

# The Impact of Effective Communication

## Chapter FastFACTS

- 1. Re-evaluating and updating your communication systems will help your practice keep pace with changes in the healthcare environment.**
- 2. Even simple techniques like using handouts can lead to better patient adherence and outcomes.**
- 3. Patient adherence increases when you actively engage the patient in a meaningful way—e.g., through reflective listening.**
- 4. Better communication can lead to cost savings.**
- 5. Spending just 30 more seconds listening to each patient can make a difference.**

**Y**ou've just told a patient that she has a chronic disease like diabetes—news that you may deliver fairly often, but to this patient it comes as a shock. In fact, after the initial words, “You have...” many of the details that follow are a blur; and the patient probably won't be able to repeat or remember anything else you said. But it doesn't have to be that way. Good communication techniques can help you make the most of each office visit so that patients better understand their conditions and what they need to do. In turn, patients who are informed are more likely to be engaged in their healthcare outcomes.

“I think that doctors often say the same thing so many times that the concepts become simple to them,” says Kelli M. Ward,

In patients with type 2 diabetes, the TITRATE® study demonstrates

# Once-daily Levemir® gets the majority of patients to goal safely<sup>1</sup>

**64% of patients achieved A1C goal <7% with once-daily Levemir®\***

The Levemir® TITRATE trial shows how a majority of patients with type 2 diabetes taking a basal insulin, some with A1C levels as high as 9%, achieved the ADA-recommended target of A1C <7%.<sup>1,2</sup> Patients experienced a mean A1C decrease of -1.2%\* and achieved goal safely with low rates of hypoglycemia, nearly all of which were minor or symptoms only.<sup>1†</sup>

\*70 to 90 mg/dL group.



Model is for illustrative purposes only.

To see how Levemir® can help your patients achieve their goals, and to learn more about TITRATE, visit [TITRATEstudy.com](http://TITRATEstudy.com).

<sup>†</sup>Minor hypoglycemia rates were 0.42 (70-90 mg/dL) and 0.26 (80-110 mg/dL) per patient-month. A single major hypoglycemic event was reported in the 70 to 90 mg/dL group; no major hypoglycemic events in the 80 to 110 mg/dL group.<sup>1</sup>

Results from a 20-week, randomized, controlled, multicenter, open-label, parallel-group, treat-to-target trial using the PREDICTIVE® 303 self-titration algorithm in insulin-naïve patients with type 2 diabetes, A1C ≥7% and <9% on OAD therapy randomized to Levemir® and OAD (1:1) to 2 different FPG titration targets (70-90 mg/dL, [n=121] or 80-110 mg/dL, [n=122]).<sup>1</sup>

PREDICTIVE = Predictable Results and Experience in Diabetes through Intensification and Control to Target: an International Variability Evaluation.

## Indications and usage

Levemir® is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

## Important safety information

Levemir® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

**Levemir® should not be diluted or mixed with any other insulin preparations.**

**Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir®. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Levemir® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetes treatment may require adjustment.**

**Needles and Levemir® FlexPen® must not be shared.**

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir® from other intermediate or long-acting insulin preparations. The dose of Levemir® may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation. Less common but more serious are severe cases of generalized allergy, including anaphylactic reaction, which may be life threatening.

Please see brief summary of Prescribing Information on adjacent page.

**References:** 1. Blonde L, Meriläinen M, Karve V, Raskin P, for the TITRATE™ Study Group. Patient-directed titration for achieving glycemic goals using a once-daily basal insulin analogue: an assessment of two different fasting plasma glucose targets—the TITRATE™ study. *Diabetes Obes Metab*. 2009;11(6):629-631. 2. American Diabetes Association. Standards of medical care in diabetes—2010. *Diabetes Care*. 2010;33(suppl 1):S11-S61.



**Levemir®**

insulin detemir (rDNA origin) injection



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## Levemir® (insulin detemir [rDNA origin] injection)

### Rx ONLY

#### BRIEF SUMMARY. Please see package insert for full prescribing information.

**INDICATIONS AND USAGE:** LEVEMIR® is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long acting) insulin for the control of hyperglycemia.

**CONTRAINDICATIONS:** LEVEMIR® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

**WARNINGS: Hypoglycemia is the most common adverse effect of insulin therapy, including LEVEMIR®. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations. Glucose monitoring is recommended for all patients with diabetes. LEVEMIR® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Concomitant oral antidiabetic treatment may need to be adjusted. Needles and LEVEMIR® FlexPen® must not be shared.**

**PRECAUTIONS: General:** Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal. LEVEMIR® is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration. **LEVEMIR® should not be diluted or mixed with any other insulin preparations** (see PRECAUTIONS, Mixing of Insulins). Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins. As with all insulin preparations, the time course of LEVEMIR® action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity. Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

**Hypoglycemia:** As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR®. Hypoglycemia is the most common adverse effect of insulins. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions). Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients' awareness of hypoglycemia. The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from their other intermediate or long-acting insulin preparations to once- or twice-daily LEVEMIR®, dosages can be prescribed on a unit-to-unit basis; however, as with all insulin preparations, dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia. **Renal Impairment:** As with other insulins, the requirements for LEVEMIR® may need to be adjusted in patients with renal impairment. **Hepatic Impairment:** As with other insulins, the requirements for LEVEMIR® may need to be adjusted in patients with hepatic impairment. **Injection Site and Allergic Reactions:** As with any insulin therapy, lipodystrophy may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR®. In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique. **Systemic allergy:** Generalized allergy to insulin, which is less common but potentially more serious, may cause rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

**Intercurrent Conditions:** Insulin requirements may be altered during intercurrent conditions such as illness, emotional disturbances, or other stresses. **Information for Patients:** LEVEMIR® must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR® therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, life-style management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, timing of dosage, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as intercurrent conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the LEVEMIR® "Patient Information" circular for additional information. As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hypoglycemia or hyperglycemia. Patients with diabetes should be advised to inform their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy). **Laboratory Tests:** As with all insulin therapy, the therapeutic response to LEVEMIR® should be monitored by periodic blood glucose tests. Periodic measurement of HbA<sub>1c</sub> is recommended for the monitoring of long-term glycemic control. **Drug Interactions:** A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring. The following are examples of substances that may reduce the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives). The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, fibrates, fluoxetine, MAO inhibitors, propoxyphene, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics. Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent. The results of *in-vitro* and *in-vivo* protein binding studies demonstrate that there is no clinically relevant interaction between insulin detemir and fatty acids or other protein bound drugs. **Mixing of Insulins:** If LEVEMIR® is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR® with insulin aspart, a rapid acting insulin analog, resulted in about 40% reduction in AUC<sub>(0-2h)</sub> and C<sub>max</sub> for insulin aspart compared to separate injections when the ratio of insulin aspart to LEVEMIR® was less than 50%. **LEVEMIR® should NOT be mixed or diluted with any other insulin preparations. Carcinogenicity, Mutagenicity,**

**Impairment of Fertility:** Standard 2-year carcinogenicity studies in animals have not been performed. Insulin detemir tested negative for genotoxic potential in the *in-vitro* reverse mutation study in bacteria, human peripheral blood lymphocyte chromosome aberration test, and the *in-vivo* mouse micronucleus test. **Pregnancy: Teratogenic Effects: Pregnancy Category C:** In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 nmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 nmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 nmol/kg/day (approximately 135 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. Drug-dose related increases in the incidence of fetuses with gall bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 nmol/kg/day. The rat and rabbit embryofetal development studies that included concurrent human insulin control groups indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity. **Nursing mothers:** It is unknown whether LEVEMIR® is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR® is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both. **Pediatric use:** In a controlled clinical study, HbA<sub>1c</sub> concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR® and patients treated with NPH human insulin. **Geriatric use:** Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR®, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

**ADVERSE REACTIONS:** Adverse events commonly associated with human insulin therapy include the following: **Body as Whole:** allergic reactions (see PRECAUTIONS, Allergy). **Skin and Appendages:** lipodystrophy, pruritus, rash. Mild injection site reactions occurred more frequently with LEVEMIR® than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy). **Other: Hypoglycemia:** (see WARNINGS and PRECAUTIONS). In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR® was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4). **Weight gain:** In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR® was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in the effects of LEVEMIR® and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

**Table 4: Safety Information on Clinical Studies\***

Treatment	# of subjects	Weight (kg)		Hypoglycemia (events/subject/month)		
		Baseline	End of treatment	Major**	Minor***	
<b>Type 1</b>						
Study A	LEVEMIR®	N=276	75.0	75.1	0.045	2.184
	NPH	N=133	75.7	76.4	0.035	3.063
Study C	LEVEMIR®	N=492	76.5	76.3	0.029	2.397
	NPH	N=257	76.1	76.5	0.027	2.564
Study D	LEVEMIR®	N=232	N/A	N/A	0.076	2.677
Pediatric	NPH	N=115	N/A	N/A	0.083	3.203
<b>Type 2</b>						
Study E	LEVEMIR®	N=237	82.7	83.7	0.001	0.306
	NPH	N=239	82.4	85.2	0.006	0.595
Study F	LEVEMIR®	N=195	81.8	82.3	0.003	0.193
	NPH	N=200	79.6	80.9	0.006	0.235

\*See CLINICAL STUDIES section for description of individual studies  
 \*\* Major = requires assistance of another individual because of neurologic impairment  
 \*\*\* Minor = plasma glucose <56 mg/dl, subject able to deal with the episode him/herself

**OVERDOSAGE:** Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid recurrence of hypoglycemia.

**More detailed information is available upon request.**

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**Levemir®**  
 insulin detemir (rDNA origin) injection

DO, a family physician and regional medical director at North Country Health Care Community Health Center, Lake Havasu City, Ariz. “They have to strive to recall that what is simple to them is more difficult for lay people to understand even in the Internet age.” In the above case, for example, giving the patient a written note of what was discussed at the visit along with a “homework assignment” to review information about her condition would help guide her and would possibly result in a better outcome.



**“I give each patient a one-page sheet that has a list of the diagnoses we discussed that day, the refills they received, and a copy of our plan for that visit in language that the patient can understand.”**

**Kelli M. Ward, DO**

Family Physician  
Regional Medical Director, North Country Health  
Care Community Health Center  
Lake Havasu City, Ariz.

Although everyone agrees that “successful” physician-patient communication—patients following their doctor’s instructions and working with their doctor to achieve the best possible health outcomes—is desirable, this kind of communication may have recently received short shrift as you contend with tight reimbursement, shortened patient visits, new computer systems, and other pressures that may impede good communication. Healthcare reform efforts have put the spotlight on communication since reform adds even more pressure for time-crunched physicians by bringing more patients into the system.

Re-evaluating and updating your communication systems and techniques will enhance your efforts to cope with the changing healthcare environment. Those efforts are more important than ever given other realities of medicine today, including increased patient involvement in their own healthcare, says Ronald M. Epstein, MD, professor of family medicine, psychiatry, and oncology, and director of the Rochester Center to Improve Communi-

cation in Health Care, University of Rochester Medical Center, Rochester, N.Y. Patient expectations are higher now, he concludes, and patients want to be part of the changes in healthcare that are being discussed today. They both need and want to take control of their health—and that means more pressure on you to effectively relay news about their health and treatment choices.

This issue of *Doctor's Digest* will give you a fresh look at key aspects of doctor-patient communication along with practical tips that you can put into practice. We'll discuss the benefits of effective communication, from increased adherence to improved accuracy to reduced malpractice risk. And there are even more benefits, says Ellen J. Belzer, MPA, president of Belzer Seminars & Consulting, LLC, Kansas City, Mo.: Healthcare providers who are skilled in communication, she says, end up with a "smoother-running practice," one with greater efficiency, improved morale, and enhanced job satisfaction.

## A Hot Topic

Because shorter patient visits are now a reality, physicians have even less time to establish their relationship with patients. Yet communication skills often take a back seat to high-tech medical procedures, testing, and new treatments. "Communication is low on the totem pole, yet it's valued a great deal. It's one of the keys to quality, cost-effective care," says Joseph W. Stubbs, MD, an internist in Albany, Ga., and immediate past president of the American College of Physicians (ACP), who notes that some patients are even willing to pay for more communication with their providers. "Concierge medicine appreciates communication and focuses on it, which shows how important it is to patients. They are willing to pay extra to be able to converse and have extra time with their doctor," he says.

Renewed focus on doctor-patient communication is largely due to reimbursement issues: A percentage of many physicians' salaries is now being held back due to patient satisfaction sur-

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vey results. This practice is not new, but for a long time the government and others have been looking for fresh ways to motivate physicians, notes Richard H. Carmona, MD, MPH, FACS, former Surgeon General of the U.S., and president of the Canyon Ranch Institute, Tucson, Ariz. There is a continuing search for the right metrics with which to enhance patient satisfaction. Recent healthcare reform measures specify the need for patient satisfaction provisions without stating any specific provisions, according to Dr. Carmona. “Patient satisfaction and physician reimbursement are all part of a continued search to find the best practices to provide us with the best doctor-patient relationships,” he says. This search will ultimately affect physician reimbursement based in part on patient satisfaction.

In addition, the Patient Protection and Affordable Care Act’s emphasis on improved primary care has intensified interest in how to deliver patient-centered care. Patient-centered communication skills, which have a positive effect on patient satisfaction, treatment adherence, and self-management, are essential to the delivery of this type of care. These skills can be effectively taught at all levels of medical education and to practicing physicians as well, yet most physicians receive only limited training in communication skills. In the future, policy makers and stakeholders may leverage training grants, payment incentives, certification requirements, and other mechanisms to develop and reward effective patient-centered communication, according to an article earlier this year in *Health Affairs*.

Moreover, physicians’ communication skills and strategies will become increasingly critical as healthcare reform takes shape. Patients will gravitate toward a primary care physician who can be reached easily, whether via open office hours, virtual office visits, or ease of emergency contact, notes Paul R. Ehrmann, DO, a family physician and medical director at Family Health Care Center, Royal Oak, Mich., and associate clinical professor at Michigan State College of Osteopathic Medicine. “I think as healthcare changes, having a good relationship between patient and physician will be even more important,” Dr. Ward says.

### **Enhanced Adherence**

Effective communication plays a “significant role” in a

patient's overall adherence to a treatment plan prescribed by the doctor, according to Wayne J. Reynolds, DO, family physician at Sentara Medical Group in Gloucester, Va. He discusses the importance of how information is conveyed to help newly diagnosed patients understand their conditions. Even the language used—and the level at which the condition is discussed—need to be coordinated with the patient's level of understanding and knowledge (see “Barriers to Patient-physician Communication”). “We’ve got to help patients understand what [diseases like] diabetes [are] so they comply. Doctors can help them understand the rationale behind treatment,” he says.

This is where the handouts Dr. Ward recommends can play a significant role. She says some physicians confuse the patient by presenting information in a scattered or offhand manner. Instead, she says, giving something as simple as patient-focused handouts discussing common medical conditions—along with personalized care plans—can facilitate good outcomes and healthier patients. “I give each patient a one-page sheet that has a list of the diagnoses we discussed that day, the refills they received,

### Barriers to Patient-physician Communication

- Speech ability or language articulation
- Foreign language spoken
- Dysphonia
- Time constraints on physician or patient
- Unavailability of physician or patient to meet face-to-face
- Altered mental state
- Medication effects
- Cerebrovascular event
- Psychological or emotional distress
- Gender differences
- Racial or cultural differences

*Source: Travaline JM, Ruchinskas R, D'Alonzo GE Jr. "Patient-physician communication: why and how." The Journal of the American Osteopathic Association. 2005;105:13-18.*



and a copy of our plan for that visit in language that the patient can understand,” she says. In addition, she focuses on one issue in each visit. Otherwise, a too-complicated assortment of hand-



**“I think doctor-patient communication is a hot topic today because patients want their doctors more involved than they were 20 to 30 years ago.”**

**Robert M. Arnold, MD**

Director

Institute for Doctor-Patient Communication at the  
University of Pittsburgh  
Pittsburgh, Pa.

outs will wind up in the patient’s circular file rather than reinforcing any point she tried to make during the visit.

Adherence increases when you engage the patient in a meaningful way. “Patients want you to actively listen and be empathic. It really amounts to ... educating them in regards to their condition and making a connection with them. If you don’t engage them in some way, they aren’t likely to listen to you,” says Richard F. Multack, DO, Olympia Fields, Ill., a faculty member of the Institute for Health Care Communication and a physician communication coach. “Active listening involves maintaining eye contact, respecting personal space, making empathic comments, using body language, and using reflective listening. Reflective listening involves repeating back concerns of the patient word for word, or as close to that as possible, showing the patient that you heard them, were listening, and that you care. For example, ‘Mrs. Smith, you said that you are afraid that you cannot give yourself the eye drops. I know that must be really scary for you. I think perhaps we can find someone to help you.’”

Attitudes associated with adherence not only impact the effectiveness of chronic care treatment regimens, but also lead to increased patient trust and satisfaction, says Robert M. Arnold, MD, director, Institute for Doctor-Patient Communication at the University of Pittsburgh, Pittsburgh, Pa. “I think doctor-patient communication is a hot topic today because patients want their doctors more involved than they were 20 to 30 years ago,”



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Physicians, medical students, residents and non-medical professionals are all welcome.

he says, perhaps because patients are better educated. “Patients today want their doctors to advocate for them, he notes.

### Improved Outcomes

A growing body of evidence connects successful physician-patient communication to positive results, such as reduced patient stress levels, better treatment adherence, increased physician satisfaction, and fewer medical malpractice lawsuits, according to Christopher Guadagnino, Ph.D., writing in *Physician's News Digest*. That communication includes the full spectrum of patient contact: making phone calls from the front office, reporting test results, conducting office visits that don't leave the patient behind, and soliciting patients' input on decisions about their medical treatments and choices.

Because of the potentially positive affect on outcomes, how information is conveyed is as important as the information itself, states John M. Travaline, MD, associate professor of medicine, Temple University Hospital, Philadelphia, Pa. “Patients who understand their doctors are more likely to acknowledge health problems, understand treatment options, modify their behavior accordingly, and follow their medication schedules,” he says. He adds that outcomes improve if physicians heed the following:

- Assess what the patient already knows about his condition
- Assess what the patient wants to know about it (not all

patients want the same level of detail)

- Are empathic
- Provide information slowly
- Keep communication simple
- Are truthful
- Are hopeful
- Pay attention to the patient's nonverbal language and cues
- Are prepared for a reaction

Better communication will help offset the increasing complexity of today's medical practice and its impact on the doctor-patient relationship. In addition, medical information is more complex today. Patients may bring in pages of information that they have found on the Internet about their medical conditions, which you



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**Richard H. Carmona, MD, MPH, FACS**  
Former Surgeon General of the U.S.  
President, Canyon Ranch Institute  
Tucson, Ariz.

must interpret or analyze for them. Because there often isn't time to go through everything, Dr. Carmona recommends suggesting that patients come to the office visit with prepared questions. “The doctor should be seen as a collaborator. He should listen carefully, analyze, and look beyond the chief complaint to detect the patient's medical problem by understanding the patient and his lifestyle,” he explains. “And [patients should] leave your office feeling that their questions have all been answered.”

That process enhances the therapeutic value in the doctor-patient relationship, he says. “So many issues are interrelated in health; for example, stress at home, stress at work, an injury,” he says. “Rather than focus on a specific problem, there is a therapeutic value in relating with the patient, and it's all part of the healing process.” To get there, he says doctors have to resist the “rapid-fire assembly line we've been forced into because of the

economics of today” in order to develop a meaningful, trusting relationship with each patient.

The connection between good communication and prevention is quite clear to Craig M. Wax, DO, a family physician in Mullica Hill, N.J. “I’m a believer that the most efficient and cost-effective healthcare is prevention,” he says. His waiting room has two large three-ring binders full of medical and preventive information for patients to read. He also hosts a regional radio show in which he discusses various medical topics that augment his time with patients in the exam room. For his “digital age” patients, he has a Website, webcast, and podcast. The webcast and podcast derive from his radio show and are online at [www.wgls.rowan.edu](http://www.wgls.rowan.edu). “I think communication is the best thing we can do on all levels for healthcare to succeed,” he says. “If we can help people do smart things to prevent illness, the cost of treating that illness is averted.”

### Effect on Healthcare Costs

A patient comes in with chest pain. Instead of just following the “chest pain protocol” and ordering serial EKGs, cardiac enzymes, and IV infusions, you may get a lot more information by asking specific questions such as how and when the pain occurs, how long the pain has lasted, what makes it better, and what happened when it first started. Depending on the answers, you may need only an EKG, then give the patient a reliable answer to his or her concern, Dr. Stubbs says. That process of communication, he says, not only limits the overall cost of diagnosis, but also makes the patient more comfortable with the process and improves his or her comfort level with the physician.

Engaging the patient in his or her own health is likely to lead to cost savings because that patient should ultimately do better

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and need fewer healthcare resources, according to Dr. Ward. “Preventing an illness or finding it early lowers cost.” Adherent patients, Dr. Multack notes, reduce costs by eliminating or reducing the number of office visits, ER visits, and extra money spent on prescriptions.

However, Dr. Arnold thinks that the full effect of communication on lowering healthcare costs has not yet been completely explored. “When doctors take time to talk about something sim-



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ple, communication can help avoid unnecessary costs,” like additional prescriptions or follow-up visits to ferret out the reasons why a patient has not adhered to treatment, he says.

Some physicians are following through on their good intentions. For example, Dr. Ehrmann doesn’t use an answering service to take his calls; instead, he gives patients his cellphone number. His personal cellphone is used for both personal and business calls and he says he doesn’t get bothered by nuisance calls. Dr. Ehrmann believes giving patients tools to communicate with their physician will help them take charge of their own healthcare and improve their relationship with him or her by fostering trust. “Fostering doctor-patient trust decreases healthcare costs since it nips problems in the bud and provides patients easier and quicker access to me, and I can then identify problems earlier that will usually not lead to the emergency room visit and hence higher healthcare costs,” he says.

## Focus on Patient Agenda

According to a study by communications experts Howard B. Beckman, MD, and Richard M. Frankel, Ph.D., published in the *Annals of Internal Medicine*, patients who were asked by a physician to describe their concerns were usually redirected after an average of 18 seconds, having verbalized only their first concern. In another study, published in *JAMA*, patients who had been redirected returned to their agenda and talked about their other healthcare concerns in only one of 52 visits, according to M. Kim Marvel, Ph.D., et al, who examined the extent to which family physicians extract patients' agendas, and concluded that physicians do often redirect patients' initial descriptions of their concerns, and once redirected, the descriptions are rarely completed. Only 28% of physicians solicit the patient's complete agenda, up only slightly from the 23% found in Beckman and Frankel's study. Missed opportunities to gather potentially important patient data and late-arising concerns are the results of incomplete initial descriptions. It takes little time to solicit patient agendas, and this practice can improve interview efficiency as well as yield more patient data, they noted.

Ms. Belzer says spending just 30 seconds more listening to each patient during the course of a visit can make a big difference. (See "Why Patients Hold Back.")

"A lot of times people put off going to a doctor because they don't think he talks to them or is open to them. So if they think their doctor will listen and make himself affable, they are more willing to go in sooner, which lowers their healthcare costs in the long run," says Daniel Levy, MD, a pediatrician in Owings Mills, Md., and past president of the Maryland chapter of the American Academy of Pediatrics (AAP).

"Despite the fact that communication is not reimbursed, probably 80% of diagnoses come from effective communication," Dr. Stubbs says. "Communication is the key to establish any doctor-patient relationship that's a healing relationship."

## Education, Recertification, and Communication

Another sign of the times is the increasing focus of medical education and assessment on communication skills. For example, the American Board of Internal Medicine (ABIM) requires

## Why Patients Hold Back

### Patients may not ask questions because they

- Fear the answer
- Want to avoid feeling stupid
- Consider their uncertainties trivial
- Feel rushed
- Were previously brushed off by the doctor

### Patients may not disclose problems because they

- Do not want to seem negative or ungrateful
- Want to be strong
- Think their concerns are not legitimate
- Do not want to add to the doctor's burdens
- Believe nothing can be done

*Source: Wenrich MD, Curtis JR, Shannon SE, et al. "Communication: What Do Patients Want and Need?" Journal of Oncology Practice. 2008; 4:249-253.*

internists and subspecialists to maintain their certification by completing a medical knowledge and practice performance self-assessment in addition to passing an exam. Among the practice performance options are three modules focusing on communication skills with peers and patients. Two of these communication modules are also available for use in training programs because they help address Accreditation Council of Graduate Medical Education (ACGME) general competencies, including Interpersonal and Communication Skills. (See fact sheets at <http://www.abim.org/about/fact-sheets.aspx>.)

And future physicians may have even more training in communication. The Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) both recently identified interpersonal and communication skills as core competencies. They were spurred by a report by the Institute of Medicine, which noted that half of all causes of mortality and morbidity in the U.S. are related to social and behavioral factors and said that the medical profession had not been successful in consolidating the knowledge of social and psychological variables into standard medical practice. And the National Board of Medical Examiners has since added a Communication and Interpersonal Skills subcomponent

to its medical licensing examination.

Some states have made specific efforts to stress professional communication skills. For example, all of Pennsylvania's medical schools have incorporated programs into their curriculum to help students cultivate empathetic encounters with patients. At the University of Pittsburgh's School of Medicine, the first communication skill-building course groups ten medical students with two simulated patients and two faculty mentors. The patients job is not to present a standardized patient's medical history, but rather to help the physicians focus on interpersonal cues and communicate effectively during presentation of difficult issues. The mentors and "patients" both coach students.

### Something You Don't Know

Given all the pressures of daily practice, it may be tempting to dismiss improving communication because it's "something you already know," Ms. Belzer says. But she notes that better skills will be valuable in today's increasingly complex health-care system: from increased adherence and patient satisfaction to fewer malpractice lawsuits.

And for those who feel there's nothing new to learn, she cautions that everyone can improve by learning updated strategies and honing existing skills on an ongoing basis. "It's a basic tenet of communication that what you say and how you say it have a direct bearing on the response you receive," Ms. Belzer says. "Keeping a focus on communicating in the manner that best reaches each individual patient will pay off in myriad benefits to the doctor and patient alike. A simple human connection with the patient as a whole human being can improve patient perceptions about everything associated with the visit—from quality of service to quality of care."



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