

## EDITORIALS

## What We've Got Here is a Failure to Communicate

Howard S. Gordon, MD and Ben S. Gerber, MD, MPH

Jesse Brown Veterans Affairs Medical Center and VA Center for Management of Complex Chronic Care, and Sections of General Internal Medicine and Health Promotion Research, Department of Medicine, University of Illinois at Chicago College of Medicine, Chicago, IL, USA.

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The single biggest problem in communication is the illusion that it has taken place.

- George Bernard Shaw

Communication is critical and plays an important, but often overlooked role in visits to physicians. Not only is good patient-physician communication necessary for most medical care, it also serves several functions including building trust and establishing the patient-physician relationship. Inadequate communication is associated with worse patient satisfaction, worse trust, more complaints and malpractice claims. Moreover, the communicative features of the consultation (e.g., information exchange, shared decision-making) can influence health care outcomes.

There is a recognized need to improve communication in medical encounters because patients who have difficulty communicating with their physicians are less involved in the visit, less informed, and less satisfied with care. Effective communication by both patients and physicians can produce better patient self-management, adherence to treatment recommendations, and follow-up, thereby lessening the burden of disease.<sup>1</sup> In the context of chronic disease, the passive transfer of educational information alone is less likely to result in improved outcomes when compared with goal setting, shared decision-making, and other collaborative approaches. These communicative processes require both active communication behaviors by the patient and patient-centered communication by the physician. Focusing solely on physician communication skills may be insufficient.

Efforts to improve patient-physician communication should recognize that communication is a two-way street. Because of norms of communication, patients who use active communication behaviors (e.g., ask questions) are more likely to influence their physicians' communication (e.g., get answers). In turn, physicians who are more supportive and relationship-centered can influence patients to become more active participants in consultations. Thus communication is a

process of mutual influence. Improving this dynamic process between patients and physicians is challenging. For physicians, communication should not be limited to medical tasks and should also include patient-centered communication behaviors that: (i) assess and address their patients' knowledge and goals; (ii) provide empathy and support; (iii) engender trust and partnership; and (iv) verify understanding. For patients it is not enough to answer physicians' questions; patients need to overcome passivity and use active participatory communication behaviors (e.g., ask questions, communicate concerns, make requests) to gain conversational control and influence the interaction with their physicians. Passive patients may not point out their needs, concerns, and beliefs. Passive communication limits the physicians' ability to identify and meet the patients' needs for information, support, and reassurance, to make accurate diagnoses, and to formulate the most appropriate and personalized treatment plans. Research supports this argument. For example, when patients assume a passive or non-participatory role in the interaction, physicians obtain less information for making appropriate treatment decisions and patients are less committed and less satisfied with those recommendations.<sup>2,3</sup> Furthermore, the evidence supports that active participatory communication behaviors are associated with positive post-consultation outcomes including adherence to and recall of physicians' recommendations, patient satisfaction, improved functional status, and even improved biomedical and physiological outcomes.<sup>4,5</sup>

Despite the recognized importance of patients and physicians making a positive effort in communication, a number of barriers exist. These barriers include differences in patient and physician race, ethnicity, gender, language, culture and many others. Communication may be most difficult when multiple barriers are present, and efforts to inform and understand one another may become frustrating for both parties involved. For example, communication difficulty disproportionately affects racial minorities. Black patients are less likely to use active communication behaviors (e.g. ask questions) in consultations with physicians when compared with white patients. The problem is potentially intensified because of a communicative cycle that perpetuates passivity where physicians provide less information to patients, and in turn patients do little to prompt physicians for more information.<sup>6,7</sup>

Although it is often said that "patients and physicians do not speak the same language," few studies have actually examined the effect of language on health care outcomes. In this issue, Fernandez et al., report results of a study evaluating associations of language barriers with glycemic control among limited English proficient (LEP) patients with type 2 diabetes mellitus.<sup>8</sup> Language barriers were assessed according to patients' ratings of how well their personal physicians spoke their language. Among Latinos with language concordant interactions there

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was no difference in glycemic control. That is, English-speaking and non-English speaking Latinos who had language concordant interactions had no statistically significant difference in glycemic control. However, after controlling for several potential covariates among LEP Latinos, patients who had language discordant interactions were almost two times more likely to have poor glycemic control when compared with patients who had language concordant interactions.

Certainly, this underscores the importance of language concordance between patients and their clinicians. However, other patient characteristics beyond language concordance may have substantial influence on communication patterns and should also be considered when interpreting the findings. Differing levels of acculturation among these patients (a limitation acknowledged by the authors) may contribute to the observed differences in glycemic control. The level of acculturation may be directly related to communication behaviors. Acculturation describes how individuals adopt the attitudes, values, customs, beliefs, and behaviors of another culture. In the U.S., Latinos with LEP may be less acculturated and consequently possess different beliefs about their role as a patient and how to actively participate in encounters with clinicians. Beliefs that their medical condition is beyond their control and that clinicians represent authority figures who should not be questioned may perpetuate patient passivity. Patients might not ask questions if they feel their situation is hopeless (fatalism) and believe their role is to listen, but not question, the doctor. These patients may be unprepared to communicate with their physicians and may miss opportunities to exchange information leading to less informed medical decisions. Though cultural values and beliefs are difficult to measure, English proficiency may be an inadequate proxy for acculturation. Furthermore, health beliefs are not easily generalizable even among specific Latino populations, as they may or may not apply to a given individual in a given situation.

Fernandez et al.<sup>8</sup> also report that the proportion of English-speaking Latinos with poor glycemic control is close to twice that for non-Latino White patients, consistent with other evidence in the literature.<sup>9</sup> Others have reported worse control according to ethnicity alone, but the results of Fernandez et al., suggest that there are contributions from both language and ethnicity. Though not reported, it is likely that racial or ethnic concordance of patient and physician was more common for the non-Latino White patients than the Latino patients. Few studies have directly evaluated communication in ethnically discordant visits using audio-recording. But for racially discordant visits, previous research indicates that racially discordant patient-physician interactions are associated with less information exchange. In these discordant interactions, communication is characterized by physicians providing patients with less information and by patients not requesting or not prompting doctors for more information.<sup>6,7,10</sup> Findings such as these suggest that the observed disparities in care may be due in part to the communicative dynamics within the medical encounter. Fortunately, communication is a skill that can be taught and improved. Efforts to improve communication should not only focus on physicians, because patients who are prepared for their visit can be more active participants in the encounter.

Communication may be more difficult in racially and ethnically discordant interactions even when language is not

an issue. Non-black physicians may rate black patients as less effective communicators and may be more contentious with them.<sup>11</sup> In turn, these physician behaviors could be cues that activate stereotype threat among minority patients. Stereotype threat<sup>12</sup> might be one mechanism leading to less effective communication behaviors among blacks and Latinos. So, what are physicians to do when providing care during racially, ethnically, or language discordant encounters? First, we must recognize that we may not necessarily know what someone's 'culture' is. We often do not understand the actions of others by not realizing others' cultural norms. Learning about the unique qualities of an individual is one of several techniques that physicians' should use to reduce stereotypes and prejudices.<sup>13</sup> Next, we need to discover ways to encourage patient participation and involvement in decision-making, while recognizing and respecting different cultural values. Utilization of culturally tailored educational media or recruitment of 'bridging' bicultural/bilingual staff or patient advocate may promote trust and better communication. Also, interventions have been developed to provide patient education and to encourage patients to be active participants in medical encounters, though many of these have not been translated into practice.<sup>14</sup> We have developed a video targeting black patients with diabetes to encourage them to be more active in their visits with physicians ("*Speak Up*"). Patients found the video to be acceptable, and it was feasible to show the video to patients prior to visits with their physician. Third, when language barriers exist, a trained interpreter is needed. Family members and friends present in an encounter may be uncomfortable fulfilling this role and may not accurately translate patient concerns. Finally, there must be recognition that language and/or ethnic concordance may not be obtainable in many contexts. Opportunities for concordant interactions could be more likely with the development of a more diverse physician work force and with efforts to recruit youths from minority ethnic backgrounds to pursue careers in medicine. In the meantime, we still need culturally sensitive interventions to improve patient and physician communication.

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**Corresponding Author:** Howard S. Gordon, MD; University of Illinois at Chicago, IHRP, Mail Room 558, 1747 West Roosevelt Rd., Chicago, IL 60608, USA (e-mail: hsg@uic.edu).

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