmen for adherence and follow-through. One of the roles Lidia Schapira, MD, has as a Boston oncologist is to convince patients that taking Tamoxifen or other hormonal therapy for their breast cancer is a good thing. She frequently encounters women who are reluctant to touch the regimen because they equate it to the much-maligned hormone replacement therapy.

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“There are many deeply held convictions about breast cancer and the harm that we may cause with chemotherapy and hormonal treatments,” Schapira says. “That becomes challenging. On the one hand are patients who are easily corrected of their misconceptions. On the other hand are those who require a lot more negotiating.”

### **Capture every moment**

Certainly, it's easier to build mutual respect and confidence if you see patients regularly. You may have a slight advantage if you're in family or internal medicine, since you court people over time. You can repeat your message often as you discover how they think and learn, but you also have many chronic reasons to change attitudes and beliefs. You want your patients to feel positive about their own future, to think of dieting not as deprivation but opportunity, to realize that giving up tobacco is not a chore but a way of living longer, to recognize that following your suggestions might be better for their health.

As Robert Schwartz, MD, the chairman of family medicine and community health at the University of Miami Leonard M. Miller School of Medicine, says, “I think a long-standing relationship is key in getting a patient to say, ‘My doctor wants me to get better and he's told me on several occasions that I need to do this and this.’ I can't tell you how many patients have come back saying, ‘You know, it's because of our conversation about what smoking was going to do to me that I stopped.’ Many people have told me they made major changes because they trusted what I said.”

Still it doesn't always require repeat encounters. You can make great strides in just one visit, even with a complex or convoluted topic. The process begins by

understanding that anytime you're with a patient you can get this person to work with you effectively. Writing in a series of 1998 *Journal of Clinical Outcomes Management* articles, Platt and his colleagues outline various techniques that can turn a teaching opportunity into a teaching moment.

It starts by “engaging” your patient. You focus on this person's story, making sure she agrees to the agenda and recognizing your different languages and goals.

“Empathy” is those caring words, feelings, and gestures that you exhibit as you listen—objectively—to this person's recitation. In “educating” and “enlisting,” you find out what's at issue before discussing a condition or medical care. Platt recommends an “educational sandwich”—ask-tell-ask—to cut through any barriers as you move someone from thinking to action, from diagnosis to treatment. You ask a question before tailoring an answer and closing the loop: “Now that I've explained this, please tell me what you've heard. I don't always make myself clear, so if I've gone astray, I want to be able to correct myself.” You really have to check back. That's what we don't do enough. We don't ask, “What do you know?” Then we underexplain, overexplain, are too technical, or not technical enough. The patient is not likely to be satisfied.”

Before Nancy Coates, MD, a Kansas City, Kansas, plastic surgeon, negotiates with her patients, she wants to know what life-changing event—classically divorce and job change—prompted the visit and what they hope to gain. Coates likes to give people wide berth to tell their stories, especially since research consistently shows satisfaction grows when patients have a few uninterrupted minutes to say what's on their minds.

Then she delivers on what might be right for them. Obviously, Coates covers

the procedural basics about a surgery that could change one's attitude or looks, but her main goal is to clarify what of this person's vision she can actually attain. “Realistic doesn't mean a less-than-spectacular or less-than-excellent outcome,” Coates says. “It just means teaching someone what's possible from the surgery. Is it going to help them get a job or get over a divorce? There's a lot of counseling, too.”

When Vittone sees a patient at Mayo, she wants to get right to the matter at hand. As a tertiary-care provider who routinely meets referrals, she diagnoses many unexplained symptoms and complaints, so getting a perspective quickly is essential. “People come in with suitcases full of outside materials that they think will be helpful, but I usually start by saying, ‘You know, I think the most important source of information is you. I'm going to set this aside now, and I want you to tell me your story.’”

The points that Schapira needs to make with her breast cancer patients are so crucial to their survival that she scrutinizes their language skills upfront. She needs to see if they're comfortable with technical terms, given the therapeutic commitment. Schapira not only inquires about a woman's background, but she also asks if anyone in her family or entourage is familiar with medicine. “I really try to figure out who I'm talking to before I start.”

She then divvies the information into digestible chunks, pausing after key points and periodically asking if she's understood. In building her case for Tamoxifen, for instance, Schapira explains estrogen's dueling roles as an important female hormone but also a growth factor for breast cancer. Then she emphasizes that women are fortunate to

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have medications that level or lower the amounts of estrogen in the body so that malignant cells can't grow. "You really need the patient to be completely on board with you," she says.

Schapira also gets assurances that they'll stick with the pill-a-day program, even though it could take five years. Well aware that many patients don't finish treatment, she addresses possible barriers upfront. "I take that very seriously. I try not to just write the prescription but to make sure that there's a buy-in."

As to questions from her patients: Too many can be as disturbing as too few since what women ask often reveals how well they're coping—or how much is going over their heads. "It has to feel just right. I'll often ask somebody to repeat what she's going to do so we have an understanding, but I still may ask her to come back sooner than necessary just as a safety check."

In fact, Platt suggests that the most efficient way to give information is to organize it around the questions patients usually want answered. The first three deal with the diagnosis, etiology, and prognosis of an illness: "What has happened to me?" "Why has it happened to me?" and "What is going to happen to me?" The others focus on the care: "What are you doing to me?" "Why are you doing that and not something else?" "Will it hurt?" and "When will you and I know the results?"

With a checklist in your mind's eye, you can cover any basics, but you want to make sure you're understood. Schwartz routinely breaks down complicated concepts he learned in training into simple phrases. "Part of getting people to take responsibility for their health is to explain things in terms they can grasp," he says. Likewise, Platt photocopies diagrams from an anatomy coloring book,

shading in parts of the body as he talks. Anatomy, he says, is the most useful starting point for most people because it helps to place the disease. "We can say, 'The trouble seems to be here.'"

There is no shortage of value-added resources to supplement the visit. The caveat, of course, is that you want to recommend resources that are trustworthy and independent. The AAOS, for instance, is gearing up its own Web site so that orthopaedic surgeons can direct their patients to an authoritative musculoskeletal source. "There's so much misinformation and consumer marketing that we want our patients to have access to filtered information that they can rely on," says Weinstein.

You may use various sources including professionals in your office and community. With doctors being pulled hither and yon, more are bringing nurse practitioners and other health professionals on board. Of course, you want to be selective, but the right nutritionists and others can lift the burden by rounding out the team.

Since many of her patients suffer chronic pelvic pain, Whitmore regularly recommends acupuncturists, hypnotherapists, and other practitioners who will help them relax, but she also depends on her nurse practitioners. The arrangement has been "fabulous," in part, because she found people with her brand of commitment. "I'm very compulsive about how I practice and how much energy I give to patients," she says. "I want colleagues who are well-trained and enthusiastic. I've had wonderful experience."

With time as her greatest challenge, Schapira gives breast cancer patients a basic primer on the chemotherapy drug combination for them, but then she turns women over to a nurse practitioner, who spends an hour on the details of

those agents. "I have many patients who are so trained to think that doctors don't have the time that they'll start the encounter with, 'We won't keep you very long,'" says Schapira. "I say, 'Don't worry. We'll stay here as long as we need so that you're comfortable.'"

As for treatment, it doesn't have to be written in a contract; a verbal buy-in will do. But there is an advantage to putting pen to paper: Everyone is on the same page. Platt draws a decision tree on the chart, with various "branches" referring to the alternatives available. Once this person selects Plan "A," "B," or "C," he circles the option, noting "patient choice." He then provides a photocopy of that chart page. "I always say, 'If anything changes, let me know. In the meantime, this is the plan.' It's not exactly a contract, but it shows what we've looked at and, perhaps, decided together."

Of course, you never exit the encounter unless you've answered questions and made sure needs are met. It's just good protocol to end the session by letting this person know that you're available for further questions by e-mail, phone, or visit. When Vittone's patients leave her office, she not only wants them to be educated about their diagnosis, but be able to recognize that they're doing the right things—or must do different things—to deal with it. "I want my patients to be empowered to take charge of their own lives. My satisfaction is in knowing that they're really doing it." ■

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