Improving physician communication skills can have direct benefits as they help patients better understand their condition and care plan. But the key is to continue sharpening those skills as the memory of attending the workshop where those skills were learned fades away.

“Transfer and sustainment of skills learned in classroom/workshop sessions into clinicians’ actual workplace behaviors has been consistently identified as a challenge in the medical education literature,” according to “Individualized coaching in health system-wide provider communication training,” a study published last year in the journal *Patient Education and Counseling*.

Repetition and feedback are keys to improving in just about any endeavor, according to cardiologist Theresa Brennan, MD, a co-author of the study and chief medical officer at University of Iowa Hospitals & Clinics, a member of the AMA Health System Program, which provides enterprise solutions to equip leadership, physicians and care teams with resources to help drive the future of medicine.
“As with anything you do that you want to be great at, mastery really requires focus and work,” Dr. Brennan said. “Whether you're a professional football player, or an artist or a physician, you need to focus on being better and practice—and you need to have feedback.”

Feedback, provided by communication coaches observing physicians during patient encounters 30 and 60 days after a workshop, has been integral to the success of the communication skills training program at University of Iowa Health Care.

After a successful pilot in 2017, the program was implemented systemwide. Aggregated patient satisfaction “top box” ratings grew from 73.9% to 75.1% following the pilot and to 79.5% following the post-workshop coaching, according to the study. (The top-box score reflects the percentage of survey respondents selecting the most favorable responses on a question.)

“Over the five-year period 2017 to 2022, when we were delivering the communications training, our ‘likelihood to recommend’ ranking from the Press Ganey patient-satisfaction scores rose 11% for outpatient care, 13% for adult inpatient care, and 31% for pediatric inpatient care compared to the national peer groups we benchmark against,” Dr. Brennan said.

The program teaches physicians, nurse practitioners and physician assistants how to improve their skills so that they reliably listen carefully, treat patients and families with empathy and compassion, and explain things in a way that patients and families understand.

It has also been shown to improve efficiency, as physicians learn how to avoid repeating what the patient already knows and keep the visit focused on an agreed-upon agenda.

Dr. Brennan recently spoke with the AMA and described how the UI Health communication program works and why it’s been successful in improving patient satisfaction and the efficiency of patient visits.

AMA: Why did you think it was important, as a health system, to focus on this area of improving communication skills?

Dr. Brennan: What I've learned over many years of practice is there are a lot of things that patients bring with them, emotional things, mental things, things that distract them from their appropriate medical care or are as important as them getting physically better.

Sometimes we don't address those in a way that the patient really needs us to. I think the concern of physicians—particularly today when we're moving faster and there's more focus on productivity—is that it's going to take more time. But this program teaches tools that physicians can use to save time in individual patient encounters and save time overall.
The tools we teach are developing relationships and building rapport, and then engaging the patient in bidirectional communication during the visit, helping them to set the agenda of what they want to talk about, using open-ended questions so the patient can tell their story, focusing on identifying times when empathy is necessary and using empathic statements to help the patient and to develop that trusting relationship.

And then lastly, to make sure that the care plan is clear and that the patient can feed it back to you.

We use feedback and a technique—chunking and checking—where we teach small pieces of information, have the patient tell us what they know, so it's really a conversation rather than a monologue from the physician.

AMA: Please explain the teach-back tool.

Dr. Brennan: Our attention spans—no matter who you are—are fairly short. Most doctors develop what we call a “spiel.” You have kind of a dedicated set of words that generally is pretty long that you will go into when you're consenting a patient or you're telling a patient about a diagnosis. It's really a monologue, just a diatribe of “this is all the stuff I need you to know.”

When we talk about chunking and checking, one example is a patient who might come in with a urinary tract infection. So, physicians tell the patient that their symptoms are consistent with a urinary infection.

We try to teach that at that point you ask: “What do you know about urinary tract infections?”

It does two things. One, it creates a level playing field where the physician and the patient know what each other knows. The other is that it improves efficiency because I can go through my long monologue and that patient might have had 10 urinary tract infections and they don't need me to tell them all that stuff.

Although we work hard to not have a power differential with the patient, patients are uncomfortable questioning their doctor. They feel the doctor knows what they're doing, and “I don't want them to feel like I don't trust them, that I don't think that they're good.” So this opens that door so patients can ask questions.

The teach-back is one of the things that our physicians find extraordinarily beneficial.

I'll tell patients what the care plan is in this chunking-and-checking way, we have a conversation and at the end, I ask what they heard and what their plan is going forward.

The challenge is, when you ask that question, there's a bit of uneasiness that the patient might feel like you're making a judgment that they're not smart enough to know what's going on.
So part of that is to try to make sure the patient knows that this is a tool, this is not a test. It's to make sure we're on the same page.

One might say: “Mrs. Smith, when you go home and talk to your husband, what are you going to tell him we decided was going on in your medical care and what the plan is going forward?”

**AMA:** What is the role of the coaches?

**Dr. Brennan:** At the end of the workshop, we ask people to commit to using one of those new tools in their practice. Then, when the coaches come in after 30 and 60 days, that tool is one of the things they focus on: Are they using it? How do I help them use it better?

What we find is twofold. One, people actually do a really good job—and they don't know it. So, the coaches use appreciative feedback techniques where they reinforce the good things that people do that they don't recognize how good it is or what the impact on the patients has been.

Secondly, what we've seen is that most of the opportunities the coaches see for physicians to do better are times when patients need an empathic statement.

Our coaches don't come to us with formal training in coaching. We identify people who have great people skills and are very dedicated to patient experience.

They get trained in the tools and techniques and learn how to evaluate their use. So they're going into the physician’s own space—whether it's an inpatient setting such as a hospital or the emergency room, or a clinic setting—and they just function as a fly on the wall. We introduce them to the patients. Some of the physicians actually say: “This is a person who's here to coach me.”

They don't necessarily stay for hours. They want to have a short period of time and get some good information. Then at the end, they give a written evaluation, with a lot of focus on what went well, reinforcing that good stuff. And then providing some opportunities where they could have done things differently, perhaps better.

Physicians have responded to it really well. It is probably the scariest part—to have somebody come in and watch and evaluate you.

**AMA:** Can you give an example of empathy statement?

**Dr. Brennan:** A patient may appear to be saddened, so just saying, “You look sad, Can you talk about that?” That's a form of empathy, recognition of an emotion and naming it.

Another form is “legitimization.” In my practice, a patient may have had a heart attack and come in depressed. And I will say, “It's normal that someone will feel down after having a heart attack because
it's a big event, and you're worried about what you're going to be able to do.”

Another form is “partnership.” I give the example of an older family member who developed cancer and was highly anxious. I was with her at the visit when her physician—at the end of the conversation—said, “You’re stuck with me for the next five years. We’re going to work on this together, and we’re going to partner” and I could just see her relax.

I call it “using my PEARLS,” for Partnership, Empathy, Apology, Respect, Legitimatization and Support.

There’s great data that shows, if doctors use empathy statements during their visits, their visits are shorter. We talk about how sitting down gives the patient the perception that, even though your visit may have been short, that you spent more time with them because they feel like the visit went better.