Implementing Effective Physician-Patient Communication Skills in IBS

Project ID: 12-0013 NL-1

Learning Objectives
Upon completion of this activity, the participant will be better prepared to:

• Explain the interaction between physician and patient attitudes and beliefs and their influence on successful treatment for functional gastrointestinal disorders (FGIDs), including irritable bowel syndrome (IBS)
• Discuss the impact of effective, bidirectional communication between the physician and patient, particularly with regard to the management of FGIDs
• Implement an incremental approach to improving the physician-patient relationship through improved communication strategies

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Introductions
The cost- and time-constrained health care environment has driven a wedge between the physician and the patient. On the health care provider side, physicians and other members of the health care team only have a few minutes in which to take a patient history and diagnose and treat the patient. On the patient side, advances in medical communication—primarily via the Internet—have led to a more informed (and often misinformed) patient population. The disconnect between the physician and the patient has only increased as advances in medical technology have made diagnostic and treatment algorithms ever more complex.

The ability to communicate effectively with the patient—even within the constraints imposed by the modern health care system—has distinct benefits. Not only does it increase the likelihood of appropriately diagnosing and treating the patient, but it also has the potential to improve safety, patient satisfaction (an increasingly important component of physician and hospital ratings), and adherence to treatment, and it may reduce the likelihood of malpractice. Recent analyses have highlighted the benefits of physician-patient communication as an important determinant of health care quality and patient safety. The impact of poor communication on outcomes has become increasingly recognized; in fact, organizations, including the Institute of Medicine, the Accreditation Council for Graduate Medical Education, and the American Board of Internal Medicine, have identified communication as a core competency required for good medical practice.

Nowhere is effective physician-patient communication more important than in cases of functional gastrointestinal disorders (FGIDs). This heterogeneous group of ailments, characterized by variable combinations of chronic or recurrent gastrointestinal symptoms, is united by the inability to make a diagnosis based on any specific test or biomarker. Thus, FGIDs are, at least at present, diagnosed based on clusters of symptoms that meet predefined (ie, Rome) criteria. For this reason, a careful history is needed to appropriately identify the symptoms required for diagnosis.

The difficulties in diagnosing and treating FGIDs is compounded by a large gap between the attitudes and beliefs...
Impact of Physician-Patient Communication on Outcomes

An abundance of studies have been conducted evaluating the impact of various physician-patient communication modalities. These studies have shown that—for the most part—these interventions improve health outcomes and patient satisfaction.

An initial meta-analysis, conducted by Stewart and published in 1995, examined randomized controlled trials and analytic studies of physician-patient communication in which patient health was an outcome variable. Of the 21 studies included in this meta-analysis, 16 reported positive results, 4 reported negative/nonsignificant results, and 1 was inconclusive. Studies were classed as examining elements of communication during history-taking or communication during discussion of the management plan.

In studies that evaluated history-taking communication, physician communication behaviors that significantly affected patient outcomes included “asking many questions” (which significantly improved patient anxiety and symptom resolution), “asking the patient about his or her feelings” (which improved psychologic distress), and “showing support and empathy” (which improved psychologic distress and symptom resolution). Patient behaviors that affected outcomes included fully expressing feelings, opinions, and emotions (which reduced role and physical limitation, improved health and functional status, and—in patients with hypertension—improved blood pressure), as well as the perception that a full discussion had taken place, which significantly improved symptom resolution.

As noted above, a number of these studies also evaluated the elements of an effective discussion of the management plan. Across all studies, several elements stood out as particularly important: encouraging the patient to ask questions, provision of information programs and packages, provision of clear information and emotional support, sharing the decision-making burden, and gaining agreement about the nature of the problem and the need for follow-up.

More recently, a systematic review of studies published over the past 4 decades demonstrates that good physician-patient communication makes a difference not only in patient satisfaction, but also in patient outcomes, including the resolution of chronic headache, changes in emotional states, lower glucose in patients with diabetes, reduced blood pressure in patients with diabetes, and other important health indicators. This analysis, which included 34 studies (18 involving physicians, 13 involving patients, and 3 involving both), found that physicians in intervention groups were more likely than controls to receive higher ratings of their overall communication style; the intervention group was also rated higher in terms of specific patient-centered communication.
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Effective Communication Interventions

Over the past 2 decades, a number of conceptual models of the medical interview have been advanced, and many individual interventions have been shown to improve the communication behaviors of physicians and patients. However, the majority of models have focused on either the physician or patient and have not examined how the physician's and patient's communication behaviors relate to each other during the interaction. The Four Habits Model, which was developed by Frankel and Stein, integrates many of these communication concepts and is firmly based on correlations between specific communications behaviors and outcomes. As the name suggests, it consists of 4 physician behaviors or “habits”: 1) invest in the beginning; 2) elicit the patient’s perspective; 3) demonstrate empathy; and 4) invest in the end.

In this section, we will take a closer look at each of these key behaviors and relate them back to a patient encounter with “Emily,” a prototypical IBS patient.

Overview

As shown in Table 2, the communication skills that make up each habit are organized into families, skills, techniques, and pay-offs. It is important to note that the each of the habits are interdependent; for example, creating rapport (part of the first habit, “invest in the beginning”) is critical for all of the downstream communications objectives. Thus, the Four Habits should not be viewed as individual skills to be developed independently; instead, the entire model must be embraced to ensure optimal outcomes.

Table 2: Patient Encounter Model (see p 6)

Habit 1: “Invest in the Beginning”

This habit integrates 3 critical communications skills: creating rapport quickly, skillfully eliciting the patient’s concerns, and planning the visit with the patient.

Creating rapport is critical for all of the downstream communications objectives. Rapport can be established initially by simply introducing yourself to everyone involved in the patient visit and acknowledging the wait (if any). A coequal relationship can also be enhanced by addressing the patient formally in initial encounters (e.g., “Ms Smith” rather than “Mary”), though exceptions are often made with adolescents or patients who were previously known to the physician. Making a social comment or asking a non-medical question can also help to put the patient at ease.

Physician preparedness is equally important for establishing trust. The physician should review patient records prior to entering the exam room and conveying knowledge of the patient’s history by commenting on a prior visit or problem. Preparedness has been

Table 1: Therapeutic principles for severe IBS and functional abdominal pain syndromes. Adapted from Longstreth and Drossman.

<table>
<thead>
<tr>
<th>Principle</th>
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<tr>
<td>Ensure patient returns for regular visits; encourage phone calls to resolve minor issues</td>
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<td>Listen to the patient, and express empathy; explain concepts and therapy options fully and reassure the patient</td>
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<tr>
<td>Identify and attempt to resolve psychosocial factors</td>
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<td>Legitimize symptoms</td>
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<td>Use tests and consultations judiciously</td>
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<tr>
<td>Deliver a diagnosis with confidence</td>
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<tr>
<td>Ensure patient returns for regular visits; encourage phone calls to resolve minor issues</td>
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<td>Emphasize the role of the patient and his or her responsibilities in the therapeutic process</td>
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<td>Identify the life effects of symptoms</td>
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<td>Believe in the reality of the condition and the potential for patient improvement</td>
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<td>Individualize drug therapy</td>
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<td>Consider behavioral therapy</td>
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<td>Foster coping with the condition (but the patient should not be encouraged to expect a cure)</td>
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These data suggest that improvement in physician-patient communication can have a significant positive impact on a number of important health outcome and satisfaction parameters. Overall, the findings of these studies can be distilled into 3 broad concepts:

1. Creating patient rapport and eliciting the patient’s concerns and perspectives
2. Provision of clear information during the discussion of the disease state and management plan
3. Gaining active agreement between the patient and physician about the nature of the problem and the course of action

Additionally, Longstreth and Drossman distilled 13 therapeutic principles for severe IBS and functional abdominal pain syndromes (Table 1). Together, these concepts—if implemented fully—may improve outcomes, but they also require a shift in the balance of power such that there is a more coequal exchange of information, ideas, and preferences between the physician and the patient. It has been suggested that the improvement in outcomes is “not simply the decision-making power of the patient that was effective, but, rather, the provision of a caring, respectful, and empowering context” in which the patient can make relevant health care decisions.

However, among the many interventions that have been studied, the question remains, which one to use in daily clinical practice?
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shown to be associated with patient satisfaction and perceptions of professionalism—in fact, patients who feel that physicians are unfamiliar with their cases or repeatedly refer to a chart rate encounters as less professional and less satisfying.1,8

Care should be taken to routinely elicit the full spectrum of the patients' reasons for coming. Often, the first complaint mentioned may not be the primary or most important complaint; this is particularly important to recognize in the case of FGIDs, in which some symptoms may be embarrassing and/or socially stigmatizing for the patient.

Two strategies are recommended for ensuring that all clinical concerns are addressed during the patient visit6:

- Drawing out the patient with open-ended questions (eg, “What concerns would you like me to address today?”)
- Using “continuers,” a set of linguistic devices that elicit continued conversation with the patient, such as “go on” or “tell me more”; encouraging the patient to elaborate ensures that all concerns will be addressed.

Visit planning is the third element of this habit.6 The patient’s concerns should be repeated back to the patient to ensure understanding, and the physician should describe what the patient should expect from the visit (eg, “Let’s start by talking more about this issue, and then I’ll do an exam, after which we’ll discuss how to treat this. Does that sound okay?” When necessary, the patient should be involved in prioritizing complaints to ensure that those that the patient feels are most important are addressed first.

Habit 2: “Elicit the Patient’s Perspective”
This habit serves to assess the patient’s perspective about the meaning of his or her symptoms and request for care and shows respect for the patient perspective.7 Furthermore, putting this habit into regular practice ensures that the physician-patient relationship is balanced. This habit consists of 3 critical elements: asking for the patient’s ideas, eliciting specific requests, and exploring the impact on the patient’s life.

The physician should initially assess patient attribution. This consists of asking for the patient’s ideas regarding the cause of their symptoms, (eg, “What do you think is causing your symptoms?”) and for their primary concerns regarding outcomes (eg, “What worries you most about this problem?”).1 Framing the discussion around patient concerns is critical for a successful visit outcome. For example, if a young patient with severe gastrointestinal symptoms consistent with IBS is concerned about colorectal cancer, the patient is more likely to leave satisfied with the visit if the discussion includes consideration of colorectal cancer.8

Approximately 18% of patients leave a physician visit with unmet expectations.9 For this reason, the physician should elicit specific requests to identify the patient’s goal in seeking care, asking, for example: “When you were thinking of this visit, how were you hoping I could help?10 Prospective identifying and addressing patient expectations can help close the gap between patient expectations and the delivery of actual care.

Understanding how the symptoms impact the patients’ life is particularly critical in patients with FGIDs, which are defined solely by the symptoms experienced by the patient. IBS, in particular, has a considerable impact on quality of life, psychological status, work, patient function, and quality of life; conversely, treatment has shown to improve these parameters significantly.10,15 All pharmacologic treatments are associated with risks; because these disorders are not life-threatening, a full understanding of the qualitative impact of symptoms relative to the risks must be used to guide the selection of medical treatments.

Many physicians report frustration when caring for patients with FGIDs,16,17 and this may color the interaction with patients. In one study, conducted by Dalton, Drossman, and colleagues, gastroenterology fellows were asked about reasons for patient-initiated after-hours telephone calls, actions taken, and perceptions about the nature of requests among patients with organic gastrointestinal diagnoses and FGID diagnoses.18 Overall, physicians believed that calls from patients with functional disorders were less serious and less reasonable, that these patients were less disabled by the symptoms, and that these patients were less liked by the physicians than patients having similar symptoms but with organic diagnoses. Another study found that physicians often have 2 definitions of IBS—one “public” definition that is consistent with textbook definitions, and a second “private” definition informed by experiences and absorbed prejudices about IBS patients that is often quite different from more official definitions.17

Habit 3: “Demonstrate Empathy”
Demonstrating empathy—understanding the patient’s distress and communicating that understanding from a more observant stance—is critical for building trust. Studies suggest that patients are more satisfied if their beliefs and concerns are elicited and validated.17,19 Validation should reflect the reality of the patient’s experience regardless of any etiology or pathophysiology. For this reason, it is critical to set aside biases based on diagnosis, as illustrated in the Dalton study.18 When used properly, this habit can lead to better diagnostic information, increase adherence, and ultimately improve outcomes.1

Physicians should be open to and aware of the patient’s emotions and assess changes in nonverbal behavior (eg, facial expression, body posture) and voice tone; in fact, physicians who are sensitive to nonverbal expression of emotion have been shown to have more satisfied patients.20 Making at least one empathetic...
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Statement (e.g., “that sounds really upsetting”) and complimenting the patient on efforts to address the problem can help build physician-patient trust. Above all, the physician should be aware of his or her own reactions. As noted above, physician perceptions of patients with FGIDs can be negative; overcoming these biases is critical to ensure that free communication between the physician and patient is not impeded. It is also important to know that empathy cannot be effectively communicated if the physician does not accept the patient’s thoughts and feelings as real.

Habit 4: “Invest in the End”

“Investing in the end” is the step in which diagnostic information is delivered, education is provided, and the decision-making process is finalized. Unlike the other 3 habits—which primarily involve information gathering—this habit focuses on information sharing.

Information retention is clearly limited following delivery of the diagnosis. Delivery of prognostic information (e.g., “first, I’d like to know that we can treat this condition successfully”) before discussing the diagnosis can proactively alleviate patient concerns and improve retention of information. Regardless of when the diagnosis is delivered, it should be framed in terms of the patient’s original concerns, and the patient’s comprehension should be tested.

Patient education is a critical component of this habit. If further tests are required—or treatments prescribed—the rationale for them should be explained fully to the patient. Both the benefits and side effects of potential treatments should be explained. If available, written materials or references to other reputable resources should be provided. If possible, the patient should be involved in exploring options for treatment, and active agreement between the physician and the patient should be obtained.

Outcomes

Implementation of the Four Habits model has been shown to improve patient satisfaction. Stein and colleagues reported on the impact of its implementation in the Kaiser Permanante organization. Physicians who received low patient satisfaction scores were enrolled in a 5-day residential course consisting of three 4-hour sessions in which groups of 4 participants practiced using the Four Habits Model. Implementation of the program resulted in substantial and statistically significant improvements in the 6 months following the course compared with the 6 months before the course; these gains were sustained or continued to improve for years after the course.

Table 3: The Four Habits Model (see p 7)

Conclusions

Health care quality is more important than ever in today’s health care environment. While numerous initiatives have focused on improving quality of care, perhaps the simplest, most cost-effective way to fundamentally improve both the efficacy and safety of treatment as well as patient perceptions throughout their journey through the health care system is to improve physician-patient communication. In fact, the ability to communicate effectively with the patient has distinct benefits in terms of improving diagnostic accuracy, selecting appropriate treatment, and improving patient satisfaction and adherence to treatment.

Here, we have discussed one comprehensive strategy for improving patient communications. While physician-patient communication is optimized by executing on the entire strategy, the reader is encouraged, at least initially, to select elements that can be put into practice easily in his or her encounters with patients with FGIDs. Even an incremental approach to improving patient communications has the potential to yield immediate benefits.

As importantly, it is critical to recognize that the health care provider’s own beliefs, prejudices, and habits can influence the physician-patient relationship, particularly in the case of FGIDs like IBS in which there is no known underlying pathophysiology or convenient diagnostic test.
Table 2: Patient Encounter Model

<table>
<thead>
<tr>
<th>Michelle Smith, a 36-year-old account manager at an advertising agency, was referred by her primary care provider to a gastroenterologist, Dr Fredrick Jones, for what she calls “irregularity.”</th>
</tr>
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</table>
| **Introduces self to patient, acknowledges wait, uses formal address** | **Doctor:** Good morning, Ms Smith. I apologize for the wait.  
**Ms Smith:** No problem. |
| **Makes a social comment to put patient at ease** | **Doctor:** Why don’t you have a seat?  
**Ms Smith:** Actually, it only took me about 10 minutes to get through the tunnel, I was pretty surprised. |
| **Assesses satisfaction** | **Doctor:** So, how was the drive in today? I heard there was a lot of traffic in the tunnel. |
| **Solicits questions** | **Doctor:** I reviewed your records earlier today, and I see that you’ve been irregular. Could you tell me more about that?  
**Ms Smith:** I’ve had difficulty with my bowels ever since my teens, but over the past year or so, I will go for days without a bowel movement and then have a day or two of urgent loose stools …  
**Doctor:** Go on …  
**Ms Smith:** I can sometimes go for a few days without problems, but eventually the problems always come back. When I’m having a bout of constipation, I only have one or two bowel movements a week and I really have to strain, and the whole thing is made worse by the fact that I have hemorrhoids. Then when I start to go, I can’t stop, and I have to go to the bathroom repeatedly until my stools become loose and watery.  
**Doctor:** Anything else?  
**Ms Smith:** I almost always have dull pain in my abdomen, and sometimes I get cramps here [gestures to lower left side of abdomen], and the bloating is really bad to the point that my clothes feel tight except just after I have a bowel movement. I also sometimes get sharp stabbing pains. |
| **Involves patient in decision making** | **Doctor:** That sounds uncomfortable. What do you think is causing the symptoms?  
**Ms Smith:** Well, it seems to be getting worse as I’ve been promoted in my company, and I’m getting more responsibilities and less time to eat or sleep regularly. I also think it’s been getting worse because my company is having major cutbacks, and I’ve had to let a number of people go … I feel bad for them and I’m afraid that my whole division is next.  
**Doctor:** So it sounds like you’ve been under a lot of stress.  
**Ms Smith:** Yes, it’s been tough recently. |
| **Explores impact on patient’s life** | **Doctor:** And what concerns you the most about your symptoms?  
**Ms Smith:** Well, it’s been making going to work really hard because I think the stress makes me worse. In fact, I’ve been calling in sick a few times a month when it’s really bad. I’m also worried because one of my friends was just diagnosed with colon cancer, and she’s only about 5 years older than me. I read online that irregularity is one of the symptoms.  
**Doctor:** Any relatives with colon cancer?  
**Ms Smith:** Yes.  
**Doctor:** Any relatives with colon cancer?  
**Ms Smith:** No problem.  
**Doctor:** Actually, it only took me about 10 minutes to get through the tunnel, I was pretty surprised. |
| **Elicits specific requests** | **Doctor:** Okay, we’ll make sure we talk about that. Finally, when you were thinking about this visit, how were you hoping I could help?  
**Ms Smith:** I just want to find a treatment that lets me leave the house without having to worry about finding a bathroom. It’s tough to do everything I’ve got to do every day when I don’t know if I’m going to have an episode of diarrhea.  
**Doctor:** Okay, so first, I’d like to talk about what medications you’ve tried, and then I’m going to examine you. After that, we’ll go over some possible ways to manage this initially, and when you come back for your next visit, we’ll have your test results, and we can discuss other potential treatments.  
**Doctor:** Okay, so first, I’d like to talk about what medications you’ve tried, and then I’m going to examine you. After that, we’ll go over some possible ways to manage this initially, and when you come back for your next visit, we’ll have your test results, and we can discuss other potential treatments. |
| **Delivers diagnostic information; framing in terms of patient’s original concerns** | **Doctor:** We have your results back. First, I know you have a family history of colon cancer, and you were concerned about that. Your colonoscopy results were normal. The other tests we did were also normal. This suggests, to me, that you have irritable bowel syndrome, which is also called IBS. This diagnosis is consistent with the tests and the symptoms you’ve reported. The good news is that we have additional options for treatment that you have not yet tried. We’ll discuss each of these options; we’ll discuss the pros and cons of each one, and then we’re going to make a decision together on what might be best for you. |
| **Assesses satisfaction** | **Doctor:** Did you get what you needed from this visit?  
**Ms Smith:** Yes, let’s give this treatment a try. |
| **Completes visit; reassures patient of ongoing care** | **Doctor:** Great. Now, I want to emphasize that we’re going to keep a close eye on your symptoms. We’ve already scheduled a follow-up visit, but if there are any issues in the meantime, I want you to give the office a call. |

On further discussion, Michelle tells the doctor that she has tried PEG 3350 without adequate relief. She has also tried bisacodyl several times, which results in severe cramping and watery diarrhea. She eats a high-fiber diet and takes fiber supplements regularly.

Diagnostic evaluations were normal (abdominal-pelvic CT scan, right-upper-quadrant ultrasound, thyroid function) and celiac test was negative. Colonoscopy results were normal. Ms Smith returns for a follow-up visit.

Accredited by: Purdue University

This material is supported by an educational grant from Salix Pharmaceuticals, Inc.
## Table 3: The Four Habits Model

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<th>Habit</th>
<th>Skills</th>
<th>Techniques and Examples</th>
<th>Pay-off</th>
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<tr>
<td><strong>Invest in the beginning</strong></td>
<td>Create rapport quickly</td>
<td>• Introduce self to everyone in the room&lt;br&gt;• Acknowledge wait&lt;br&gt;• Convey knowledge of patient’s history by commenting on prior visit or problem&lt;br&gt;• Attend to patient’s comfort&lt;br&gt;• Make a social comment or ask a nonmedical question to put patient at ease&lt;br&gt;• Adapt own language, pace, and posture in response to patient</td>
<td>• Establishes a welcoming atmosphere&lt;br&gt;• Allows faster access to real reason for visit&lt;br&gt;• Increases diagnostic accuracy&lt;br&gt;• Requires less work&lt;br&gt;• Minimizes “Oh, by the way ...” at the end of the visit&lt;br&gt;• Facilitates negotiating an agenda</td>
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<tr>
<td>Elicit the patient’s concerns</td>
<td>Start with open-ended questions: “What would you like help with today?” or, “I understand you’re here for ... Could you tell me more about that?” or, “What else?”&lt;br&gt;• Speak directly with the patient when using an interpreter</td>
<td>• Determine patient’s goal in seeking care: “When you’ve been thinking about this visit, how were you hoping I could help?”&lt;br&gt;• Prioritize when necessary: “Let’s make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can’t get to the other concerns, let’s ...”</td>
<td>• Respects diversity&lt;br&gt;• Allows patient to provide important diagnostic clues&lt;br&gt;• Uncovers hidden concerns&lt;br&gt;• Reveals use of alternative treatments or requests for tests&lt;br&gt;• Improves diagnosis, depression, and anxiety</td>
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<tr>
<td>Plan the visit with the patient</td>
<td>Repeat concerns back to check understanding&lt;br&gt;• Let patient know what to expect: “How about if we start with talking about ... then, I’ll do an exam, and then we’ll go over possible tests/ways to treat this? Sound OK?”&lt;br&gt;• Prioritize when necessary: “Let’s make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can’t get to the other concerns, let’s ...”</td>
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<td><strong>Elicit the patient’s perspective</strong></td>
<td>Ask for patient’s ideas</td>
<td>• Assess patient’s point of view: “What do you think is causing your symptoms?” and, “What worries you most about this problem?”&lt;br&gt;• Ask about ideas from significant others</td>
<td>• Adds depth and meaning to the visit&lt;br&gt;• Builds trust, leading to better diagnostic information, adherence, and outcomes&lt;br&gt;• Makes limit-setting or saying “no” easier</td>
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<tr>
<td>Explore the impact on the patient’s life</td>
<td>Elicit specific requests</td>
<td>• Determine patient’s goal in seeking care: “When you’ve been thinking about this visit, how were you hoping I could help?”&lt;br&gt;• Prioritize when necessary: “Let’s make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can’t get to the other concerns, let’s ...”</td>
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<tr>
<td><strong>Demonstrate empathy</strong></td>
<td>Be open to patient’s emotions</td>
<td>• Assess changes in body language and voice tone&lt;br&gt;• Look for opportunities to use brief empathic comments or gestures&lt;br&gt;• Name a likely emotion: “That sounds really upsetting.”&lt;br&gt;• Compliment patients on efforts to address problem&lt;br&gt;• Use own emotional response as a clue to what patient might be feeling&lt;br&gt;• Take a brief break if necessary</td>
<td>• Adds depth and meaning to the visit&lt;br&gt;• Builds trust, leading to better diagnostic information, adherence, and outcomes&lt;br&gt;• Makes limit-setting or saying “no” easier</td>
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<td>Make at least one empathic statement</td>
<td>Be aware of your own reactions</td>
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<tr>
<td><strong>Invest in the end</strong></td>
<td>Deliver diagnostic information</td>
<td>• Frame diagnosis in terms of patient’s original concerns&lt;br&gt;• Test patient’s comprehension&lt;br&gt;• Explain rationale for tests and treatments&lt;br&gt;• Review possible side effects and expected course of recovery&lt;br&gt;• Recommend lifestyle changes&lt;br&gt;• Provide written materials and refer to other sources&lt;br&gt;• Discuss treatment goals&lt;br&gt;• Explore options, listening for the patient’s preferences&lt;br&gt;• Set limits respectfully: “I can understand how getting that test makes sense to you. From my point of view, since the results won’t help us diagnose or treat your symptoms, I suggest we consider this instead.”&lt;br&gt;• Assess patient’s ability and motivation to carry out plan</td>
<td>• Increases potential for collaboration&lt;br&gt;• Influences health outcomes&lt;br&gt;• Improves adherence&lt;br&gt;• Reduces return calls and visits&lt;br&gt;• Encourages self-care</td>
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<td>Provide education</td>
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<td>Involve patient in decision making</td>
<td>Complete the visit</td>
<td>• Ask for additional questions: “What questions do you have?”&lt;br&gt;• Assess satisfaction; “Did you get what you needed?”&lt;br&gt;• Reassure patient of ongoing care</td>
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References


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If you wish to receive acknowledgement of participation for this activity, please complete this posttest, evaluation form, and request for credit (pages 9-13) and fax to 973-867-3684.

Please select the one best answer by circling the appropriate letter.

1. Data suggest that only 1 in ___ patients with symptoms consistent with an FGID agree with a functional diagnosis.
   a. 2
   b. 5
   c. 8
   d. 13

2. What percentage of patients leave physician visits with unmet expectations?
   a. 10
   b. 18
   c. 27
   d. 35

3. Which of the following is included in the Four Habits Model for successful patient communication?
   a. Demonstrate empathy
   b. Order tests/consultations that the patient insists are required
   c. Ensure patient biases are addressed
   d. Identify and proactively address comorbidities

4. Ideally, when should prognostic information be first discussed?
   a. At the first visit, before a diagnosis has been confirmed
   b. Just before discussing the diagnosis
   c. After the diagnosis, but before discussing treatment options
   d. Only after a treatment option has been trialed

5. Enrollment in a residential course focusing on the Four Habits Model has been shown to improve patient satisfaction for:
   a. 1 to 3 months
   b. 3 to 6 months
   c. 6 months to 1 year
   d. Greater than 1 year

6. “Investing in the beginning” involves all of the following skills except:
   a. Creating rapport quickly
   b. Ensuring preparation before the patient visit
   c. Use of continuers to elicit the full spectrum of the patients’ complaints
   d. Ensuring the patient is educated about their condition
7. Specialists underestimate the number and severity of symptoms in approximately ___% of patients with FGIDs.
   a. 30%
   b. 40%
   c. 50%
   d. 60%

8. Which of the following physician communication behaviors has been demonstrated to significantly affect patient outcomes?
   a. Asking a patient about his or her feelings
   b. Prescribing the treatment the patient requests proactively
   c. Ordering diagnostic tests that the patient requests
   d. Describing in technical detail the diagnostic tests utilized to arrive at a diagnosis

9. Symptom resolution has been shown in studies to be improved by:
   a. Asking the patient about the impact of symptoms on work
   b. Asking the patient about his or her feelings
   c. Showing support and empathy
   d. Prescribing the treatment the patient requests proactively

10. Which of the following is not a technique that has been shown to have a significant positive impact on health outcome and satisfaction parameters?
    a. Creating patient rapport and eliciting the patient’s concerns and perspectives
    b. Provision of clear information during the discussion of the disease state and management plan
    c. Selecting treatments from among the options that the patient suggests based on their own research
    d. Gaining active agreement between the patient and physician about the nature of the problem and the course of action
Dietary Interventions in IBS: An Update

Purdue University College of Pharmacy respects and appreciates your opinions. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few minutes to complete this evaluation form.

• Explain the interaction between physician and patient attitudes and beliefs and their influence on successful treatment for functional gastrointestinal disorders (FGIDs), including irritable bowel syndrome (IBS)

<table>
<thead>
<tr>
<th>This learning objective did (or will) increase/improve my:</th>
<th>High Impact</th>
<th>Moderate Impact</th>
<th>No Impact</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
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<td>Competence</td>
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<td>Performance</td>
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<td>Patient Outcomes</td>
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</tbody>
</table>

• Discuss the impact of effective, bidirectional communication between the physician and patient, particularly with regard to the management of FGIDs

| Knowledge                                                |             |                |           |                |
| Competence                                               |             |                |           |                |
| Performance                                              |             |                |           |                |
| Patient Outcomes                                         |             |                |           |                |

• Implement an incremental approach to improving the physician-patient relationship through improved communication strategies

| Knowledge                                                |             |                |           |                |
| Competence                                               |             |                |           |                |
| Performance                                              |             |                |           |                |
| Patient Outcomes                                         |             |                |           |                |

Impact of the Activity

• Please indicate which of the following American Board of Medical Specialties/Institute of Medicine core competencies were addressed by this educational activity (select all that apply):
  - Patient care or patient-centered care
  - Practice-based learning and improvement
  - Interpersonal and communication skills
  - Employ evidence-based practice
  - Interdisciplinary teams
  - Professionalism
  - Quality improvement
  - Medical knowledge
  - System-based practice
  - Utilize informatics
  - None of the above

• The content of this activity matched my current (or potential) scope of practice.
  - No
  - Yes, please explain

• Was this activity scientifically sound and free of commercial bias* or influence?
  - Yes
  - No, please explain

* Commercial bias is defined as a personal judgment in favor of a specific product or service of a commercial interest.
Dietary Interventions in IBS: An Update

- The educational activity has enhanced my professional effectiveness in treating patients
- The educational activity will result in a change in my practice behavior
- How will you change your practice as a result of participating in this activity (select all that apply)?
  - Create/revise protocols, policies, and/or procedures
  - Change the management and/or treatment of my patients
  - This activity validated my current practice
  - I will not make any changes to my practice
  - Other, please specify: ______________________________

- What new information did you learn during this activity?

- Please indicate any barriers you perceive in implementing these changes.
  - Lack of experience
  - Lack of resources (equipment)
  - Lack of time to assess/counsel patients
  - Lack of consensus of professional guidelines
  - Lack of opportunity (patients)
  - Lack of administrative support
  - Reimbursement/insurance issues
  - Patient compliance issues
  - No barriers
  - Cost
  - Other ______________________________

- If you indicated any barriers, how will you address these barriers in order to implement changes in your knowledge, competency, performance, and/or patients’ outcomes?

- Comments to help improve this activity?

- Recommendations for future CME/CPE topics.

To assist with future planning, please attest to time spent on activity:

I spent _____ hours on this program.
REQUEST FOR CREDIT

If you wish to receive acknowledgement of participation for this activity, please complete this request for credit and fax to 973-867-3684.

Please do not use abbreviations.

We need current and complete information to assure delivery of participation acknowledgement.

Degree (please mark appropriate box and circle appropriate degree):

☐ MD/DO  ☐ PharmD/RPh  ☐ NP  ☐ PA  ☐ RN  ☐ Other

Full Name (please print clearly)

Last Name: ____________________________  First Name: ____________________________  Middle Initial: ____________________________

Street Address: ____________________________

City: ____________________________ State or Province: ____________________________ Postal Code: ____________________________

Phone: ____________________________ Ext: ____________________________ Fax: ____________________________

Specialty: ____________________________

E-mail Address: ____________________________

Signature is required to receive statement of credit.

Signature: ____________________________ Date: ____________________________

Attestation to time spent on activity is required.

Purdue University College of Pharmacy designates this enduring material for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

☐ I participated in the entire activity and claim 1.0 AMA PRA Category 1 Credit(s)™.

☐ I participated in only part of the activity and claim ______ credits.