

Breaking Down Barriers To Effective Communication

According to the Institute of Medicine's (IOM) report, "Health Literacy: A Prescription to End Confusion," more than 90 million adults—nearly half of American adults—have trouble understanding and using health information. While that number seems unbelievable at first, ask 10 people to bring you a teaspoon. How many will actually get a measured teaspoon used for cooking?

"There's no consensus about what a teaspoon is in America,"

Many people don't have the basic skills needed to use our health system effectively. Or they have different understandings of terms and concepts that are critical to following their physicians' recommendations. And that leads to poorer health, higher health-care costs and another challenge for healthcare providers.

says William Smith, Ed.D., executive vice president of the Academy for Educational Development and a member of the IOM's Committee on Health Literacy. "People bring out all kinds of spoons," ranging from 3.5 cc's to 8 cc's. "Yet the teaspoon measure is something we take for granted in medicine, particularly for children."

Herein lies the problem: Many people don't have the basic skills needed to use our health system effectively. Or they have different understandings of terms and concepts that are critical to following their physicians' recommendations. And that leads to poorer health, higher health-care costs and another challenge for healthcare providers.

Health literacy is more than being able to read. It involves the skills of writing, listening and speaking as well as the knowledge of math and other concepts. The IOM defines health literacy as the degree to which individuals have the capacity to obtain, process and understand basic information and services needed to

make appropriate decisions regarding their care. Health literacy can be complicated by language and cultural differences, lack of education, and other issues, including information overload and differences in communication styles.

“If you think of it just as a problem of education level or language skill, then you miss all kinds of people—like the elderly,” Dr. Smith explains.

But, as the IOM pointed out in their report, the roots of a health literacy problem may not be so much in the characteristics of the particular patient as in the system itself. “It’s not just [the ability to] understand health words,” says Dr. Smith. “It’s more the relationship with the system, a system that doesn’t work very well.”

If it’s a system problem, then a system solution is needed. “Health literacy is the responsibility of multiple people,” says Dr. Smith. “It’s not that it’s not the patient’s responsibility. It’s that it’s not only the patient’s responsibility.”

All the facets of the healthcare team and the healthcare environment—from the signs directing patients to different depart-

Basic Health Literacy Skills

According to William Smith, Ed.D., executive vice president of the Academy for Educational Development, health literacy takes into account the following skills:

- **Listening.** The ability to attend to what a physician or other healthcare team member is saying.
- **Understanding.** The ability to comprehend what is being said or explained.
- **Questioning.** The ability to formulate questions that will elicit the desired information.
- **Being prepared.** The ability to arrive at the clinician’s office with the tools you need to have a constructive exchange. That means information about prescriptions (the pill bottles in a brown bag, if that’s easiest), contact information for other healthcare providers, insurance information and even a friend or family member for support and/or assistance.
- **Literacy and Numeracy.** The ability to read and to understand instructions, numbers and graphs.

ments to the caregivers—need to work together to make the system more accessible.

This means, he says, that the people who design signs need to make them clearer (using terms the patient will understand, rather than the latest technical jargon), and writers who develop patient-information materials must use words that are clear and direct, and physicians and staff who have patient contact need to take time to understand and answer their questions. “And, yes, the people who are trying to read and understand those things have some responsibility, too,” he adds.

The IOM report recommended that healthcare systems recognize the increasing complexity of healthcare with its new technologies, scientific jargon, policies and procedures.

In fact, not only is the healthcare system riddled with medical jargon, it now has a large dose of legalese, too. Just one look at a HIPAA form proves that.

“People [in healthcare] have to understand that what they’re talking about is complicated,” says Dr. Smith. “We have to be sensitive to one another.”

The Institute of Medicine’s report on health literacy recommended that healthcare systems recognize the increasing complexity of healthcare with its new technologies, scientific jargon, policies and procedures. “People have to understand that what they’re talking about is complicated,” says William Smith, a member of the IOM’s Committee on Health Literacy. “We have to be sensitive to one another.”

Recognizing the Signs

Providers also need to take into consideration cultural and language differences and to have systems on hand to overcome those barriers.

But the IOM went farther than the healthcare system. It also looked to the educational system in our country to provide opportunities for children and adults to learn how to navigate the healthcare system. The IOM recommends that health examples be used in English, math and other classes so that students learn to read the charts, graphs and other instructions on medications.

While there’s no test for health literacy, there are cues that physicians and their staffs can look for that might indicate that

a patient may need assistance. The key is to be open to the possibilities and to be ready to help—no matter who your patient is.

The receptionist at the front desk may be in the best position to spot a potential problem. The patient who fumbles through her purse muttering, “I must have forgotten my reading glasses,” may actually be too embarrassed to say the intake form is too complicated to understand. A patient who is quiet and doesn’t ask any questions may actually be having trouble with language.

While there’s no test for health literacy, there are cues that physicians and their staffs can look for that might indicate that a patient may need assistance. For example, the patient who fumbles through her purse muttering, “I must have forgotten my reading glasses,” may actually be too embarrassed to say the intake form is too complicated to understand.

Elderly patients may have more difficulties because of decreased eyesight, hearing and access to information.

As more and more people live longer with chronic diseases, more and more people may face problems with understanding health issues. Patients may actually need a higher level of health literacy in order to properly monitor and measure their conditions—to be true partners in their care.

In some cases, especially when managing chronic diseases in which behavior and adherence can play a large role in outcomes, a group visit of patients with similar health issues may be more useful than a one-on-one meeting with a doctor. Dr. Dean Schillinger and colleagues at the University of California in San Francisco currently are studying this model for patients of diverse backgrounds who share a common diagnosis, such as breast cancer or diabetes.

“One can imagine that instead of a physician saying, ‘I want you to get vigorous exercise,’” Dr. Schillinger explains, “in a group session, someone might say, ‘My nephew got me a stationary bike, and I watch “Wheel of Fortune” while I ride.’”

It also helps to hire staff from a variety of backgrounds that reflect the cultural and language backgrounds of the practice’s patient population. Involving people of different experiences in the healthcare system will help ensure that the system can deal with a diverse patient population.

But the techniques that help people who have language and cultural differences or health literacy challenges to navigate the health system are the same as those that help everyone deal with it:

■ **Be friendly.** Dr. Smith says this may be the number-one piece of advice to physicians and their staff. If staff people are friendly, patients will feel that they can approach with a question. He points out that what many people need is a kind of “H&R Block for health issues.” Without such a service available, the office staff becomes that information source. While it may feel as if staff doesn’t have time for this, it’s actually a service that patients want and need—and the physicians’ office is the best source for that service.

■ **Listen.** Ask open-ended questions and take the time to listen to the answers. Put down your pen and look patients in the eye. Consider their answers as you outline the next steps.

■ **Be sensitive and express empathy.** Remember that the health-care system can be overwhelming in the best of circumstances; most of the patients who are coming into an office are feeling sick and maybe even scared. Empathy builds trust and sets the stage for successful communication.

■ **Prioritize information.** Think about what is most important for the patient to take away from the office visit. Is it that the medication must be taken at a certain time in order to be effective? Is it that the patient needs to call to make an appointment for additional tests and procedures? Determine the essential messages, and make sure they’re delivered using the teach-back techniques described in Chapter Two.

■ **Be clear.** Speak directly and concisely, using visual aids to assist. According to Rima Rudd, Sc.D., a principal investigator with the National Center for the Study of Adult Learning and Literacy, one study of physicians’ conversations with white-collar and blue-collar patients actually found that physicians used plainer language when talking to white-collar patients. “When people are not like you, you tend to be more formal in your presentation,” she explains. Instead she urges healthcare providers to stop and ask patients, “Was I clear?” (rather than “Do you understand?”). Here again, the teach-back method works well.

A plain-language thesaurus can help identify easily understandable (and easily translatable) words to replace the gob-

bledygook of medical jargon. Even seemingly familiar words may not be completely understood when used in a healthcare context, says the Partnership for Clear Health Communication, a coalition of organizations working to promote awareness and solutions around the issue of low health literacy and its effect on health outcomes. The group has developed a “Words to Watch”

Problem Words to Avoid

Even highly literate people sometimes have trouble understanding words used in healthcare, according to the Partnership for Clear Health Communication (www.askme3.org). The partnership breaks these problem words into four groups and offers more common words to use as alternatives.

Problem Word	Use Instead
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Medical Words

Ailment	Sickness, illness, problem with your health
Benign	Will not cause harm, is not cancer
Dysfunction	Problem
Lesion	Wound, sore, infected patch of skin
Oral	By mouth

Concept Words

Avoid	Stay away from, do not use (or eat)
Collaborate	Work together
Factor	Other thing
Gauge	Measure, get a better idea of, test
Intake	What you eat or drink, what goes into your body

Category Words

Adverse (reaction)	Bad
Cognitive	Learning, thinking
Hazardous	Not safe, dangerous
Generic	Product sold without a brand name, like ibuprofen
Support	Help with your needs—for money, friendship or care

Value Judgment Words

Adequate	Enough
Adjust	Fine-tune, change
Excessive	Too much
Increase gradually	Add to
Moderately	Not too much

fact sheet that translates common medical terms into more patient-friendly words (*see box on page 66*).

The Difficult Patient

Most physicians regard the physician-patient relationship as the center of their profession and the main reason they chose medicine as a career. So it can be difficult to admit that sometimes patient relationships can be difficult. Sometimes, says Greg Carroll, Ph.D., executive director of the Institute for Healthcare Communication, physicians at first will deny that they have difficult patient relationships or that communicating with patients can occasionally be frustrating. He sees this in the communications workshops he holds for physicians in practice.

But, Dr. Carroll says, the instructor then asks them if they cringe when they see a certain patient's name on the day's roster or on a telephone message. Suddenly there's a list on the blackboard of situations and characteristics "that give the doctor the immediate desire to go home."

Then there is a flash of recognition: all physicians experience these frustrations at times. "What people all realize in a giant 'Aha!' is that we are all frustrated when [communication] does not work well," says Dr. Carroll. "Many people are surprised at how deep the frustration goes and how common it is. There are a lot of similarities in the things that frustrate people. And that's something that day after day, week after week, month after month grinds away at their ability to be as good a clinician as they want to be—as good a listener, adviser and diagnostician."

While the first reaction may be to blame the patient—poor historian, non-compliant, argumentative, hypochondriac—Dr. Carroll urges physicians to "get over the hurdle of what 'difficult' modifies." For example, the Institute for Healthcare Communication calls one of their seminars the "Difficult Clinician-Patient Relationship," and Frederic W. Platt, M.D., and Geoffrey H. Gordon, M.D., titled their book *Field Guide to the Difficult Patient Interview* (Lippincott Williams & Wilkins, 1999). In their preface, Drs. Platt and Gordon write "This book is not really about difficult patients...The book is about the difficult interaction, the difficult relationship, and the difficult interview."

In the Nov. 15, 2005, issue of the *American Family Physician*,

Dr. Leonard Hass and colleagues explain that, in most practices, about 15 percent of relationships can be described as “difficult.” Many factors can come into play. It could well be that the patient has a co-existing psychiatric problem or an emotional issue that is complicating the interview. It may be that the

Eight Dimensions of Patient-Centered Care

A decade of research conducted by the Picker Institute, a Boston-based nonprofit organization, and Harvard researchers uncovered what’s most important to patients. Using more than 8,000 interviews and focus groups with patients and healthcare professionals, they found eight dimensions of care that matter most to patients.

1. Respect for patient’s values, preferences and expressed needs. Patients indicate a need to be recognized and treated as individuals. They are concerned with their illnesses and conditions and want to be kept informed.

- An atmosphere respectful of the individual patient should focus on quality of life.

- Involve the patient in medical decisions.

- Provide the patient with dignity and respect a patient’s autonomy.

2. Coordination and integration of care. Patients report feeling vulnerable and powerless in the face of illness. Proper coordination of care can ease those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:

- Coordination of clinical care.

- Coordination of ancillary and supportive services.

- Coordination of “front-line” patient care.

3. Information and education. Patients express a fear that information is being withheld from them and staff is not being completely honest about their condition and prognosis. Providers should focus on three communication items to reduce these fears:

- Information on clinical status, progress and prognosis.

- Information on processes of care.

- Information to facilitate autonomy, self care and health promotion.

4. Physical comfort. The level of physical comfort patients report has a tremendous impact on their experience. Three areas were reported as particularly important to patients:

- Pain management.

- Assistance with activities and daily living needs.

- Hospital surroundings and environment.

patient brings up a physician's own emotional issues. The health system may also be the root of the problem. Patients who have had a difficult time navigating the system may be tired, angry, confused or disillusioned by the time they actually meet with the physician.

5. Emotional support and alleviation of fear and anxiety. Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to:

- Anxiety over physical status, treatment and prognosis.
- Anxiety over the impact of the illness on themselves and family.
- Anxiety over the financial impact of illness.

6. Involvement of family and friends. Patients continually addressed the role of family and friends in the patient experience, and often expressed concern about the impact illness has on family and friends. Family dimensions of patient-centered care were identified as follows:

- Providing accommodations for family and friends.
- Involving family and close friends in decision making.
- Supporting family members as caregivers.
- Recognizing the needs of family and friends.

7. Transition and continuity. Patients often express considerable anxiety about their ability to care for themselves after hospital discharge. Meeting patient needs in this area requires the following:

- Provide understandable, detailed information regarding medications, physical limitations, dietary needs, etc.
- Coordinate ongoing treatment and services after discharge.
- Provide information regarding access to clinical, social, physical and financial support on a continuing basis.

8. Access to care. Patients need to know they can access care when it is needed. Focusing mainly on ambulatory care, the following areas were of importance to the patient:

- Access to the location of hospitals, clinics and physician offices.
- Availability of transportation.
- Ease of scheduling appointments.
- Availability of appointments when needed.
- Accessibility to specialists or specialty services when a referral is made.
- Clear instructions provided on when and how to get referrals.

Source: NRC + Picker (<http://nrcpicker.com/Default.aspx?DN=22,2,1,Documents>)

But whatever the cause of the difficulty, the physician has the responsibility to recognize that something is going wrong and to adjust his or her approach to improve the situation. Dr. Hass and colleagues point out that blaming the patient—or even ignoring the difficulty—is counterproductive. It won't solve the problem, the authors point out, and it may actually provoke anger and counter-blaming.

The first step in dealing with difficult patient relationships is to recognize the problem, says Greg Carroll, Ph.D., executive director of the Institute for Healthcare Communication. Often a physician doesn't recognize his or her frustrations until after the patient encounter. The key is to recognize the difficult situation when you're in it.

So what is a physician to do? The first step is to recognize the problem, says Dr. Carroll. Often a physician doesn't recognize his or her frustrations until after the patient encounter—maybe even not until that evening when home with his or her family. The key is to recognize the difficult situation when you're in it.

“When you're feeling frustrated or feeling an emotional reaction come on in the presence of a patient, that's data,” Dr. Carroll says. “That's a sign to pay attention. It's difficult if you miss that sign because it's like a train missing a signal—all of a sudden you're off the rails.” Feelings of hostility, defensiveness and impatience are all cues to slow down and look more carefully at the situation.

Using the skills and interview models described in Chapter Two can help keep the interview on track. In fact, if a physician finds that he or she experiences more difficult relationships than his or her colleagues, it may be a sign that a refresher course in communication skills may be in order.

In addition, according to Dr. Hass and colleagues, the difficult patient relationship may indicate the patient has an undiagnosed psychiatric disorder, such as depression or anxiety. Acknowledging the patient's stress and asking questions about how that stress is affecting his or her daily life may shed light on the cause and on whether treatment for the psychiatric condition may be indicated.

Other suggestions for managing difficult relationships include the following:

■ **Network with community resources in mental health and social services.** These colleagues may help you decipher the dif-

faculties and help you point the patient to appropriate services.

■ **Schedule longer visits.** Let the scheduling staff know if some patients will need longer appointment times; this will help accommodate that patient while preventing wait times that might actually lead to more angry and disgruntled patients.

■ **Set an agenda and stick to it.** Firm limits are especially important when managing a difficult relationship. Set an agenda for the visit with the patient in the first few minutes of the encounter. Any additional concerns brought up at the last minute will have to wait until the next visit.

How to Handle a Hot-Headed Patient

The patient has lost his temper and is screaming at your front-desk clerk. Your staff is tense, and the other patients can hear the turmoil and are getting uncomfortable. What should you do to keep the situation from escalating? Kristine Eckis, president of Bottom Line Medical Administrative Consultants, a practice management firm in Lake Wales, Fla., offers the following tips:

■ **Move the patient to a private area**, such as your office, to avoid others from overhearing your conversation. Sit down, and ask him to sit down.

■ **Let him vent.** Ask him to explain the problem without interrupting. If he starts off screaming, reassure him that you will listen to his whole story, but he needs to lower his voice. When he appears to be finished, ask if he's told you everything or has anything else to add.

■ **Speak in a low, reassuring and sympathetic tone**, which will ensure a higher probability of agreement. If you speak in a monotone, patients will be less responsive. If your tone is cold and indifferent, it will arouse antagonism and make the situation worse.

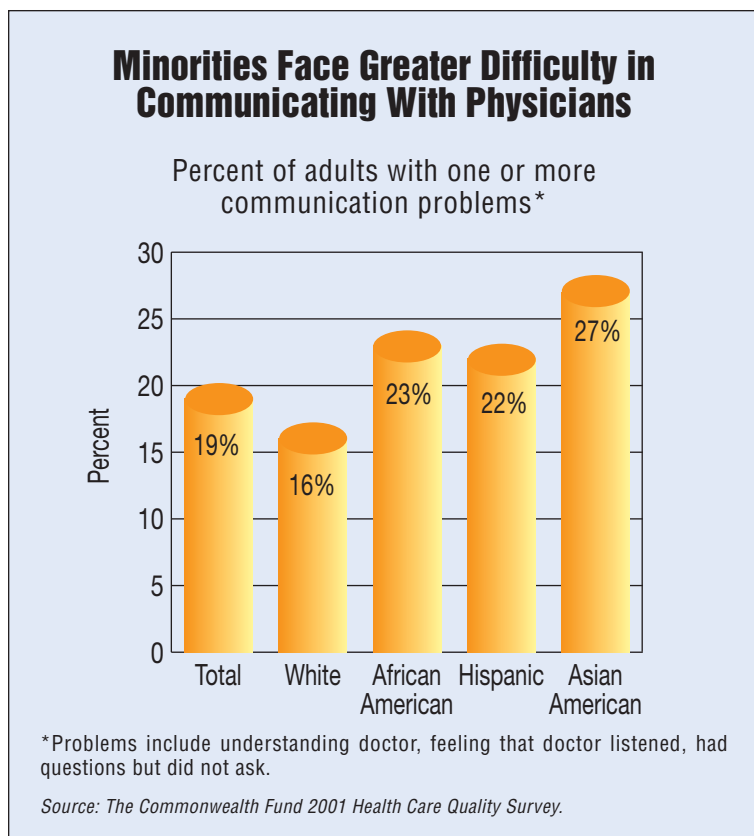
■ **Don't argue, be defensive or take the complaint personally.** Keep in mind that if you win, the patient loses, and he will feel very bad about it. Your goal is to constructively resolve the problem and save the patient's relationship.

■ **Understand the patient's point of view.** There are many phrases you can use to demonstrate that you understand his perspective. Here are several: "This never occurred to me," "Tell me more about it," or "You know, you may be right about that." These types of responses give patients the feeling that you're really listening. And when they feel you understand their side, their hostility diminishes.

■ **Schedule more frequent visits.** Shortened intervals between follow-up visits may increase feelings of trust and support and may help put the patient at ease. E-mail and telephone contact can further strengthen the relationship.

Cultural and Language Differences

A 2002 study by The Commonwealth Fund reveals that on a wide range of healthcare quality measures—including effective patient-physician communication, overcoming cultural and linguistic barriers, and access to healthcare and insurance coverage—minority Americans do not fare as well as whites. African Americans, Asian Americans and Hispanics are more likely than



whites to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving healthcare, to experience barriers to access to care such as lack of insurance or not having a regular doctor, and to feel they would receive better care if they were of a different race or ethnicity.

“Communication is essential to quality medical care, and a disturbingly high proportion of patients feel that their doctors do not listen to them or report that they do not understand what their doctors say. So even when a patient reaches the doctor’s office, they might not receive optimal care,” said Dr. Karen Scott Collins, vice president at The Commonwealth Fund. “Physicians need support to make communication a priority, both during medical training and in practice.”

Language differences may be a very obvious barrier to communication in some cases. Some patients may come in with a family member or neighbor who will translate for them. Although this may be helpful, it can also become another barrier, since the family member may also have language challenges or cultural differences.

Asian American patients are much more likely than whites (27 percent vs. 16 percent) to cite one or more communication problems such as not understanding the doctor, not feeling the doctor listened to them or that they had questions for the doctor but did not ask, the survey says. Nearly one-fourth of Hispanics (22 percent) and African Americans (23 percent) experience similar communication difficulties.

Communication problems often arise when physicians treat patients of different ethnic and cultural backgrounds. “Health is such a fundamental part of us,” says Dr. Smith, “that culture begins to define what’s healthy, what’s fat, what’s a fever. Every culture has developed some way of thinking of it.”

For example, in many traditional societies, it is not proper for a woman to talk to a doctor, especially a male doctor. Yet in our society, the physician is trained to protect the confidentiality of the patient and to encourage independent communication. When a male American physician, in particular, treats a woman from a traditional Indian or Middle Eastern society, he may be surprised and frustrated to find that he can’t talk to his patient directly.

Some cultures define obesity differently. African-American

women are often more satisfied with a larger body frame than other cultures and may become offended by talk of weight loss even if their body-mass index (BMI) indicates a potential health problem. Therefore physicians may avoid discussing obesity with these patients. A recent community health study of residents in Charleston, S.C., found that whites with diabetes were three times as likely to be diagnosed with obesity as African-Americans with diabetes—despite the fact that all diabetics in the study had a BMI of more than 30. The researchers felt that cultural bias—or concerns about offending the patient—may play a role in the disparity.

The National Cancer Institute is currently researching the effectiveness of “tailored health messages,” which take patients’ cultural backgrounds and values into consideration when communicating messages of prevention, early detection and treatment of cancer.

Assuming that a patient will fit a particular ethnic profile

What Is Cultural Competency?

Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.

Culture and language may influence the following:

- Health, healing and wellness belief systems.
- How illness, disease and their causes are perceived by the patient.
- The behaviors of patients who are seeking healthcare and their attitudes toward healthcare providers.
- The delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

Source: Office of Minority Health, U.S. Department of Health and Human Services

can be just as damaging as ignoring ethnic differences, experts say. In their book, *Field Guide to the Difficult Patient Interview*, Drs. Platt and Gordon urge physicians to elicit the patient's own views of their illness and health and to consider them with respect, rather than putting them aside as uninformed or outmoded.

Understanding the patient's cultural framework can help the physician know how to proceed and will increase the chance of a positive communication—and a positive outcome.

Language differences may be a very obvious barrier to communication in some cases. Some patients may come in with a family member or neighbor who will translate for them. Although this may be helpful, it can also become another barrier, since the family member may also have language challenges or cultural differences. Many hospitals have access to translators either in person or by phone to help in these instances.

Press Ganey Associates, a South Bend, Ind.-based company that monitors patient satisfaction for hospitals and healthcare organizations across the country, reports that formal translation service—either on staff or through a dial-up service—has been shown to improve patient-satisfaction ratings. It also helps to have educational materials available in languages common to the practice's patient population.

Even patients who have relatively good English skills may have difficulties understanding in the healthcare environment. First of all, they probably don't feel very well and they may be scared, especially if the illness is serious. Also, even a person who converses well in a second language in a social setting may have more trouble when trying to translate medical terms and to understand the nature of an illness.

"There are people who appear to the doctor to speak English pretty well, but they really don't," says Dr. Smith. "They may also have some cultural issues that might confuse them." He gives the example of writing a prescription for a Latino patient who is just learning English. In the medication instruction, "Take once a day," a person struggling with language may quickly notice the familiar word "once" but attach its Spanish meaning ("11") rather than its English meaning ("one time"), resulting in a disastrous overdose of medication.

Elderly Patients

Older patients can present a number of communication challenges for physicians. Many elderly patients suffer from hearing or vision loss, which can be a barrier to effective communication. Some medical schools ask students to put on glasses that blur their vision or insert ear plugs that block hearing and then send them off to a doctor's appointment. This gives them first-hand knowledge of some of the barriers experienced by many elderly patients.

The government manuals that are supposed to help guide patients in decisions about their Medicare and supplemental coverage are difficult to understand in even the best of circumstances, says William Smith, Ed.D. These documents challenge even very literate, college-educated patients. "They can't understand health information because the people who write the information don't understand them," he says.

As patients age, they are more likely to be dealing with multiple conditions and multiple medications. The possibilities for drug interactions increase, as does the chance of taking the medications incorrectly.

"A person may be taking five or six medications, and they're all different colors and shapes," says Dr. Smith. They might use

timers, compartmentalized pillboxes and other devices to help them remember to take their medications. "They've kind of got it worked out, but if you ask them what that one is for, they answer, 'I don't know. My doctor told me to take it.'"

Dr. Smith gives the example of his own mother, who took a variety of medications. When he accompanied her to her doctor's appointment, he brought along all the pills. When the doctor went through them, he found that his mother had continued taking medications that had been changed and was not taking other medications that were very important to her health.

It is estimated that about 40 percent of elderly patients do not take their prescription medicines as directed. Noncompliance with medication instructions can stem from a variety of factors, including lack of comprehension, poor communication, cultural issues and financial difficulties.

According to a 2005 survey by AARP, the vast majority of Americans over the age of age 65 (87 percent) say that they have

taken a prescription drug in the past five years. Those who are currently taking prescription drugs regularly say that they take an average of four different prescriptions drugs daily.

Complex drug regimens—multiple drugs, frequent dosing,

Digital Divide or Education Divide?

We hear a lot about the “digital divide”—the gap between those who have access to the Internet and other information technology and those who don’t. As more and more health communications move to the Internet and other computer-based systems, certainly some people will be left behind.

“If things are only available on the computer, that puts people at a disadvantage,” says Dr. Joseph Kvedar, dermatologist with Partners Healthcare in Boston.

Access is only one part of the equation. Some people just don’t feel comfortable with getting information or conducting transactions by computer. “There’s a subset of patients who find the Web sterile and off-putting,” says Dr. Kvedar. “And some people just do better on the phone,” rather than e-mail or by recorded messages.

In that case, says Kris Baird, RN, of Baird Consulting in Fort Atkinson, Wis., the healthcare system needs to be responsive to the patient’s needs and preferences, offering a range of communications options.

More than the digital divide, it’s the education divide that worries Bradford W. Hesse, Ph.D., chief of the Health Communication and Informatics Research Branch for the National Cancer Institute (NCI). In the Health Information National Trends Survey conducted by NCI, users with higher levels of education were more likely to trust Internet-based information than less-educated people.

Since much of the information on the Internet is not reliable, that finding seems contradictory at first. But, Dr. Hesse says, it makes sense: “One thing you’re taught in college and graduate school is how to solve problems by looking for information.” Educated surfers know how to look at the source of the information—whether on the Internet, in the newspaper or in a marketing leaflet—and determine if it is trustworthy or not. But people without that education may not know “what to trust or even who to talk to see if the information they’ve downloaded makes sense,” Dr. Hesse says.

Even if everyone had equal access to technology, there would still be this education divide. “I think it’s going to be the next challenge for the next decade,” says Dr. Hesse.

variable doses—increase the risk of noncompliance, according to The Merck Manual of Geriatrics (www.merck.com/mrk-shared/mmg/home.jsp). Elderly patients are better able to comply with regimens that include drugs with once- or twice-daily dosing than those with more frequent dosing. “The drug regimen should be discussed with the patient to help form a partnership and to keep the regimen simple,” the manual states.

Another factor that influences medication compliance is cost. The AARP survey revealed that one in four Americans over the age of 50 who have taken a prescription drug in the past five years say they did not fill a prescription written by their doctor in the past two years. Cost was reported as the main deterrent. Other reasons cited—such as “thought drug wouldn’t help much” and “didn’t think I needed it”—could indicate that the physicians were not effectively communicating the need for the prescription to the patients.

The Merck Manual states that patients are more likely to comply with doctor’s orders if they have a good relationship with the physician, one in which they are included in the decision making. “Clear prescription instructions and explanations of why the treatment is necessary and what to expect (i.e., delayed benefits, general adverse effects) also help ensure compliance. Trust in the physician is crucial.”

In addition, elderly patients are often confused by the complexity of the healthcare system. The government manuals that are supposed to help guide patients in decisions about their Medicare and supplemental coverage are difficult to understand in even the best of circumstances, says Dr. Smith. These documents challenge even very literate, college-educated patients. “They can’t understand health information because the people who write the information don’t understand them,”

he says.

Attempts to make the publications easier to read have been thwarted by the legal sys-

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tem. “There are words the lawyers insist you use, and you can’t change them,” Dr. Smith says. “So we’re all confronted with part medicalese and part legalese.”

The introduction of the recent Medicare prescription program is another case in point. Dealing with patients’ questions and helping them navigate the system and get the medications they need put an increased burden on physicians, pharmacists and other healthcare providers.

“With the Medicaid/Medicare changes this year, we have experienced a much higher volume of denials for medications,” says Dr. Cathy McCray, a family physician in Fulton, Mo. “Sometimes we go through the prior-authorization process only to be denied and be forced to change medications. We all know that blood-pressure medicine is not ‘one size fits all.’ The patient only knows that we are failing to get the medication that they have been taking successfully for years.”

All this can lead to anger and frustration on the part of both patient and physician.

“Our medical system has been squeezed,” says Dr. Smith. “It’s more time-dollar conscious than it was 10 to 15 years ago.” At

Elicit the Patient’s Perspective on Illness

Patients of different backgrounds and cultures may have different perspectives on illnesses—even giving them different names and attributing different causes. Getting this information from the patient can help the physician communicate more effectively and increase the chance of a positive outcome. Here are some questions that may help elicit the patient’s perspective:

- What do you call the problem?
- What do you think caused the problem?
- Why do you think it started when it did?
- How does the problem work, and what does it do to you?
- How severe is the problem, and how long will it last?
- What kind of treatment is needed, and what do you hope it will achieve?
- What difficulties has the problem caused for you?
- What do you fear most about the problem?

Source: The Four Habits Approach to Effective Clinical Communication.

the same time, he adds, there are greater numbers of elderly patients, who need more time.

In addition, many of the time-saving techniques and technologies that practices put into place to increase efficiency are not helpful to many older patients. For example, many practices have started making lab results available by an automated phone system: patients call a special number, log in with their code and hear their doctor explaining their lab results. Web-based information may also be of limited usefulness to older patients who do not feel comfortable with the Internet.

“Boomers might be comfortable with either of these, but older people might want someone to call them on the phone,” says Kristin Baird, R.N., of Baird Consulting in Fort Atkinson, Wis. She urges practices to find out how patients want to receive lab results or health information. “You need to meet patients where they live,” she says.

Providing a safe environment in your office for elderly patients can also communicate to them that you are concerned about their welfare. Ophthalmic Mutual Insurance Company, a professional liability insurer based in San Francisco, offers the following tips to make your practice a safe environment for your senior patients:

- Make sure that hallways are well lit and that office floor coverings are easily traversed by patients on foot, with walkers or in wheelchairs.
- Patients with mobility problems should be supervised and assisted at all times when being moved in and out of exam rooms or on and off chairs.
- Pathways leading to the office and parking lot areas should be well lit and free of obstacles.
- Ramps are extremely helpful in entrance and exit areas.
- Routinely check equipment and office furnishings for loose fittings and unstable tables or chairs.

The Knowledgeable Patient

It’s becoming a pretty familiar sight: the patient who comes in with a stack of printouts from the Internet or an advertisement from a magazine or a book touting a miracle treatment. While an informed patient is usually seen as an asset, not a barrier,

there are times when you can have too much of a good thing—or too much of the wrong type of information.

“People are inundated with health information from more sources and in more volume than ever before,” says Dr. Smith. “There’s more health news now than there was 15 years ago. Product advertising uses health as a major setting benefit.”

Not only is more information being pushed at consumers—consumers are looking for information more than ever before. A study published in the *Journal of the American Academy of Orthopedic Surgeons* found that 55 percent of patients with musculoskeletal conditions sought information about their diagnosis prior to their office visit.

“Once you get onto Google, it’s a crapshoot where you end up,” says Brad Hesse, Ph.D., acting chief of health communications and informatics research for the National Cancer Institute. **“Patients recognize that, so they don’t entirely trust what they find on the Internet. But what they do trust is this person who has been highly trained.”**

Increasingly patients are turning to the Internet and typing quick terms like “cancer,” “depression” or “diabetes” into a search engine like Google. Another survey published in the July 28, 2003, edition of *Archives of Internal Medicine* found that 31 percent of 3,209 respondents had looked up health information on the Internet during the past year. Eight percent of the respondents had taken that health information to their doctor’s office. Of the portion who took the information to their doctors, only one-fourth wanted to use the information to convince the doctor of a certain course of treatment. The majority just wanted their doctor’s opinion of the information.

“Once you get onto Google, it’s a crapshoot where you end up,” says Brad Hesse, Ph.D., acting chief of health communications and informatics research for the National Cancer Institute. “Patients recognize that, so they don’t entirely trust what they find on the Internet. But what they do trust is this person who has been highly trained.”

And so the patient arrives at the doctor’s appointment laden with information that the physician must then go through to separate the wheat from the chaff. “Some physicians embrace it, some are angry about it,” says Martie Moore, R.N., senior vice

president of patient care at MaineGeneral.

Actually, says Dr. Hesse, “most physicians are taking to the role pretty well.” In the Archives of Internal Medicine survey cited above, 67 percent of patients who took Internet information to their doctors said that the clinicians reacted favorably, and 27 percent reported a neutral reaction. Only 15 percent thought their physician felt “challenged” by the information, and just 7 percent said their doctors responded negatively. However, those who sought a specific treatment course were more likely to report a negative reaction from their physician.

About one-third of the patients felt that bringing information to their physician had had a positive effect on their relationship with the clinician, reporting a greater sense of control and involvement in their healthcare. Only 4 percent felt that the physician-patient relationship was damaged by bringing in the information.

“Taking information on the Internet to their physicians could have a positive or negative impact on the physician-patient relationship, depending on the physician’s reaction and communi-

Instruction Options

A growing number of organizations offer courses in patient communication. While even a few hours of training can help a physician realize the importance of communication skills, studies show that true change and significant improvement are most likely with at least 20 hours of training. The following organizations can offer more information about training opportunities:

American Academy on Communication in Healthcare
 16020 Swingley Ridge Road, Suite 300
 Chesterfield, MO 63017
 Telephone: 636-449-5080
 Fax: 636-449-5051
www.aachonline.org

Institute for Healthcare Communication, Inc.
 555 Long Wharf Drive, 13th Floor
 New Haven, CT 06511-5901
 Telephone: 800-800-5907 or 203-772-8280
 Fax: 203-772-1066
www.healthcarecomm.com

ation skills,” the authors write. They go on to say that the relationship was more likely to be damaged if the patients reported that the physician acted challenged or had poor communication skills, or if the patient felt hurried during the consultation.

According to Dr. Hesse, there are two take-away messages in this study. First, he says, “We have myths and concerns that physicians aren’t going to react well. Most physicians do indeed welcome this.” However, it does have implications for a physician’s time and for the healthcare system as a whole. “We have to think of nontraditional ways to let that expanded communication occur over time.”

He points to the concepts of “information therapy” and “information prescriptions.” Perhaps a nurse or health technician can work with patients to assess health information. Practices might try holding health seminars for patients with similar concerns, such as hormone replacement therapy or breast cancer treatment options. “The worst thing we can do is put our heads in the sand and say, ‘I’m not going to change anything I do,’” Dr. Hesse says. “We need to make this a systems problem and not just a physician’s problem.”