

Patient-Clinician Communication: Basic Principles and Expectations

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ACTIVITY

Marketing experts, decision scientists, patient advocates, and clinicians have developed a set of guiding principles and basic expectations underpinning patient-clinician communication. The work was stewarded under the auspices of the **Best Practices and Evidence Communication Innovation Collaboratives of the Institute of Medicine (IOM) Roundtable on Value & Science-Driven Health Care**. Collaborative participants intend these principles and expectations to serve as common touchstone reference points for both patients and clinicians, as they and their related organizations seek to foster the partnership and patient engagement necessary to improve health outcomes and value from care delivered.

BACKGROUND

Health care aims to maintain and improve patients' conditions with respect to disease, injury, functional status, and sense of well-being. Accomplishment of these aims is predicated upon a strong patient-clinician partnership, in which the insights of both parties are drawn upon to guide delivery of the best care, tailored to individual circumstances. An important component of this partnership is effective patient-clinician communication.

In the 2001 IOM report **Crossing the Quality Chasm**, patient-centeredness was defined as one of the six key characteristics of quality care and has continued to be emphasized throughout the IOM's Learning Health System series of publications. Dimensions of patient-centeredness include respect for patient values, preferences, and expressed needs along with a focus on information, communication, and education of patients in clear terms. Consistent and effective communication between patient and clinician has been associated in studies not only with improved patient satisfaction and safety, but also ultimately with better health outcomes, and often with lower costs. Breakdowns of communication, or disregard for patient understanding, context, and preferences, have been cited as contributors to healthcare disparities and other counterproductive variations in healthcare utilization rates. **Moreover, professional ethics in health care stress the intrinsic importance of respectful and effective communication as a core aspect of informed consent and a trusting relationship.**

In an era of increasingly personalized medicine and escalating clinical complexity, the importance of effective communication between the patient and the clinician is greater than ever. As the ultimate stakeholders, patients should expect an active role in, and often shared

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responsibility for, making care decisions that are best for them. Clinicians, in turn, should respect and support patients in this role, valuing their inputs and prioritizing their preferences in shaping care choices.

Whether considering risks and benefits or personal values and preferences, patients and clinicians each have unique and important information to contribute to understanding and deciding on prevention, diagnosis, or treatment options. Obtaining the highest-value care for each individual requires establishing common goals and expectations for care through shared deliberation that marshals the best information. Effective communication therefore requires clarity on patient and clinician roles, responsibilities, and expectations for health care; principles to guide the spirit and nature of patient-clinician communication; and approaches to tailor communication appropriately to circumstance (e.g., routine care, chronic disease management, life-threatening disease) and individual patient needs (e.g., health literacy and numeracy, living circumstances, language barriers, decision-making capacity).

Passage of the **Patient Protection and Affordable Care Act of 2010** offers both opportunity and mandate to reorient strategies, incentives, and practices in support of health care that reliably delivers Americans the best care at the highest value—care that is effective, efficient, and most appropriate for the circumstances. As an element of best practice, the effectiveness of patient-clinician communication can be as important as that of a diagnostic or treatment tool and should be the product of similarly systematic assessment and evaluation. The principles and expectations identified in this document offer a framework to evaluate and improve patient-clinician communication, and to sharpen and focus patient discussion tools, patient safety assessment (e.g., the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), organizational and individual performance assessment and quality improvement efforts (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS), and clinician certification processes (e.g., the American Board of Internal Medicine (ABIM)).

BASIC PRINCIPLES AND EXPECTATIONS FOR PATIENT-CLINICIAN COMMUNICATION

Many factors affect the quality and clarity of communications between patients and clinicians. However at the core of the matter, certain basic principles pertain and serve as the starting point for the expectations of patients and clinicians: **mutual respect, harmonized goals, a supportive environment, appropriate decision partners, the right information, full disclosure, and continuous learning.**

Patient-Clinician Communication

Basic Principles

1. Mutual respect
2. Harmonized goals
3. A supportive environment
4. Appropriate decision partners
5. The right information
6. Transparency and full disclosure
7. Continuous learning

Drawing from these principles, the basic individual and mutual expectations of both patients and their clinicians can be identified. These expectations are discussed below and summarized in the accompanying figure.

1. Mutual respect

- *Each patient (or agent) and clinician engaged as full decision-making partners.* Communication should seek to enhance healthcare decision making through the exchange of information and by supporting the development of a partnership relationship—whenever possible—based on trust and focused on the whole patient. This includes considering psychosocial needs, identifying and playing to the patient’s strengths, and building on past experience to meet immediate need and anticipate future concerns.
- *Respect for the special insights that each brings to solving the problem at hand.* Information exchange should be characterized by listening, inquiry, and facilitation that is both active and respectful on the part of both the patient and the clinician. Information needs include patients’ ideas, preferences, and values; living and economic contexts that may affect patients’ health or decision making; the basis and evidence for alternative choices and recommendations; and uncertainties related to the proposed course of action.

2. Harmonized goals

- *Common understanding of and agreement on the care plan.* Full understanding—to the extent practicable—of care options and the associated risks, benefits, and costs, as well as patient preferences and expectations, should lead to an explicit determination of the shared agenda and goals. Factors should include health, lifestyle, and economic preferences and should accommodate language or cultural differences and low health literacy.

3. A supportive environment

- *A nurturing and secure services environment.* The success of the care plan depends on the attention paid in the service setting to patient culture, skills, convenience, information, costs, and implementation of the care decision.
- *A nurturing and secure decision climate.* The comfort and ability of the patient and clinician to speak openly is paramount to discussion of potentially sensitive issues inherent to many health decisions.

4. Appropriate decision partners

- *Clinicians, or clinician teams, with skills appropriate to patient circumstances.* With increasingly complex problems, and time often a factor for any individual clinician, it is important to ensure that the patient has access to clinicians with skills appropriate to a particular encounter; that, as indicated, alternative clinician opinions are embraced; and that provisions are made for the communication needed among all relevant clinicians.
- *Assurance of competence and understanding by patient or agent of the patient.* Understanding by both patient and clinician is crucial to arriving at the most appropriate decision. Understanding of patient options is important: how specific they are to circumstances; the associated risks, benefits, and costs; and the needed follow-up. If indicated, an appropriate family member or similar designee should be identified to act as the patient’s agent in the care process.

Expectations

1. Mutual respect

- Each patient (or agent) and clinician engaged as full decision-making partners.
- Respect for the special insights that each brings to solving the problem at hand.

2. Harmonized goals

- Common understanding of and agreement on the care plan.

3. A supportive environment

- A nurturing and secure services environment.
- A nurturing and secure decision climate.

4. Appropriate decision partners

- Clinicians, or clinician teams, with skills appropriate to patient circumstances.
- Assurances of competence and understanding by patient or agent of the patient

5. The right information

- Best available evidence at hand, choices and trade-offs thoroughly discussed.
- Presentation by patient of relevant perceptions, symptoms, personal practices.

6. Transparency and full disclosure

- Candid and explicit acknowledgement to patient of limits in science and system.
- Patient openness to clinician on all relevant circumstances, preferences, medical history.

7. Continuous learning

- Effective approach established for regular feedback on progress.
- Established periodicity for course assessment and alteration as necessary.

5. The right information

- *Best available information at hand, choices and trade-offs thoroughly discussed.* The starting point for shared decision making should be the sharing of all necessary information. When working collaboratively to craft an appropriate care plan clinicians should provide evidence concerning risks, benefits, value, and costs of alternative options. All options should be discussed to bring out patient preferences, goals, and concerns and to explicitly consider the impact of various options on these issues.
- *Presentation by patient of relevant perceptions, symptoms, personal practices.* The clinician's appreciation and understanding of patient circumstances depends on accurate sharing by the patient of perceptions, symptoms, life events, and personal practices that may have a bearing on the condition and its management.

6. Transparency and full disclosure

- *Candid and explicit acknowledgment to patient of limits in science and system.* A basic element of the care process is comprehensiveness and candor with respect to the limits of

the evidence, delivery system constraints, and costs to the patient that may affect the range of options or the effectiveness of their delivery.

- *Patient openness to clinician on all relevant circumstances, preferences, medical history.* Only by understanding the patient's situation can the most appropriate care be identified. Patient and family or agent openness in sharing all relevant health and economic circumstances, preferences, and medical history ensures that decisions are made with complete understanding of the situation at hand.

7. Continuous learning

- *Effective approach established for regular feedback on progress.* Identification and implementation of a system of feedback between patients and clinicians on status, progress, and challenges is integral to the development of a learning relationship that is flexible and can adapt to changing needs and situations.
- *Established periodicity for course assessment and alteration as necessary.* Early specification of treatment strategy, expectations, and course correction points is important for ongoing assessment of care efficacy and to alert both clinician and patient to possible need for care strategy changes.

TAILORING IMPLEMENTATION TO NEED AND CIRCUMSTANCE

These Principles and Expectations offer general guidance for successful patient-clinician communication. Moderating factors or constraints present in individual circumstances require certain tailored approaches and expectations for a particular visit—still with the aim of maximizing faithfulness to the principles to the fullest practical extent. Examples of such considerations include:

Visit reason

- Prevention
- Chronic condition management
- Acute or urgent episode

Decision characteristics

- Number of decisions to be made during the visit
- Certainty, uncertainty, and relevance to the available evidence
- Decisions related to a preference-sensitive arena or choice
- Access to and use of the Internet

Patient characteristics

- Functional capacity (level of physical or mental impairment)
- Communication capacity (language, literacy/numeracy, speech disorder)
- Receptivity (motivation, incentives, activation, learning style, trust level)
- Support (skilled family or other caregiver, financial capacity)
- Living situation (housing, community, grocery, pharmacy, recreation, safety)

Clinician and practice characteristics

- Patient volume and complexity
- Patient support systems (language aids, interpreters, physical space, digital capacity)
- Decision support systems (digital platform, information access, decision guidance)
- Professional team profile and culture
- Condition-specific skill network and referral follow up systems
- Reimbursement and other economic barriers

DEVELOPING THE TOOLS AND PROCESSES FOR ADAPTIVE TARGETING

As touchstone reference points for patients and clinicians, the Principles and Expectations presented here are vital to achieving the full measure of potential health outcomes and value from care delivered. But achieving that potential requires intent, commitment, and creativity in developing the tools and processes for adaptive targeting in the myriad conditions and circumstances found in different healthcare settings. Noted below are questions that may stimulate thought, conversation, and innovative approaches to their successful implementation in various settings and circumstances.

For clinicians and healthcare organizations

- How are we doing now with respect to the Principles and Expectations?
- For which of them is our current culture and practice pattern most challenging?
- What initial steps might be good starting points for systems changes necessary?
- How can we enlist patients and staff working together to help develop and lead?
- How can we take advantage of initiative and help from professional societies?
- What community tools or resources might be adaptable for us?
- How can we measure the impact for feedback to patients and staff on the results?

For patients, consumers, and advocates

- What makes a clinician a good listener?
- What should we expect in conversations about health care with clinicians?
- How can available care and condition-specific materials be more easily understandable?
- Are there helpful ways to judge a care setting's support of effective communication?
- What should we expect from clinicians to help interpret medical evidence?
- How can we best help clinicians in their efforts to improve information sharing?
- How will "continuous learning" from my care lead to better health care?

For professional societies, policy makers, health plans, insurers, and employers

- How do current practices compare with the Principles and Expectations?
- What ought to be our expectations for clinicians we support?
- What metrics will be most useful for quality improvement and feedback?
- What tools are most needed to assist in application and site-specific tailoring?
- Can we develop case material to illustrate approaches and feasibility?
- What information can help demonstrate material returns in outcomes and value?
- Which reimbursement incentive structures are most important to consider?

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This statement of Principles and Expectations was developed by participants drawn from organizations engaged in the Best Practices Innovation Collaborative and the Evidence Communication Innovation Collaborative of the IOM Roundtable on Value & Science-Driven Health Care. It is intended to help inform and stimulate discussions and to serve as a resource to others in practice and research. Although it does not necessarily represent official policy of participating institutions, organizations expressing support for the aims of this individually-authored Discussion Paper include those indicated below. Information on related work and follow up activities may be obtained from the IOM Program Officer facilitating the projects of the two Collaboratives: Isabelle Von Kohorn, MD, PhD (ivonkohorn@nas.edu).

