A Decade of Experience with a Multiday Residential Communication Skills Intensive: Has the Outcome Been Worth the Investment?

By Terry Stein, MD

Abstract

Objective: To present three outcome measures from a multiday residential Communication Skills Intensive provided to 525 clinicians in a large health care organization over ten years. The Intensive includes 10-12 hours of videotaped role-play with actors, extensive feedback, and self-reflection.

Methods: The background, content, and format of the Intensive are described. Results of three outcome measures are presented: program evaluations, a one-time physician satisfaction survey, and longitudinal patient satisfaction scores.

Results: A sampling of evaluations from three programs (n = 73) showed mean scores of 4.83 (on a Likert scale of 1-5) in response to the item “I will incorporate the skills acquired at this program into my clinical practice” and 4.90 in response to the item “Overall, this training was valuable.” On a follow-up physician satisfaction survey, nearly all (99%) of the 70 respondents indicated that the course had helped to improve their communication skills with patients. Most (89%) also said that applying the techniques they learned had increased their own professional satisfaction. Patient satisfaction scores for cohorts of course participants showed consistent increases in the six months following the course compared to the six months prior. This improvement has been sustained for as long as seven years.

Conclusion: Physicians have highly valued their participation in the Communication Skills Intensive. The impact of attending the course has been noticed by their patients. Offering physicians the opportunity for in-depth learning to enhance their interpersonal skills is a worthwhile investment for a health care organization.

Introduction

Three typical scenarios:

“I must be missing something. I thought my patients liked me.”

Dr M is a 32-year-old internist who completed his residency two years ago. He prides himself on his thoroughness even though he usually runs an hour behind and stays late most nights to finish his charting. Being so dedicated to his patients, Dr M is shocked when his patient satisfaction scores are among the lowest in his department. His chief suggests that he attend the Communication Skills Intensive, a multiday residential program focusing on effective communicating with patients. Though he questions the validity of his scores, he also feels angry—at his patients, at the organization, and at himself. He decides to enroll in the Intensive, cautiously hopeful that he will better understand his patients’ perceptions and find out how he can improve.

“I’m not very good at the touchy-feely stuff.”

Dr B is a 51-year-old orthopedic surgeon who is regarded by his colleagues and his patients as having excellent technical skills. For most of his 18-year career, he has been rewarded for his successful surgical outcomes and high productivity. More recently, he has been told by his chief that he needs to improve his patient satisfaction scores and that too many of his patients file complaints saying that he is rushed, businesslike, and doesn’t listen. He wants to achieve scores that would more accurately reflect his competence and he doesn’t want to incur any financial penalty. Though he believes that he is “too old to change,” he signs up for the Intensive.
A Decade of Experience with a Multiday Residential Communication Skills Intensive: Has the Outcome Been Worth the Investment?

The Permanente Medical Group (TPMG) approved the author's proposal to pilot a five-day residential program designed by the Bayer Institute for Healthcare Communication. The initial goal of the program was to improve the communication skills of physicians who fit any of four suggested criteria: low scores on the MPS survey, frequent patient complaints, medical-legal cases involving poor communication, and difficulty communicating with colleagues or staff. These criteria were meant to guide but not limit enrollment.

Interventions to enhance clinician-patient communication must be effective in an environment of greater time constraints, new technology, and shifting consumer expectations. The outcomes resulting from the Communication Skills Intensive showcase the power of physicians to change, demonstrate that patients notice the changes, and provide a snapshot view of how communicating differently can enhance morale.

Methods

Background

Since 1990, when the first regionwide educational program on clinician-patient communication was instituted, The Permanente Medical Group (TPMG) has shown strong commitment to enhancing the communication skills of its physicians. TPMG currently consists of more than 6000 physicians who serve over three million members of the Kaiser Foundation Health Plan in Northern California.

In 1994, the organization first distributed its MPS survey to Health Plan members after office visits. The MPS survey was developed and validated by survey experts within the organization. It includes a total of 25 questions, most of which address the patient's care experience: calling for an appointment, interacting with staff, seeing the health care professional, visiting lab and radiology, and filling a prescription. Physicians receive reports of their scores on the five questions that pertain to the patients' interactions with them. The questions ask patients to rate the quality of the physician's skills and abilities; their confidence in the care the physician provided; how well the physician listened and explained, involved them in decisions about their care, and showed familiarity with their medical history. Once distribution of individual scores became routine, questions arose as to how to assist physicians who scored below the mean calculated for their department. It was thought that existing one-day or lunchtime educational programs were not adequate to enable physicians to change the way they interacted with patients.

In 1995, the Board of Directors of TPMG approved the author's proposal to pilot a five-day residential program designed by the Bayer Institute for Healthcare Communication. The initial goal of the program was to improve the communication skills of physicians who

The three physicians described above represent many of the clinicians who have attended the Communication Skills Intensive in Northern California over the past ten years. Physicians in the first years of their career, like Dr M, can feel devastated when they receive low patient satisfaction scores. Seasoned physicians who get patient complaints like Dr B may feel defensive and skeptical. Other physicians seek to better handle difficult interactions or aim for general improvement in their interactions regardless of their patient satisfaction scores, like Dr S.

The Intensive is a 4- to 5-day residential clinician-patient communication program that includes videotaped role-play practice with actors. By working on customized scenarios with feedback from actors, faculty, and peers, participants in the Intensive gain insights about their interpersonal skills and learn strategies to communicate more effectively.

This article highlights the experience of 525 clinicians who attended the Communication Skills Intensive between 1996 and 2005. I describe the background, format, and content of the course and present three outcome measures: a brief summary of program evaluations, results of an online survey about the effect of the program on participants' communication behaviors and professional satisfaction, and patient satisfaction results from the regional Member Patient Satisfaction survey (MPS) tracked up to seven years following a program.

The story of the Intensive addresses several important questions: Can physicians change their communication habits by attending communication skills training? If physicians change how they interact, are patients more satisfied? Is improvement in patient satisfaction temporary or sustained over time? How does participation in an intensive communication skills course affect physician satisfaction? Is training physicians to communicate more effectively worth the investment?

Dr S is a 36-year-old pediatrician who enjoys her job running the adolescent medicine clinic and consistently gets high patient satisfaction scores. Since her chief attended the Communication Skills Intensive a couple years ago she has been encouraging each member of the department to enroll so that as a group they can communicate even better with patients, families, and each other. She has heard that it is an excellent program so she eagerly gets on the waiting list for the next course.

“I think I’m good at communicating with my patients, but I’m sure I have some blind spots.”

Dr S is a 36-year-old pediatrician who enjoys her job running the adolescent medicine clinic and consistently gets high patient satisfaction scores. Since her chief attended the Communication Skills Intensive a couple years ago he has been encouraging each member of the department to enroll so that as a group they can communicate even better with patients, families, and each other. She has heard that it is an excellent program so she eagerly gets on the waiting list for the next course.

The story of the Intensive addresses several important questions: Can physicians change their communication habits by attending communication skills training? If physicians change how they interact, are patients more satisfied? Is improvement in patient satisfaction temporary or sustained over time? How does participation in an intensive communication skills course affect physician satisfaction? Is training physicians to communicate more effectively worth the investment?
Table 1. Description of four-day intensive educational program for improving communication skills of physicians

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Agenda</th>
<th>Format</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant preparatory work</td>
<td>Speak with small-group faculty by phone; read two or three articles (provided); audiotape two patient visits; complete self-assessment checklist when reviewing taped visits; complete questionnaire about communication beliefs and style</td>
<td>Phone calls made one to two weeks before start of course: answer questions, address concerns, discuss taping, review personal nature of the course, ensure confidentiality; materials sent three to four weeks before start of course</td>
<td>Clarify expectations; identify participants who lack motivation or who might pose specific challenges; prompt thinking and self-reflection before start of program; record actual patient interactions</td>
</tr>
<tr>
<td>Day 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning</td>
<td>Introductions and overview; Four Habits Model presentation; assess trigger videotapes</td>
<td>Large-group session: didactic, demonstrations, table work</td>
<td>Increase comfort and familiarity; present Four Habits Model as framework for practice sessions</td>
</tr>
<tr>
<td>Afternoon</td>
<td>Introductions, background; discuss preparatory-work questionnaires; review segments of audiotapes</td>
<td>Small-group sessions</td>
<td>Begin observing and coaching others; create safe environment for small-group work; identify individual strengths and areas for improvement</td>
</tr>
<tr>
<td>Evening</td>
<td>Read one or two articles; prepare list of goals</td>
<td>Individual</td>
<td>Clarify specific behavioral goals</td>
</tr>
<tr>
<td>Day 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning</td>
<td>First video practice session in which actors portray typical (nonchallenging) patients</td>
<td>Small-group sessions in which actors rotate to different groups every 50 minutes</td>
<td>Practice current and new strategies to address goals; get feedback from actors, faculty, group; appreciate own strengths, clarify areas to improve</td>
</tr>
<tr>
<td>Afternoon</td>
<td>Challenging interactions—dynamics and strategies; dramatize role of personal history and culture in shaping communication behavior; complete worksheet on personal history</td>
<td>Didactic, demonstrations, table work; short play presented by actors; debrief using questions from worksheet</td>
<td>Deepen understanding of own contribution to difficult interactions; present model for handling conflict</td>
</tr>
<tr>
<td>Evening</td>
<td>Discuss personal history worksheet, meaning in work, self-care</td>
<td>Individual; small-group sessions</td>
<td>Connect life experiences to current communication habits and challenges; share own stories with others; enhance self-awareness</td>
</tr>
<tr>
<td>Day 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning</td>
<td>Second video practice session in which actors depict participants’ challenges (eg, angry or demanding patients)</td>
<td>Small group sessions with actors rotating every 50 minutes</td>
<td>Practice current and new strategies for handling own “hot button” interactions; increase confidence in dealing with strong emotions</td>
</tr>
<tr>
<td>Afternoon</td>
<td>Health literacy presentation</td>
<td>Large-group session: didactic, interactive</td>
<td>Emphasize prevalence of low health literacy and importance of using understandable language</td>
</tr>
<tr>
<td>Evening</td>
<td>Individual meetings with small-group faculty</td>
<td>20-minute one-to-one check-in</td>
<td>Share individual perceptions; summarize progress</td>
</tr>
<tr>
<td></td>
<td>Group dinner and entertainment</td>
<td>Improvisational activities with actors</td>
<td>Celebrate, have fun together</td>
</tr>
<tr>
<td>Day 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning</td>
<td>Third video practice session in which actors portray scenarios requested by faculty or participants; summarize feedback Program evaluation, closing comments</td>
<td>Small-group sessions in which actors rotate to different groups every 35 minutes; list strengths and suggestions Large-group session: individual work</td>
<td>Consolidate new skills; document feedback from self, faculty, peers; discuss additional clinician-patient communication resources List two or three skills to emphasize when returning to patient care (copy kept to distribute at start of follow-up day)</td>
</tr>
</tbody>
</table>
Over time, as early participants spoke enthusiastically about the program with their colleagues, physicians enrolled who were motivated to improve though they did not fit the criteria. The majority of the physicians who have attended the program, however, enrolled because of lower-than-desired patient satisfaction scores. Nearly all of the 22 courses have been full and wait-listed.

Program Description
The Communication Skills Intensive was piloted in March 1996. Because the pilot program was well received, the Intensive was established as an ongoing program conducted two or three times per year, starting in September 1996. Initially, the five-day residential course was followed by the opportunity for individual coaching monthly for one year, but logistical constraints prevented continuation of this coaching as intended.

The faculty consists of carefully selected and trained physicians and psychologists. Faculty members receive training from the course directors on models for teaching clinician-patient communication as well as training for leading small groups, setting up practice sessions with the actors, coaching, and addressing resistance. For the first several years, the ratio of course faculty to participants was 2:4; more recently, it has become 1:4.

In Fall 2001, the residential part of the course was shortened to four days. The fifth day became a follow-up session conducted two to three months after completion of the residential program. The content and format of the four-day program are described in Table 1.

The design of the course attempts to reach both the minds and hearts of participants. Cognitive components of the program include a brief overview of the evidence about clinician-patient communication and its outcomes, description and demonstrations of a communication model—the course began to use the Four Habits Model (Figure 1)—and exploration of the dynamics of conflict and “hot buttons.” Strong emotions are often evoked during small-group discussions about personal history, culture, and meaning in one’s work. These exchanges illuminate the connection between life experience and communication styles. Detailed feedback from faculty, peers, and the actors during the small-group role-play sessions enables course participants to begin assimilating new communication behaviors.

Specific topics and methods of instruction in the large-group sessions have varied over time, although the structure and intent of the program have remained consistent. The overarching focus is on relationship-centered communication strategies that prove effective in the real world of a busy clinical practice.

The core constants of the program are:

- 10-12 hours of videotaped role-play with actors
- use of a communication framework or model as the foundation
- strong focus on handling difficult interactions
- structured self-reflection
- exploration of the link between personal history and current communication patterns
- high faculty to participant ratio
- a supportive, safe, and confidential environment
- interactive teaching methods
- reinforcement of learning after the course ends.

Outcome Measures
1. Program evaluation: At the conclusion of each program participants completed an evaluation with both quantitative and qualitative questions. The quantitative questions asked about the likelihood of incorporating the skills into their clinical practice and for their rating of the value of the overall program.
2. Physician satisfaction: In October 2005, an online survey was e-mailed to the 118 clinicians who attended a Communication Skills Intensive in 2004 or 2005 to assess the effects of the course on their communication behaviors and on their professional satisfaction. Physician satisfaction following the program had not been measured previously.
3. Patient satisfaction: Participants’ scores on the MPS survey have been tracked since 1998 (when a revised version of the original survey was implemented). To maintain confidentiality, cohorts were formed by aggregating the scores of
### THE FOUR HABITS MODEL

<table>
<thead>
<tr>
<th>HABIT</th>
<th>SKILLS</th>
</tr>
</thead>
</table>
| Invest in the Beginning | Create rapport quickly:  
- Introduce self to everyone in the room  
- Refer to patient by last name and Mr. or Ms. until a relationship has been established  
- Acknowledge wait  
- Make a social comment or ask a non-medical question to put patient at ease  
- Convey knowledge of patient’s history by commenting on prior visit or problem  
- Consider patient’s cultural background and use appropriate eye contact and body language  |
| Elicit the patient’s concerns | Start with open-ended questions:  
- “What would you like help with today?”  
- “I understand that you’re here for. . . . Could you tell me more about that?”  
- Speak directly with patient when using an interpreter  |
| Plan the visit with the patient | Repeat concerns back to check understanding  
- Let patient know what to expect: “How about if we start with talking more about. . . . then I’ll do an exam, and then we’ll go over possible tests/ways to treat this. Sound OK?”  
- 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…” |
| Elicit the Patient’s Perspective | Ask for the patient’s ideas:  
- Assess patient’s point of view: “What do you think might be causing your problem?”  
- “What worries or concerns you most about this problem?”  
- “What have you done to treat your illness so far?”  
- Ask about ideas from loved ones or from community  
- Determine patient’s goal in seeking care: “How were you hoping I could help?”  
- Check context: “How has the illness affected your daily activities/work/family?” |
| Demonstrate Empathy | Be open to the patient’s emotions:  
- Respond in a culturally appropriate manner to changes in body language and voice tone  
- Look for opportunities to use brief empathic comments: “You seem really worried.”  
- Compliment patient on efforts to address problem  
- Use a pause, touch, or facial expression |
| Invest in the End | Deliver diagnostic information:  
- Frame diagnosis in terms of patient’s original concerns  
- Explain rationale for tests and treatments  
- Review possible side effects and expected course of recovery  
- Discuss options that are consistent with patient’s lifestyle, cultural values and beliefs  
- Provide resources (e.g. written materials) in patient’s preferred language when possible  
- Discuss treatment goals; express respect towards alternative healing practices  
- Assess patient’s ability and motivation to carry out plan  
- Explore barriers: “What do you think we could do to help overcome any problems you might have with the treatment plan?”  
- Test comprehension by asking patient to repeat instructions  
- 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.”  
- Summarize visit and review next steps  
- Ask for additional questions: “What questions do you have?”  
- Assess satisfaction: “Did you get what you needed?”  
- Close visit in a positive way: “It’s been nice meeting you. Thanks for coming in.” |

<table>
<thead>
<tr>
<th>TECHNIQUES AND EXAMPLES</th>
<th>PAYOFF</th>
</tr>
</thead>
</table>
|                        | Establishes a welcoming atmosphere  
- Allows faster access to real reason for visit  
- Increases diagnostic accuracy  
- Requires less work  
- Minimizes “Oh by the way…” at the end of visit  
- Facilitates negotiating an agenda  
- Decreases potential for conflict |
|                        | Respects diversity  
- Uncovers hidden concerns and diagnostic clues  
- Reveals use of alternative treatments or requests for tests  
- Improves diagnosis of depression and anxiety |
|                        | Adds depth and meaning  
- Builds trust, leading to better diagnostic information and outcomes  
- Makes limit-setting or saying “no” easier |
|                        | Increases potential for collaboration  
- Influences health outcomes  
- Improves adherence  
- Reduces return calls and visits  
- Encourages self care |

Revised April, 2003 in partnership with the Kaiser Permanente Institute for Culturally Competent Care  
http://kpmnet.kp.org/cpc/

Figure 1. The Four Habits Model.
all of the clinician participants who attended the course each calendar year. These cohorts ranged in size from 37 to 60 clinicians each and totaled 322 clinicians for all cohorts combined.

Results
Participants
From 1996 through 2005, 525 TPMG clinicians attended the program (Table 2). These participants represented a broad spectrum of specialties, with 301 (57%) coming from primary care or medical subspecialties. Sixty (11%) were surgical subspecialists; 43 (8%) were hospitalists or emergency medicine specialists.

An equal number of participants had worked in TPMG for two years or less (140) as had worked for more than ten years (141) at the time they took the course. The largest percentage of participants ranged from 31 years to 40 years of age. Thirty percent, however, were over 50 years of age, and 15% had worked in the organization for over 16 years.

Program Evaluations
Data collected from evaluation forms completed at the conclusion of each program have consistently shown positive results. For example, using a five-point Likert scale (on which 1 = strongly disagree, and 5 = strongly agree), aggregate scores for three separate administrations of the course (n = 73) included a mean score of 4.83 in response to the survey item: “I will incorporate the skills acquired at this program into my clinical practice” and a mean score of 4.90 in response to the survey item “Overall, this training was valuable.”

Physician Satisfaction Survey
Of the 118 TPMG physicians who received the follow-up survey after attending the course in 2004 or 2005, 70 (60%) completed and returned the survey. Nearly all (99%) indicated that the course had helped to improve their communication skills with patients; 39% said the course had improved their skills “a lot.” When asked to describe what they were doing differently to communicate better with patients, respondents most commonly reported that they were using empathy, listening without interrupting, eliciting the patient’s perspective, and structuring the visit. Specific comments included the following: “I understand how to listen actively to my patients. I express empathy to my patients a lot more frequently, and it really makes them satisfied with my care. I now have the tools to think through and analyze when some visits or interactions don’t go well” and “I now am having a structure to the visit, emphasizing closure, [and] letting parents and patients do the talking without interruption.”

Most (88%) of the 70 respondents said that the course has had a positive impact on how patients respond to them during outpatient visits. Physicians noted that their patients more frequently expressed satisfaction with the visit, shared more information, and were less likely to escalate during potentially difficult interactions. One physician reported that patients seemed “much more engaged in the process, more welcomed into the process, happier with the outcome, and I am hearing from the primary care physicians that patients are conveying to them their greater satisfaction with my services.” Another physician noted that patients seemed “more appreciative and happier with the visits.”

<table>
<thead>
<tr>
<th>Table 2. Demographic characteristics of 525 clinicians participating in the Communication Skills Intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Not recorded</td>
</tr>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>25-30</td>
</tr>
<tr>
<td>31-40</td>
</tr>
<tr>
<td>41-50</td>
</tr>
<tr>
<td>51-60</td>
</tr>
<tr>
<td>Not recorded</td>
</tr>
<tr>
<td>Tenure with TPMG (years)</td>
</tr>
<tr>
<td>0-2</td>
</tr>
<tr>
<td>3-5</td>
</tr>
<tr>
<td>6-10</td>
</tr>
<tr>
<td>11-15</td>
</tr>
<tr>
<td>&gt;15</td>
</tr>
<tr>
<td>Not recorded</td>
</tr>
<tr>
<td>Specialty</td>
</tr>
<tr>
<td>Primary care (internal medicine, pediatrics, Ob/Gyn)</td>
</tr>
<tr>
<td>Medical subspecialties (cardiology, nephrology, neurology, oncology, pulmonology, rheumatology)</td>
</tr>
<tr>
<td>Surgical subspecialties and anesthesiology (general surgery, urology, cardiovascular anesthesia, cardiovascular surgery, head and neck, neurosurgery, plastic surgery)</td>
</tr>
<tr>
<td>Emergency medicine or hospital-based</td>
</tr>
<tr>
<td>Dermatology</td>
</tr>
<tr>
<td>Occupational medicine</td>
</tr>
<tr>
<td>Ophthalmology or optometry</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Other (allergy, electrophysiology, home care, administration, nuclear medicine, rehabilitation, pain management, radiation oncology)</td>
</tr>
<tr>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Most (89%) also said that applying the techniques they learned has increased their own professional satisfaction. Many mentioned having greater confidence, feeling more appreciated, and having a stronger sense of connection with their patients. One physician reported, “I have much less stress with clearer boundaries. I generally leave work on time and leave work behind. I feel like I have more time in my day with more efficient visits/other means of communication. Members tell me that they feel heard and cared for. It’s becoming a better partnership.” Another physician wrote, “I just feel better about coming to work; it’s not a battle any more.”

**Patient Satisfaction Surveys**

The MPS survey includes five questions about the interaction with the physician or health care professional (HCP). Scores on the survey are reported as the percentage of patients who indicated responses of “very good” or “excellent” on the following items: Your MD/HCP’s skills and abilities, confidence in care MD/HCP provided to you, MD/HCP listened and explained, MD/HCP involved you in decisions about your care, MD/HCP familiar with your medical history. For each clinician, the combined scores for all five questions were averaged to generate the clinician’s overall mean score.

For each cohort of physicians who attended the Communication Skills Intensive in 1998 through 2004, Figure 2 compares the mean combined scores for all five questions as determined six months before the course began and six months after the course ended. Five of the seven cohorts achieved a statistically significant increase (p < .05), and scores for all cohorts showed improvement over time.

For the same span of years, Figure 3 compares the percentage change in the mean combined scores for all five questions for two sets of TPMG physicians: the cohorts in the present study (physicians who attended the Communication Intensive) and the population of all TPMG physicians for whom MPS scores were collected. The cohort scores for the course participants reflect improvement achieved in the six months after the course, compared with the six months before the course. Scores for the general population of TPMG physicians represent totals collected at the end of one year compared with scores collected at the end of the following year. (For example, the cohort of physicians attending the Communication Skills Intensive in 2001 improved their mean scores by 4.6% in the six months after the course, whereas the mean scores for TPMG physicians in the general TPMG population rose 1.1% from the end of 2001 to the end of 2002.) This comparison accounts for the regionwide changes occurring over each period of time and thereby approximates a control group of
physicians who did not receive the intervention. Service enhancements introduced throughout TPMG (such as increased access to appointments with members’ personal physicians and with specialists) contributed to a greater rate of improvement in survey scores between 2002 and 2004. Even during this period of regionwide increases in scores, our data show a pattern of substantially larger improvement for course participants.

For each cohort of participants in the Communication Skills Intensive, Figure 4 presents the longitudinal mean combined scores for all five questions over time (through 2005). The greatest increases in scores occurred during the year after the course ended and between 2002 and 2004, probably reflecting the improvement observed regionwide during the same period.

Discussion

Our results show that physicians can change their communication habits by attending an intensive communication skills training that includes videotaped role-play practice with actors and extensive self-reflection. The changes lead to improvement in patient satisfaction, most pronounced in the 6-12 months after completion of the course and sustained for as long as seven years. Most physicians who attended the course found value in the experience and indicated that they would incorporate the skills they learned into their practice. A sampling of recent course participants reported positive changes in their post-course communication behavior with patients and enhanced professional satisfaction.

Several studies have documented measurable changes in physicians’ communication behavior following communication skills training. After viewing videotapes of patient visits, Fallowfield et al. reported that expressions of empathy, use of open-ended questions, appropriate responses to patient cues, and psychosocial probing were more frequent among physicians who attended a three-day course than among a control group. Follow-up videotapes recorded one year later showed that all of these behaviors endured except expressions of empathy. Similarly, Levinson and Roter showed that compared with baseline (pre-intervention) behavior, physicians asked more open-ended questions, more frequently solicited patients’ opinions, and gave more biomedical and psychosocial information after attending a 2.5-day course on communication skills. Jenkins and Fallowfield also showed improvement in physicians’ attitudes and beliefs toward psychosocial issues and in their self-reported awareness of their own style of questioning patients. The changes in physicians’ attitude correlated with changes in their behavior.

A systematic review of previous interventions de-

---

Figure 3. Twelve-month change in Member Patient Satisfaction Survey scores for general population of TPMG physicians (“all TPMG”) compared with change in survey scores among physician cohorts attending the Communication Skills Intensive course (“CSI Cohorts”).
signed to enhance physicians’ communication skills in outpatient clinical settings identified eight studies that assessed patient satisfaction as an outcome of the intervention. (JK Rao, MD, personal communication, 2006)

In five of the eight studies, practicing staff physicians were the recipients of the educational intervention; in the other three studies, the intervention was given to medical residents. One study showed a postintervention increase in patient satisfaction; seven studies failed to show a difference in outcomes between experimental and control groups. One of these studies also reported that visit-specific physician satisfaction was unchanged after oncologists attended a three-day training course on clinician-patient communication skills. Hulsman et al measured patient satisfaction after providing computerized feedback to a group of physicians on their communication skills. Despite showing an increase in the quality of communication behavior after the intervention, the authors did not find an increase in patient satisfaction.

The data from our outcome measures add to this field of inquiry because of the large sample size of physician participants and their patients, tracking that uses a visit- and physician-specific patient satisfaction survey, initial scores in a range sufficient to show subsequent improvement, and our longitudinal follow-up. Because we did not study the real-time communication practices of course participants, our ten-year experience with the Communication Skills Intensive cannot tell us how the intervention leads to changes. Our longitudinal data on patient satisfaction and our snapshot of physician perceptions support one possible sequence: changes in attitudes and behaviors can be inferred to result from communication training and thus subsequently to lead to improved patient and physician satisfaction. Comments on the physician survey as well as the continuity in the patient satisfaction scores over time together indicate that for many participants the new skills they integrated into their clinical practices following the Intensive took hold and became habitual.

Our data have several limitations in addition to the lack of a formal control group. Attempts to construct historical control groups using patient satisfaction scores from physicians matched by specialty, tenure, age, and facility were unsuccessful. It is possible that controlling for the effects of familiarity and/or for the predictable increase in scores during a new physician’s first three years of practice could have diminished or eliminated the improvement that we are attributing to attending the Intensive. Nonetheless, a strong level of reliability is suggested by two consistent patterns: substantial improvement in patient satisfaction as reported in the six months after the course ended, compared with satisfaction reported in the six months before the course began; and maintenance of this improvement over many years.

We were not able to track subsets of our yearly cohorts by their performance level on the MPS prior to enrollment. Designating participants in subsets would have given us a comparison of changes in patient satisfaction.

Figure 4. Mean Member Patient Satisfaction Survey scores for course participants over time (1998 through 2005).
A Decade of Experience with a Multiday Residential Communication Skills Intensive: Has the Outcome Been Worth the Investment?

At the Communication Skills Intensive

Dr M discovered that his quest to offer comprehensive care to each of his patients often resulted in his asserting his own agenda for the visit and not paying adequate attention to his patients’ questions and concerns. He found that using open-ended questions and planning the visit enabled him to hear about patients’ issues while still keeping a sense of control. He also learned how to slow down the pace of his speech, use simpler vocabulary, and log onto the computer only after taking a moment or two to create rapport with the patient. Dr M became better aware of how to use his strengths: his obvious caring and commitment to his patients, his strong nonverbal skills, and his natural empathy.

Dr B struggled to break out of his biomedical approach to patient interactions. He was reluctant to be “too touchy-feely” at first. Feedback from the actors enabled him to see that patients who are intimidated by his take-control style may not understand his explanations and have worse outcomes. He also was beginning to understand that competently responding to his patients’ emotions was actually part of his job. Once he took this feedback seriously, he was quickly able to explore new ways of interacting, even keeping his equanimity when an actor-patient burst into tears.

Dr S worked on some of the communication challenges unique to adolescent medicine. She learned new strategies for talking with anxious parents, discussing confidentiality with parents and teens, and giving bad news. She also developed a more effective way to collaborate with obese teenagers about diet and exercise.

for physicians with low versus average or high scores. Also, the absence of directly observed or recorded interactions of participants precludes correlation of their behavior with the patient satisfaction scores. Another limitation is that the survey results regarding physician perceptions and satisfaction represent only a subset of course participants at a single point in time.

Is training physicians to communicate more effectively worth the investment? Our experience with the Communication Skills Intensive signifies that the investment of time, energy, and dollars is highly worthwhile. Participants have told us that after the course they change the way they communicate with their patients—they create new habits (See box: At the Communication Skills Intensive). They change how they interact with patients because the new behaviors become self-fulfilling. Many participants have described recapturing meaning in their work by enhancing connection with their patients. Longitudinal MPS results demonstrate that these changes are noticed by patients. Also impacted by better communication are accuracy of medical diagnoses, patients’ adherence to prescribed treatment regimens, patients’ health outcomes, physicians’ medical-legal risk, and overall satisfaction of patients and physicians.19-24

Conclusion

Though numerous studies have shown that interactive (nondidactic) continuing medical education, such as the Intensive, can be effective in changing physician performance,15 our experience with the Communication Skills Intensive is the first time that such a large number of physicians have taken part in an organization-sponsored multiday residential clinician-communication program and then have been followed for so many years. The story of the Intensive tells us that when physicians are given an in-depth opportunity to explore their communication skills in a supportive and safe environment, physicians, patients, and health care organizations all benefit.

Acknowledgments

The author would like to acknowledge Philip Bellman, MPH, and Janet Ban, BA, for technical assistance and Vaughn F Keller, MFT, EdD, for creating the original design of the course. Editorial assistance was provided by the Medical Editing Service of The Permanente Medical Group Physician Education and Development Department.

References

2. Stein T, Frankel RM, Krupat E. Enhancing clinician communication skills in a large healthcare organization: a longitudi-
God doesn’t require us to succeed; he only requires that you try.