Is Communication a Skill? Communication Behaviors and Being in Relation

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Patient-physician communication has been conceptualized as both a skill and as a way of mindful "being in relation" to the other. Summarizing research and theoretical analyses, the two approaches are differentiated. The skill-focused approach to communicative competence relies heavily on observed behaviors; the mindful being-in-relation approach emphasizes the perceived effects of the relationship on the participants. The distinctions between these two approaches are important to teaching and research. Teaching can, and should, focus on both changing behaviors and on the personal development of mindfulness in the learner. Research methods should routinely include both observer and participant responses. Reconciling these two views supports the thesis that good communication is both a skill and a way of being, that it is both innate and teachable, and that it must be cultivated by integrated methods of teaching and research.

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Is communication a skill or a "way of being" in relation to others? In this article, we describe and attempt to unite two trends in the current conceptualization of medical interviewing. The first emphasizes the observable: the acquisition of skills and the application of qualitative and quantitative coding schemes to the observed behaviors of physician and patient. The second emphasizes the intangible experiences: the physician's reflection, self-awareness, transformation, and application of qualitative and quantitative assessments of the received effect of the physician's presence from the patient's perspective. Although it might seem obvious that the two trends must be related, approaches to teaching and research often emphasize one and ignore the other.

The logical extension of questioning the division of interviewing into these two domains is to ask whether skillful communication can be taught or whether it is innate, a part of a person's personality, or life experience prior to medical training. The answer we would offer, based on research, is that communication is both a skill and a way of being and that it is both innate and teachable. In this article, we explore the fundamental dilemma concerning training medical students and residents in skillful communication and offer some recommendations concerning educational and research efforts.

It is clear that patients' relationships with physicians have powerful influences on health, functioning, and satisfaction. Similarly, physicians who have satisfactory relationships with patients are more likely to enjoy practice and stay in practice.[1] Communication processes, both verbal and nonverbal, condition the quality of those relationships. Because of this, medical schools and residency programs have developed courses on communication skills for trainees, and some health care organizations have similar initiatives for practicing physicians. While many programs are undoubtedly successful in producing measurable changes in physician behaviors, critics have expressed concern that skills-focused training is not always directed toward fostering a genuine, strong, compassionate, caring relationship between physician and patient.

There may be a difference between the process of skillful communication with a patient versus having communication skills. In her book, *Medicine and the Family,*[2] Candib argues that research and teaching about the medical interview have been inappropriately focused on communication skills. Candib's view is that an isolated, even skillful, interaction between patient and physician is quite different from a relationship. An

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interaction is characterized by an observable exchange of behaviors, whereas a relationship is characterized by more-subjective qualities, such as caring, concern, respect, and compassion. Candib defines the role of the physician as one of "caring in relation." Candib charges that a response to paternalism by physicians (and as a result of consumerism by patients) has been the advocacy of a contractual model of interaction. This view describes informative, but emotionally detached, "health care providers" who may see their roles as fostering the individual decisions of an autonomous patient. This tends to define mutuality as a meeting of equals and minimizes the profound power dimensions of the relationship between ill patients and physicians. Candib argues that the act of caring for a patient changes the physician as well and that neither patients nor physicians truly desire relationships that are cool and sterile.

If these charges have merit, then our teaching in medical education about communication in the patient-physician relationship may be too narrow and shallow. When feelings, thoughts, and experienced history are reduced to "skills," and the complex, multilayered interaction between people reduced to "behaviors," greater emphasis is placed on the seen (verbal behaviors, gestures) than on the unseen (subtle nonverbal cues, vocal nuances, timing, what is not said). By extension, our research may not be examining some critical components of what really matters both to patients and to their ultimate health, including factors in the medical educational environment that support and foster learners' development in relationship skills.

Recently, both undergraduate and graduate medical education programs have been moving toward competency-based assessment of learners' skills. Motivated by the Accreditation Council for Graduate Medical Education, residency programs will be asked to determine the skill levels of residents in a number of areas, including communication, beginning in 2002. This emphasis on manifested behaviors, not curriculum, requires that teachers are clear about the expected outcomes of communication processes, which may (or may not) be measured solely by observational methods. In this paper, we elucidate some of the possible deficits of the behavioral emphasis commonly used in training and assessment and offer some alternative views of communicative competency that may affect the thinking and practice of medical educators. We examine some of the ways in which a synthesis of the behavioral and experiential perspectives can enrich research in the doctor-patient relationship, communication competency, and the acquisition of skills. We also discuss the key role of intersubjectivity as a marker of a successful medical encounter.

Intersubjectivity in the Medical Encounter

Patients and physicians often have disparate experiences during the same patient-physician encounter. In research about patient and physician perceptions of the same encounter, patients and physicians often differ in their recall of what topics were discussed, how long the visit lasted, and what the follow-up is planned to be.[3,4] Since disagreements about both the content and process of the encounter are common, it is likely that there are frequent discrepancies between patients' and physicians' sense of being "connected," in tune with each other, congruent emotionally, and moving toward the same goals. Yet, these intangibles may be the most critical to examine when we look at successful or unsuccessful interactions.

Intersubjectivity includes the creation of shared meaning. It is the process by which we understand others and are understood by them. The degree of intersubjectivity in communication can be marked by the degree to which both parties share the same goals, thoughts, and intentions concerning their work together. Patient-physician congruence about the subject discussed is likely to be higher when patient and physician have spent time clearly identifying their goals to each other. A patient-centered approach, in which the patient's ideas, expectations, and feelings are addressed explicitly, probably makes intersubjectivity or congruence more likely.

Measures of Communication and the Outcomes of Care

In a study of the relationships among patient-centered behaviors and patient outcomes, Stewart[5] reported that when patients perceived that they had reached common ground with their physicians, patient outcomes improved (including satisfaction, decreased concern or worry about illness, and fewer requests for referrals to other physicians). However, there was no relationship between coded (observed) patient-centered behaviors and patient health outcomes. This finding supports assertions by Street and others that the patient's experience may provide a more useful and relevant measure of the quality of the patient-physician relationship than observer-based coding schemes;[6,7] it is also congruent with Cassell's assertion that the goal of medicine is to address suffering as perceived by the patient.[8] The distinction noted by Candib between physicians acting interested in patients and truly being interested in the patient's perspective is of relevance here. Stewart[5] noted that because their coding of audiotaped interactions:

> . . . failed to capture the important essence of the dynamic interaction between doctors and patients . . . differences in interviewing skills may not be associated with patient responses. Physicians may learn to go

> through the motions of patient-centered interviewing, without understanding what it means to be a truly attentive and responsive listener and without the patient noticing . . .

In fact, the experience of interviewing patients with attention to patient perspective likely elicits different responses from patients, which in turn modifies the physicians' behaviors toward their patients. Mutual malleability occurs when each person is open to the influence of the others.

So, what do patients notice about physicians when they communicate? Are their impressions conscious and explicit, or are they intangible and tacit? Do patients notice the same aspects that physicians (or researchers) consider most important? How is it that patients make judgments about the affective qualities of interactions and the quality of relationships with physicians? Perhaps untrained observers and patients base their most accurate judgments on the very dimensions of interaction that are most intangible.

What the patient notices is a key point. Most observational research has tended to rely on the observable, tangible data of language and some dimensions of affective display (eg, laughter, anger) as key data points for analysis. On the other hand, surveys of patients and physicians tend to focus on the received effect of a relationship on the patient, which is only loosely correlated with the observational data about communication. Neither method may fully describe the patient's moment-by-moment experience of the relationship with his/her physician.

One clue to resolving the problem of the observed versus perceived impressions of a medical encounter comes from the work of Ambady et al.[9] Using "thin-slice analysis" techniques on 250 encounters, the researchers were able to distinguish physicians who had been sued from those who had not. Thin-slice analysis uses brief segments (thin slices) of audiotapes of patient-physician interviews that were presented to untrained observers who assessed the affective content of voice-filtered audiotapes. The voice-filtering process allowed the listener to discern the tone and rhythm of speech, but the words were rendered unintelligible. Observers characterized interactions with surgeons who had been sued as more "hostile" than with surgeons who had not been sued (described more as "anxiously concerned") based only on the paralinguistic components of the interaction. In another study that used the same audiotapes, more-commonly used qualitative and quantitative analysis techniques focusing on the verbal content could not distinguish between the two groups of physicians.[10] The thin-slice method, also used in many other types of interactions, demonstrates that nonverbal communication and nebulous impressions—the things that patients might lump together as bedside manner—may be undervalued (and underexamined) in both communication research and training.

However, most research methods, both qualitative and quantitative, have focused largely on verbal content; conversation analysis or other qualitative methods typically employ transcripts to examine interaction. Coding systems rely on statement or utterance types (for example, that of Stiles and Putnam[11]) and may include vocal or nonverbal overtones as a secondary element of the coding system; they often attempt to predict outcomes of care based on distributional analyses (who did how many of what kind of behavior). Sequential, developmental aspects of interaction are often relegated to a less important place in analysis, and when they are used explicitly, often only include turn taking, the number of exchanges, or changes of topic. Neither type of analysis seems to tap into the domain identified in Ambady's work. Thus, incorporation of the thin-slice technique holds exciting prospects not only for predicting outcomes but also perhaps for rendering some of the intangibles in medical encounters more explicit.

What works may differ for people who are in the room, in the encounter, or who are examining the interaction from the vantage point of the health care system. In a chapter on the outcomes of care, Beckman et al[12] identify possible outcomes at the level of the communication process, the individuals in the interaction, the health status of the patient, and the health care system. While most of our concern about outcomes has focused on the level of the interactions and the patient's health outcomes, it is important to look at communication processes as effective mediators of health system and societal outcomes as well.

Communication and Relationship As Moral Issues

Frey[13] and McWhinney[14] assert that family medicine is primarily about the relationship with the patient and only secondarily about the delivery of medical care, consultation, or services. In that regard, it becomes important to ask whether we teach caring (if that is possible) or just the words of caring. Caring is a charitable act and occurs regardless of liking a patient. While no one would argue that every patient can, or should, bring joy to the heart of a clinician, it is also true that many obstacles to true caring about a patient are within the physician. The physician who feigns caring is likely to be perceived as less helpful than one who truly cares.

When the physician's own perceptions or barriers get in the way of the ability to truly care for the patient's well-being, then the relationship is compromised. Yet physicians often have few resources, abilities, or opportunities to cultivate self-awareness about the difficulties they have in caring for patients.[15-17] Brody would argue that inability to acknowledge power differences between patient and physician can, in fact, obscure the question of true caring. While the physician can (and frequently may) behave like a skilled technician, competently performing adequate medical care, Brody argues that there is a moral responsibility inherent in the relationship between patient and physician to find ways

of surmounting barriers to the truly authentic caring for the patient.[18] Candib says:

> Clinicians show caring through devotion . . . How we conduct ourselves, live our lives, and work with patients offers a model of how to be a caring whole person in the world . . . Our capacity for bringing ourselves into our work emerges in our self disclosures; we are revealed as genuine.[19]

From this perspective, the difficulty inherent in teaching behavioral science and communication as sets of skills becomes apparent.

More concerning is the potential to undermine connection, presence, attentiveness, and caring by mistaking communication techniques for communication. One can ask, "How do you feel about that?" in a way that explores further the patient's experience of illness; or conversely, if timed incorrectly or said with the wrong inflection, the same question can effectively close off further discussion. However, training that emphasizes the physician's true experiences (and expression) of feeling over performance of skills may offer a more challenging view of the patient-physician relationship to learners: is it important to share a patient's experience, to be touched by it, changed? Or is it sufficient to offer superficial (even if convincing) support to patients? The tension between training learners to perform for the patient versus experience with the patient is nowhere greater than in the area of communication training.

The moral dimension of the tension in communication training is epitomized by discussions about the expression of empathy. In his essay, "The Depth of a Smile,"[20] Francesc Borrell i Carrio considers the common situations when a physician might have ambivalent or antipathetic feelings toward a patient. No one would encourage the physician to be brutally honest, express each momentary negative feeling, and growl at the patient. Rather, Borrell i Carrio suggests that the somewhat forced "smile of accommodation" cannot be considered a spontaneous emotion but rather a sentiment that we bring ourselves to exhibit. He notes:

> The more effort that it requires of us, the more value it brings to the relationship . . . When we smile at someone who does not inspire us to some natural sympathetic reaction, we give him the opportunity to show himself to us as he is, not in the way that we might model a relationship in which we, and only we, show off our power. Because of that, forcing ourselves to smile is not hypocrisy but rather a transcendent act of will . . .

In that situation, how can the smiling physician keep from performing a meaningless and superficial playacting, a mockery of deep emotion? Finestone and Conter, in that regard, make an important distinction between playacting and the methods used by stage actors.[21] Actors are generally trained in one of two approaches, either from the "outside in," which involves great attention to the display of specific gestures, facial expressions, and patterns of inflection to convey a believable sentiment or from method acting, which requires the actor to display emotion from "inside out." Actors call up in their imagination a situation likely to provoke the emotion that they wish to convey. Actors may, for example, imagine a great loss in their own lives to convincingly display tears or sadness. Finestone and Conter call this the "stimulation" rather than the "simulation" of emotion. For physicians, then, the preferred method (inside out or outside in) is not clear. The stimulation of emotion may be a core task of empathy, especially when the patient's experience and demeanor are very different from that of the physician. The simulation of emotion may more likely be perceived as insincere but may also have its place when other approaches fail. To avoid the pitfalls, the practitioner must have the self-awareness to know the difference between the spontaneous emotion and the invoked one and Machiavelli's "appearance of sincerity."[22]

Although Communication Behaviors Can Be Taught, Do They Change the Patient-Physician Relationship?

Skills-based communication training for physicians does make a difference; it can improve the quality of the interactions they have with patients.[23] These interventions, diverse as they may be, have some common principles: active listening, helping patients tell their stories, decreasing the biomedical focus of the interview, and increasing patient participation in decision making. Research has demonstrated that some of the "gaps" between physician and patient may be wider due to physician interruption,[24,25] physician inattention to cues and clues,[26] and differences between patient and physician attributions about causality.[25] These differences can be addressed with simple interventions, such as teaching physicians to hold specific follow-up questions until patients have listed all of their concerns. Just as playing scales and finger exercises are essential to becoming a pianist, these behavioral changes are fundamental to train students to communicate with their patients.

No musician, however, would suggest that finger exercises are music. Speech has prosody just as music has rhythmic nuance. But, unlike musical training, inflections, gestures, and eye contact are rarely included in communication skills training, although these aspects may reflect more deeply who the physician is as a person than his or her choice of words. We simply don't know whether these behaviors can be changed, but it

will be important to find out. Also, which changes affect the patient's global perception of the quality of the patient-physician relationship?

Balint,[15] Balint,[27] and Dimsdale[28] have identified factors within the physician that impede accurate diagnosis, effective treatment, and satisfactory patient-physician relationships. Fatigue, dogmatism, unexamined negative emotions, and an overemphasis on behavior (rather than on self-awareness) may close the mind to ideas and feelings and diminish the possibility of forming a relationship.[17] If medical education does not offer physicians ways to surmount these barriers, and explicit training to both communicate and to self-reflect, the capacity to achieve intersubjectivity and true understanding with patients may be limited.

Being in relation is characterized by mindfulness. Mindful practice embodies more than emotional self-awareness, which has been effectively promoted in Balint groups.[17] It also includes the application in the moment with the patient of awareness of one's own mental processes, whether it relates to medical decision making, technical procedures, or data gathering from patients. Mindful physicians can be easily identified by patients and colleagues—they are present, attentive, curious, and unhindered by preconceptions. We believe that these attributes can be cultivated—they are, for example, cultivated routinely in students of music performance and are also characteristic of good clinical teachers—but we may need a new method of training physicians that focuses explicitly on fostering these attributes.

At What Level and to Whom Should Interventions Be Directed?

Both the cumulative effect of a patient-physician relationship and observed communication behaviors affect the outcomes of care.[5] It would make sense that interventions to improve relationships should be directed toward physicians, patients, and the health care system. Successful patient interventions to improve patients' biomedical outcomes were demonstrated by Kaplan and Greenfield[29] in the 1980s, who offered a 20-minute training to empower patients to read their own medical charts and ask specific questions of their physicians. For example, patients with diabetes involved in this demonstration experienced lower glycosylated hemoglobin levels.

Intensive training of physicians has resulted in possibly more modest results; studies demonstrate improved patient satisfaction, adherence to treatment, and attunement to patients' psychosocial distress.[30] In addition, it is unclear how the environment around patients and physicians affects the quality of interaction. System-level interventions to improve communication are just now being studied.

Few studies have used both physician-level and patient-level interventions concurrently to achieve better results than from either alone. While we believe that patients want to have some say in how they want to approach their own medical care, it is also true that the "activated patient" model may work better for some types of patients than others. We do not know enough about the common mechanisms of such interventions. For example, it is unlikely that increasing a patient's cognitive understanding of his or her illness is a sufficient explanation for the success of patient-level interventions in communication. Communication skills training might help physicians wittingly or unwittingly develop higher emotional tone in the interaction and change their nonverbal behavior, such as tone and rhythm of speech, eye contact, and posture. We believe that these changes might be made visible to an observant participant in the medical dialogue but only one who has the equanimity to accommodate to personal biases while engaging in self-observation—no small task. But, is it necessary that minute changes be made explicit and focused on by learners? Perhaps not, just as when learning to ride a bicycle, one does not need to know explicitly the principles of gravity and inertia, but tacit knowledge of their effects is crucial. Learners who can perceive the general rhythm, pace, and balance needed to remain upright may not require specific training in the micro adjustments required to do so.

Conclusions: Who Can Judge the Quality of Communication?

Although it may seem obvious that only the patient can be the ultimate arbiter of the physician's success at communication, it is difficult to reconcile that view with the observation that different patients view the same physician differently. Patient-centered communication measures, for example, were able to predict outcomes for individual encounters, or patient-physician dyads in Stewart's study,[5] but there was significant variability among patients of the same physician. So, the ideal, patient-centered care, may be more determined by the idiosyncratic qualities of the relationship than by either the characteristics of the individual physician or patient. Based on this view, training physicians to be flexible communicators may be the highest-order skill needed for competent communication with patients and their families. Most communication skills training approaches emphasize the performance of specific behaviors rather than the assessment and adaptation to individual patients; it is necessary to emphasize the learner's strengths and self-awareness, being in relation, if flexibility is paramount in communication.

Communication researchers have made tremendous progress over the past 30 years in understanding how to study patient-physician communication. But, there are several domains that should make us redirect our efforts to better understand how to approach some of the aspects of communication that have not been well understood. Communication can and should be viewed

as a means to, and a marker of, being in relation. Research, then, should take a dual perspective, concurrently using the standpoints of both participants and observers in the assessment of the quality of medical encounters. By juxtaposing the perspectives of the observer and participant, observed behaviors can be correlated with their received effects experienced by the patient. Also, the dual perspective can help us redefine what may be important to observe. The degree to which communication contributes to relationship can and should be studied. Flexibility can be assessed, and perhaps training will then avoid rigid adherence to one set of communication standards but will emphasize adaptability as the highest demonstration of competence. In general, despite the predictive power of patient ratings of physicians' communication, patients have been relatively underused as informants and participants in communication research. Tacit dimensions of knowledge, such as vocal inflections, can be made explicit for the purposes of study and teaching. The purpose of communication—the creation of healing relationships—can and should guide future efforts in teaching and research.

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References

1. Mechanic D. Health and illness behavior and patient-practitioner relationships. Soc Sci Med 1992;34(12):1345-50.
2. Candib L. Medicine and the family. New York: Basic Books, 1995.
3. Frieden RB, Goldman L, Cecil RR. Patient-physician concordance in problem identification in the primary care setting. Ann Intern Med 1980; 93(3):490-3.
4. Starfield B, Wray C, Hess K, Gross R, Birk PS, D'Lugoff BC. The influence of patient-practitioner agreement on outcome of care. Am J Public Health 1981;71(2):127-31.
5. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on patient outcomes. J Fam Pract 2000;49(9):796-804.
6. Street RL. Analyzing communication in medical consultations: do behavioral measures correspond to patients' perceptions? Med Care 1992; 30(11):976-88.
7. Folger J, Poole MS. Relational coding schemes: the question of validity. Communication Yearbook 5. Beverly Hills, Calif: Sage Publications, 1982.
8. Cassell E. The nature of suffering and the goals of medicine. N Engl J Med 1982;306:639-45.
9. Ambady N, LaPlante D, Nguyen T, Chaumeton N, Rosenthal R, Levinson W. Thin-slice judgments of physicians' affect vocal cues associated with malpractice claims among primary care physicians and surgeons. In press.
10. Levinson W, Gorawara-Bhat R, Lamb J, et al. A study of patient clues and physician responses in primary care settings. JAMA 2000;284: 1021-7.
11. Stiles W, Putnam S. Analysis of verbal and nonverbal behavior in doctor-patient encounters. In:Stewart M, Roter D, eds. Communicating with medical patients. Newbury Park, Calif: Sage Publications, 1989.
12. Beckman H, Kaplan S, Frankel R. Outcome-based research on doctor-patient communication. In: Stewart M, Roter D, eds. Communicating with medical patients. Newbury Park, Calif: Sage Publications, 1989.
13. Frey J. The clinical philosophy of family medicine. Am J Med 1998; 104:327-9.
14. McWhinney IR. William Pickles Lecture 1996. The importance of being different. Br J Gen Pract 1996;46:433-6.
15. Balint M. The doctor, his patient, and the illness. New York: International Universities Press, 1964.
16. Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the physician: personal awareness and effective patient care. JAMA 1997;278(6):502-9.
17. Epstein RM. Mindful practice. JAMA 1999;282(9):833-9.
18. Brody H. The healer's power. New Haven, Conn: Yale University Press, 1992.
19. Candib L. Medicine and the family. New york: Basic Books,, 1995:229.
20. Borrell i Carrio F. The depth of a smile. Medical Encounter 2000;15: 13-4.
21. Finestone HM, Conter DB. Acting in medical practice. Lancet 1994;344:801-2.
22. Machiavelli N. The prince. New York: Bantam Books, 1981.
23. Smith RC, Lyles JS, Mettler J, et al. The effectiveness of intensive training for residents in interviewing. A randomized, controlled study. Ann Intern Med 1998; 128(2):118-26.
24. Beckman H, Frankel R. The effect of physician behavior on the collection of data. Ann Intern Med 1984;101(5):692-6.
25. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA 1999;281(3):283-7.
26. Lang F, Floyd MR, Beine KL. Clues to patients' explanations and concerns about their illnesses. Arch Fam Med 2000;9:222-7.
27. Balint E. Before I was I. London: The Guilford Press, 1993.
28. Dimsdale JE. Delays and slips in medical diagnosis. Perspect Biol Med 1984;27:213-20.
29. Kaplan S, Greenfield S, Ware J. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Med Care 1989; 27(3):S110-S127.
30. Roter DL, Hall JA, Kern DE, Barker LR, Cole KA, Roca RP. Improving physicians' interviewing skills and reducing patients' emotional distress—a randomized clinical trial. Arch Intern Med 1995;155:1877-84.