DOCTOR-PATIENT COMMUNICATION, HEALTH OUTCOMES AND HEALTH DISPARITIES

Carol M. Ashton

From Michael E DeBakey VA Medical Center and Baylor College of Medicine, Houston, Texas

INTRODUCTION

Effective communication between doctor and patient forms the foundation of high-quality medical care. The best physician is one who provides state-of-the-art pharmacological and technological interventions to the patient in the context of a working relationship marked by information exchange, acknowledgement that the patient's views of the illness and its optimal treatment may differ from the physician's, and negotiation toward the achievement of shared goals.

DOCTOR-PATIENT COMMUNICATION AND PATIENTS' OUTCOMES

Empirical research confirms that communication during medical encounters influences patient satisfaction,[1] adherence to the doctor's recommendations,[1] and the likelihood of malpractice claims.[2] What is surprising, at least to most physicians, is the evidence tying good communication during the medical encounter to better biomedical outcomes, including better blood pressure control in hypertensives[3] and better glycemic control in diabetics,[4] among others. Some of this evidence comes from studies that analyzed doctors' communication behaviors during medical encounters in order to examine their associations with better patient outcomes. The strongest evidence, however, comes from randomized trials in which the subject of the intervention was the patient as a communicator rather than the doctor. Interventions that "activate" patients, in other words, coach them on how to prepare for visits, ask questions and negotiate with their doctor, have uniformly been shown to lead to better biomedical outcomes, as well as greater satisfaction and trust in their physicians.[4,5]

Most physicians find it easy to accept that good communication during medical interactions leads to better affective outcomes in patients (as well as physicians). But by what mechanism might communication lead to better health outcomes? Communication styles and behaviors of the interactants affect the amount of information exchanged during the encounter. This information exchange allows the patient and physician to understand and acknowledge what medical sociologist Arthur Kleinman called the explanatory model of the patient's sickness - a mental construction by which the patient and the doctor explain the condition's cause, symptoms, pathophysiology, prognosis and best treatment.[6] The patient's mental construction of his illness impels him to engage in activities that he believes will lead to the best health outcomes.

As depicted in Figure 1, explanatory models are products of culture, ethnicity, education, social class, religious beliefs and personality traits. Both patient and doctor have one, though their respective contents may vary. Explanatory models are important because they drive behavior: the doctor's clinical behavior (formulation of a differential diagnosis, diagnostic evaluation and treatment plan) and the patient's illness behavior (monitoring and interpretation of bodily symptoms, care-seeking behavior, salutary self-management behaviors and adherence to recommended treatment plans).

Consequently, a principal task during the medical encounter is for the doctor and patient to achieve an understanding of one another's perspectives and develop some degree of congruence between the respective models. To illustrate, consider the term "hypertension." This term evokes vastly different explanatory models in physicians and some patients. The patient who believes hypertension is related to tension and stress will wonder why his doctor prescribed a "water pill" and dietary salt restriction instead of a tranquilizer for his newly diagnosed hypertension. Such a patient will not adhere to the treatment plan and may suffer poor outcomes as a result. The doctor who is an effective communicator will ensure that he or she elicits enough of the patient's explanatory model, and shares enough of his or her own model, to create the footing for an treatment plan with which the patient can comply.

Situational and organizational pressures such as short appointment times can strain doctor-patient communication. The truth is that saying to a patient, "Tell me what you understand about your

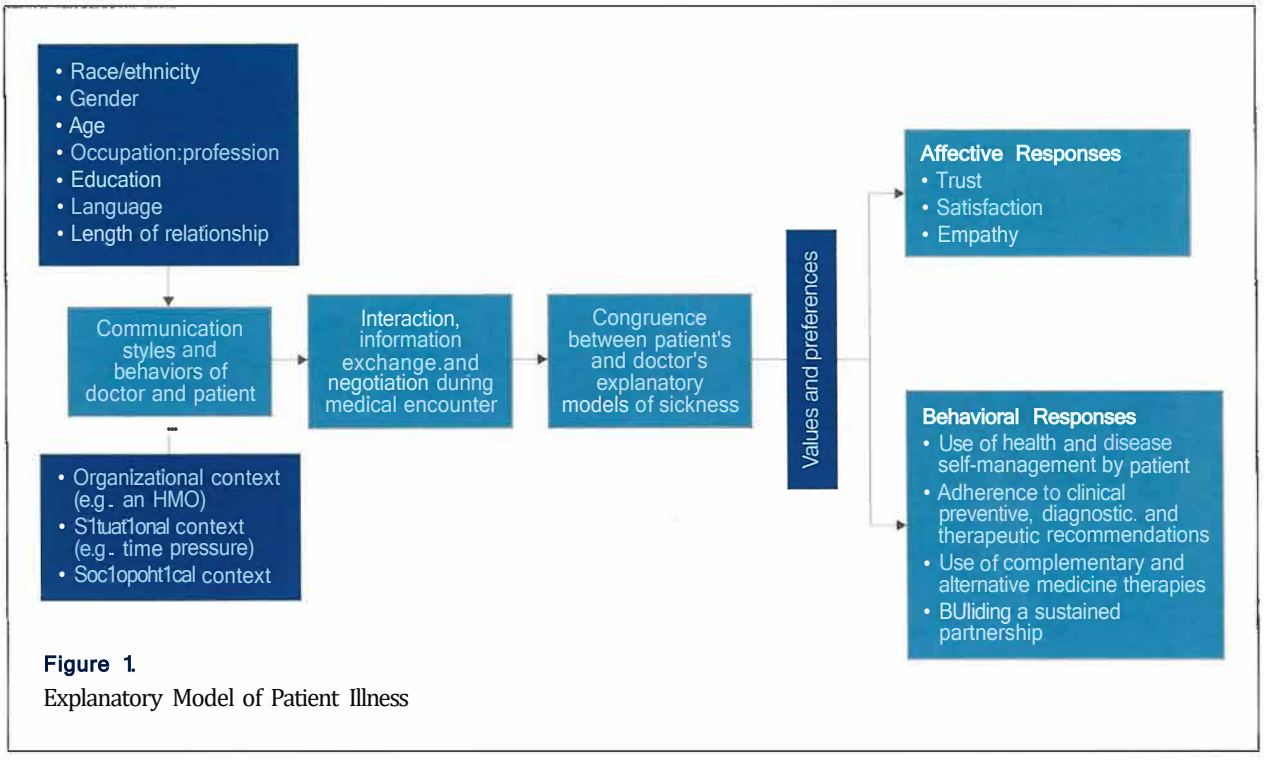

Figure 1.
Explanatory Model of Patient Illness

condition," or "What do you think is causing your chest pain?" adds only seconds to the length of the encounter, while adding immeasurably to the doctor's understanding of factors motivating the patient.

DOCTOR-PATIENT COMMUNICATION AND RACIAL/ETHNIC HEALTH DISPARITIES

Even when access to care is the same, African-Americans and Latinos use fewer health services, and, in many cases, have worse health outcomes than whites. Disparities between whites and nonwhites in service use and patient outcomes in the United States have been observed in virtually every health condition. In March 2005, *Circulation* devoted an entire issue to highlighting racial/ethnic disparities in cardiovascular risk factors, conditions, treatments and outcomes.

If nonwhite patients use services that require a doctor's prescription (invasive diagnostic and/or therapeutic procedures and hospitalizations) at lower rates than whites, this means that some disparities in care arise from the context of the doctor-patient relationship, not from the inability to get to the doctor in the first place. Based on our own research and that of others, we contend that racial bias on the part of physicians, as well as differential preferences for care on the part of patients, play minor roles in producing health disparities. Rather, the main problem appears to be poor communication between physicians - most of whom are white - and their nonwhite patients.[7] Without exception, studies have shown that with nonwhite patients, doctors have poorer interpersonal skills, are less supportive, provide less information and use a less participatory decision-making style.[8]

Language and dialect discordance pose the most obvious difficulties for doctor-patient communication. But even when the same language is spoken, partners coming from different racial or ethnic backgrounds may use and interpret terms, idioms and metaphors differently, and may have different styles of communicating. Difficulty communicating means that the doctor and patient face formidable obstacles as they try to develop a shared understanding of each other's perspective (explanatory model) on the patient's health problems. As a consequence, the patient's affective and behavioral responses to the encounter are suboptimal and health outcomes are undermined.

CAN COMMUNICATION STYLES AND BEHAVIORS BE CHANGED?

Communication patterns are consistent as well as adaptable. People develop communication styles that they use consistently across social encounters, including medical interactions. However, people adapt their communication behaviors to different partners and situations. Doctors and patients adapt their communicative behaviors during medical encounters because of cognitive and affective factors such as the purpose of the visit (e.g.,

communication patterns will differ if the visir is for a regular follow-up versus discussion of advance directives), length of the doctor-patient relationship, perception of the partner and the emotional state of the partners. In addition, just as ocher communicators do, doctors and patients adapt their communication behaviors in response to the other's communicative (verbal or nonverbal) action. For example, interpersonal norms of social interaction require certain etiquette in conversation that includes providing answers in response to questions, raking cums and allowing topics to develop in discussion. Within the medical interaction, doctors and patients can use these conversational norms and forms of speech in order co influence their partner's communicative behaviors. For example, open-ended questions yield more information from patients than questions requiring only yes or no answers.

Work that ochers and we have done shows chat patients can exploit these conversational norms and pares of speech co make their doctors better communicators. Empirical work demonstrates chat patients can influence their doctor's behavior by providing a health narrative (which reveals the patient's explanatory model), asking questions, expressing concerns and being asserrive.9 Patients who ask more questions and actively participate in the encounter get more information from doctors and are better able to recall doctors' recommendations. Likewise, doctors race patients who ask more questions as better communicators and feel chat they are beccer able to determine patiencs' needs and the extent co which they are satisfying chem. For the past five years, we have been holding a series of popular two-hour community-based educational furums for lay Housconians during which we reach these verbal behaviors. The forums, citied "How to Talk to Your Doctor (and Get Your Doctor to Talk co YOU)," are pan of a federal gram studying the influence of communication on racial and ethnic health disparities. During rhe forums, parricipants learn to recognize barriers co good communicacion with their doctors, learn good patient communication techniques and praccice their new skills. Participants rate the forum very highly and report an increased abili$_{ty}$ co communicate with their doctors.[10]

Most physicians are devoted to cheir continued professional educacion and to scaying abreast of diagnostic and therapeutic advances. Unfortunately, culcivacing skills to better communicace wich patients is generally not on the agenda. For physicians who wane co know what their patients chink of chem as communicators, several short questionnaires have been developed char patients can complete after their visits. For the physician who wants to learn to communicate more effectively, a variety of opportunities exists, for example, through the American Academy on Patient and Physician: **www.physicianpatient.org,** and the Bayer Institute for Health Care Communication: **www.bayei:institute.org.**

Someone once said that 80% of leadership is communication, and chat communication is listening as well as talking. The same is true for medicine.

REFERENCES

1. *Ong LML, deHaes JCJM, Hoos AM, Lammes FB. Doctor-patient communication: a review of the literature. Soc Sci Med 1995;40:903-18.*
2. *Levinson W, Roter DL, Muliooly JP, Dull VT, Frankel RM. Phy,ician-patient communication: the relatirmship with malpractice claims among primary care ph_ysiam and surgeons. JAMA 1997:271:553-559.*
3. *Orth JE, Stiles WB, Scherwitz L, Hennrikus D, Val/bona C. Patient exposition and provider explanation in routine interviews and hypertensii•e patients' bloodpressure control. Health Psycho/ 1987;6:29-42.*
4. *Greenfield S, Kaplan SH, Ware JE, Yano EM, Frank HJL. Patients' participation in medical care: effects on blood sugar and quality of life in diabetics. J Gen Intern Med 1988;3:448-51.*
5. *Kaplan SH, Greenfield S, Ware JE. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Med Care 1989;27(suppl)S110-121.*
6. *Kleinman AM, Eisenberg L, Good B. Culture, illness, and care. Clinical lessons f,om anthropological and cross-cultural research. Ann Intern Med 1978,-88:251-8.*
1. *Ashton (1'-1, Haider P, Paterniti DA, Collins TC. Gordon HS, OMalley K, Petersen LA, Sharf BF, Suarez-Almazor ME, Wray NP, Street RL. Racial and ethnic disparities in the use of health services. Bias, preferences, or poor communication? J Gen Intern Med 2003,-18: 146-52.*
8. *Johnson RL, Roter D, Powe NR, Cooper LA. Patient race/ethnicity and quality of patient-physician communication during medical visits. Am J Public Health 2004;94:2084-90.*
9. *Street RL. Active patients as powerful communicators: the linguistic foundations of participation in health care. In: Robinson WP, Giles H (eds.) Handbook of la_ng_uage and social psychology, 2nd ed. Chicester; john Wil_ey, 2000.*
JO. *Tran AN, Haider P, Street RL, O'Malley KJ, Martin F, Ashton CAI Empowering communication: a community-based intervention for patients. Patient Educ & Counseling 2004;52: II3-21.*