A Model for Communication Skills Development for Family Practice Residents

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The purpose of this paper is twofold: (1) to demonstrate the need for including interpersonal communication skills training in family practice residency programs, and (2) to present a communication model that can be used for such training. Interpersonal communication skills are important in almost all areas of contact with patients: history taking, physical examination, prescription writing and patient education, counseling, and psychotherapy. Presentation of the communication model includes definition of the interpersonal communication skills that would be stressed in family practice residency programs. These skills include empathy, respect, warmth, concreteness, genuineness, self-disclosure, confrontation, immediacy, and behavior modification. Examples of how a family physician may communicate each of these skills are also included. The implementation of the communication model in a department of family practice for training residents and faculty in the use of these communication skills is also described.

How can the most effective family physicians be trained? Family practice residency programs all over the country are seeking and developing answers to this question. The goal of any program should be to train the family practice resident in ways that will ultimately result in effective health care for his/her patients. There is no doubt that today's physicians have readily available the most advanced technology of all time, but there is an increasing recognition of a gap in patient care that cannot be bridged by technology.[1] This gap includes failure of the physician to develop and use effective interpersonal communication skills.[2] For some physicians these skills come naturally, for others they must be gained only through long years of practice.[3] In some situations patient care quality is likely to deteriorate from lack of the physician's communication skills.[4]

Communication skills are critical in taking patient histories, performing physical examinations, prescribing medications, educating patients, and interacting in counseling and psychotherapy. History taking is a part of the basic teaching of all medical schools, but many medical educators have recognized that just asking for information does not always get the required information. Effective history taking often depends upon close attention by the interviewer to the facilitation of communication, instead of just data collection.[5] All physicians recognize that nonverbal communication by the patient, eg, physical expression of pain, yields valuable information during physical examinations. The physician also facilitates communication through a wide variety of nonverbal means, such as gestures, postures, tone of voice, touch, or facial expressions.

Writing prescriptions seems straightforward, but a recent study showed 27 percent of patients

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Table 1. A Systematic Interpersonal Communication Skills Development Model for Family Practice Residency Training. Adapted from Gazda's 1975 Model for Use in Health Sciences

Facilitative Dimension	Transitional Dimension	Active Dimension
1. Empathy (depth-understanding)	4. Concreteness (ability to be specific)	7. Confrontation (pointing out discrepancies)
2. Respect (belief in)	5. Genuineness (honesty-realness)	8. Immediacy (dealing with the here and now)
3. Warmth (nonverbal)	6. Self-disclosure (ability to convey appropriately "I've been there, too.")	9. Behavior modification A. Develop new behavior B. Strengthen new behavior C. Maintain new behavior D. Stop inappropriate behavior

misunderstood their medication instructions.[6] Patient education involved another 18 percent who misunderstood their treatment or diet instructions. A total of 54 percent either forgot to tell the physician all their medical problems or forgot other instructions relating to their diagnosis and treatment. Any one or all of these may lead to noncompliance by the patient, resulting in treatment failure. That such patient noncompliance is usually underestimated by physicians has been recognized.[7] One contributing factor to patient compliance or noncompliance concerns the physician-patient relationship, ie, how the patient perceives positive or negative feelings toward himself from the physician, regardless of whether that perception is accurate or not.

Counseling and psychotherapy are a definite part of family practice. In the American Medical Association's "Essentials" for residency training in family practice it is stated, "the resident should learn how to diagnose and manage most psychosomatic and emotional problems."[8] That these problems comprise a large part of any general or family practice is well documented.[9-13] The psychiatric problems of chronically ill patients are also well recognized.[14] The behavioral emphasis of family practice residency training programs reflects the recognized need for inclusion of counseling and psychotherapy skills.[15] Moreover, essential to any counseling or psychotherapy are effective communication skills.

Thus, the family physician can better care for patients in the many phases of his/her personal interaction with them, including history taking, physical examination, prescribing medication, patient education, and counseling and psychotherapy. To accomplish these skills requires training in an interpersonal communication model which is effective and thorough but simple enough to be useful in all these areas.

A Model for Interpersonal Communication Skills Development

One way to develop and master interpersonal communication skills is through a systematic training approach. In fact, some family practice residency training programs now have such training in their curricula. This training has two basic purposes: (1) to help residents sharpen their abilities to perceive what people are conveying through verbal and nonverbal messages, and (2) to help residents change their verbal and nonverbal behaviors in ways that create more effective communications.

The model that is used for this training is shown in Table 1. Although this model has been modified for use in medicine, it evolves primarily from the works of Rogers,[16] Carkhuff,[17] and Gazda.[18] Unlike most theoretical models that deal with interpersonal communication skills, the interpersonal dimensions in this model were developed as a result of thorough and rigorous research (See De-

neen,[19] Carkhuff,[17] and Gazda[18] for research summaries). The authors have used this model successfully to improve interpersonal communication skills in settings such as medicine, nursing, dentistry, allied health fields, and city and state governmental branches.

Briefly stated, the choice for this model is based on the highly action-oriented nature of medicine. Often action is taken with the intention of modifying the patient's behavior in ways that will produce effective health care. Psychological research[18-20] has demonstrated that behavioral change is affected by the relationships between the parties involved in the change process. Therefore, the physician-patient relationship may determine the effectiveness of any treatment program designed to alter the patient's health care behavior.

The model to be described offers a systematic training approach for developing the family practice resident's interpersonal communication skills. Although this model is explained in terms of the physician-patient relationship, it applies to any professional relationship within the medical environment. There are three dimensions to this model—facilitative, transitional, and active.

Facilitative Dimension

The attributes of empathy, respect, and warmth form the facilitative dimension of this model. These attributes are involved in helping physicians to build positive relationships with patients. The physician's skills in projecting these attributes facilitate the patient's efforts to understand himself in relation to his health care.

Empathy

The first attribute in the facilitative dimension is empathy, which is concerned with depth of understanding. The model is based on empathic understanding of the patient's communications. That is, physicians assure their patients that they have been understood. For example: "Mrs. Edwards, I'm sensing that you are a little anxious about the examination I'm about to perform. Not knowing what is going to happen can make anyone anxious. Let me explain." Such a statement lets the patient know that the physician has understood what the patient was feeling and, consequently, the patient feels understood and cared for. In essence, the physician sees things through the patient's eyes and communicates this to the patient. Without empathy there cannot be an effective physician-patient relationship. Other ways a physician may verbally express empathy are: "that must be very frustrating for you," and "it must be discouraging for you to keep having this pain."

Respect

Respect is the ability of physicians to accept their patients as they are with their own set of values, to listen actively to what they have to say, and to convey belief in their ability to develop and maintain an effective health care program. If physicians can value and believe in patients and communicate this to them, patients will then begin to value themselves, to gain confidence in their ability to overcome their particular health problems, and therefore, to accept responsibility for providing themselves with good health care. Among the things that communicate lack of respect are arguing about the facts of a matter as a patient sees them, making fun of the patient's feelings, insisting that the patient's feelings are wrong, and forcing one's own opinion on the patient.

To illustrate the communication of respect, assume that the physician has just completed a history and physical examination. The physician might respond to the patient by saying, "I can see several problems developing, but after talking with you I know you are motivated to provide the best care possible for your health. So with your help I think we can resolve the problems." Essentially, the physician has communicated to the patient that he has confidence and faith in the patient's ability to become involved with the responsibility for his/her own treatment and that the physician is willing to do everything possible to help the patient. Respect may be verbally communicated by opening statements such as: "What are some ways you can think of to help?" and "I'll bet you have some ideas about how to. . . ."

Warmth

Warmth is the degree to which physicians communicate caring about their patients. It is a physical expression of empathy (understanding) and respect (caring). It is generally conveyed through a wide variety of nonverbal means, such as gestures, postures, tone of voice, touch, and facial expressions. Not only must physicians be aware of their own nonverbal messages, but if they

are to truly understand their patients, they must become skillful in interpreting their patients' nonverbal messages. It is primarily through nonverbal messages that the physician's caring for the patient is communicated.

Physicians can communicate warmth through such nonverbal messages as these: a check on possible patient discomfort during a physical examination, use of good eye contact when talking with patients, and being as gentle as possible during an examination or procedure that may be uncomfortable or painful to the patient.

It is important that the physician's verbal and nonverbal messages be congruent. That is, verbal messages that a physician communicates must be identical to his nonverbal messages. If incongruency occurs, the patient may become confused, anxious, and even hurt or angry. For example, if verbally the patient has been told, "all is fine," yet the physician nonverbally shows deep concern by taking excessive time in examining reports or looking at x-rays, then patient anxiety is apt to be increased.

Thus, when the physician communicates the facilitative attributes of empathy, respect, and warmth, patients are encouraged to explore their health care problems in detail. This is important for two reasons: (1) it gives the physician a clear picture of the patient's problems, and (2) it aids in building physician-patient rapport which can lay the foundation for patient counseling, if necessary, at a later date.

Transitional Dimension

The communicative qualities of concreteness, genuineness, and self-disclosure form the transitional dimension. These attributes help patients go beyond the exploration of feelings, yet they do not fully enable them to change their behavior. This means that in the transitional dimension there are certain facilitative qualities present, and there are certain qualities that involve risk taking that are intended to move the patient toward problem solving and the active dimension. For example, a certain degree of threat is felt by the patient when the physician: (1) presses for greater concreteness on the part of the patient; (2) becomes more genuine and, therefore, sets the stage (by modeling genuineness) for the patient to become more genuine; and (3) shares his own feelings and experiences with the patient, thereby encouraging patient self-disclosure that builds greater intimacy in the physician-patient relationship.

However, such threat is greatly reduced when the physician has developed a strong positive relationship with the patient. Typically, these attributes help patients establish concrete goals for themselves and develop trust in the physician so that the problem solving skills of the physician and patient become more effective.

Concreteness

Concreteness is the ability of physicians to help their patients be specific about their feelings and experiences. The physician facilitates concreteness by being specific himself. When a physician responds with high levels of concreteness, patients are better able to identify their own feelings concerning their health-related problems. Concreteness may be communicated by physicians when they help their patients discover underlying feelings such as insecurity, fear, embarrassment, and anger. Other ways of communicating concreteness include being as specific as possible about the length of time needed to complete treatment, the number of visits needed, and the cost of treatment.

Genuineness

The ability of physicians to be real and honest in their relationships with their patients is called genuineness. Physicians need to be as real as they can be—they should try to be themselves. Their verbalizations should be congruent with their inner feelings.

Whether or not a physician's genuineness is useful to his patients will often depend on the physician's ability to time his level of honesty so as to develop greater trust and understanding. If brutal honesty is employed and patients are not capable of dealing with it to improve themselves, then genuineness may be useless or possibly harmful. Thus, the degree of genuineness communicated depends on the strength of the physician-patient relationship, or facilitative base.

Examples of a physician communicating genuineness are: "this examination will create some discomfort for you," and "it is upsetting to me to hear how angry you are about the long wait in my office. Let's talk about it." The physician may also offer genuine compliments such as: "I'm really proud of the efforts you have put into your diet program. Your weight loss looks great," and

"it gives me a lot of satisfaction to work with people who are really concerned about their health."

Self-Disclosure

Self-disclosure is the ability of physicians to share their own experiences as they relate to their patient's feelings, thoughts, and experiences. The sharing of such experiences, especially similar ones, often establishes a closer physician-patient relationship. Here are some ways physicians may communicate self-disclosure: "I know rehabilitation after knee surgery is rough. I had surgery two years ago and I had a lot of doubts about my recovery, however. . ." and "I, too, found dieting and exercising programs extremely tedious, but let me explain some ways that made it less tedious for me." However, too much self-disclosure by the physician may overwhelm the patient and may even destroy the relationship. Too much physician self-disclosure may also bring the focus of attention to the physician instead of the patient.

Thus, when the physician communicates the transitional dimension of concreteness, genuineness, and self-disclosure, patients are better able to understand their health-related concerns. Better understanding enables the patient and physician to deal more effectively with the patient's health problems.

Active Dimension

The active dimension may be considered as the most important dimension of this model. For it is in this dimension that problem solving occurs. The physician must be capable of helping develop a plan or strategy for the patient that will lead him to the successful resolution of the patient's current problem and provide him with a method of attacking future problems. The attributes of confrontation, immediacy, and behavior modification form the active dimension.

Confrontation

Confrontation involves honest communication on the physician's part. In pointing out discrepancies between what patients say and what is evident from their history and physical examination, the physician will enable patients to understand their problems as they really are and to deal with them effectively. Confrontation can be extremely helpful when the patients have learned, from earlier experiences, that physicians are concerned about their welfare and care enough to risk their relationship to level with them. However, unless there is a strong facilitative base, or physician-patient relationship, the patient may perceive confrontation as offensive. This may lead to defensive patient behavior (ie, argumentative behavior, withdrawal, passive resistance), patient noncompliance, and even loss of the patient from one's practice.

Examples of the physician communicating confrontation are: "you say you have been dieting, but so far you have failed to show any weight loss. Perhaps we need to examine your daily eating record," and "you say health is important to you, but you have not been in for a check-up in five years. Let's talk about it."

Immediacy

Immediacy is the physician's ability to understand different feelings and experiences that are going on between the physician and the patient at the moment. The physician makes patients aware of these immediate feelings and experiences and helps them to talk about them.

Examples of a physician communicating immediacy are: "you feel that I'm not really being myself—sort of phony," and "I know it's difficult for you to talk about your experience and it seems like you're afraid I'll reject you if you do." Thus, the physician has to deal with the immediate physician-patient relationship in order to progress with problem solving and/or patient behavior change.

Behavior Modification

This interpersonal skill enables the physician to intervene effectively and provide solutions once a thorough understanding of the problem is reached. Behavior modification also gives the physician an effective means for influencing the health care of the patient, the office activities of paramedical personnel, and the behavior of patients in the examining room. Included in the behavior modification section of this model are principles of teaching desirable health care behavior. These include the discriminate use of positive and negative reinforcement, modeling, shaping, prompting, and systematic desensitization.

Thus, the appropriate use of confrontation, immediacy, and behavior modification skills helps patients see their problems as they really are and helps them to improve their total health care program.

This completes the outline of the model. It is important to note that the three dimensions should be used sequentially, from the facilitative through the transitional to the active dimension. This allows a strong positive physician-patient relationship to be developed before the physician becomes involved in the active dimension. Such an approach to the development of the family practice resident's interpersonal communication skills will result in more effective health care programs.

Implementation of Model in Residency Training Program

This model may be used as a basis for both didactic and experiential instruction. A didactic approach is used to introduce and discuss the cognitive aspects of the model and the relevance of the model dimensions to family medicine. An experiential learning approach is used to develop and demonstrate individual competency in communicating and using the nine skills of the model. Thus, not only is the future family physician made aware of the need to develop interpersonal communication skills, but he/she is also given the opportunity to practice these skills under close supervision and perceive their effects on patients.

Specifically, this model has been used successfully by the authors in developing interpersonal communication skills with residents and faculty in the Department of Family Practice at the Medical College of Georgia. During the past two years, 16 residents and 17 full-time faculty have received approximately 20 hours of training in the use of this model for interpersonal communication skills development. Residents meet in small groups, four to six members each, and receive their training over a four-week period; faculty receive their training during a two-day faculty retreat workshop. Skills developed during the training are reinforced (post-training) via videotape feedback for both residents and faculty. Feedback is given concerning resident-patient, faculty-patient, and faculty-resident interactions. Residents receive feedback continuously during their last two years of training.

In summary, a model has been presented which can be used to develop the family practice resident's interpersonal communication skills. Definitions of the nine communication skills were presented and examples of how a family physician may communicate each of the skills were described. The implementation of the model in a department of family practice for training residents and faculty was also described.

References

1. Engel GL: Are medical schools neglecting clinical skills? JAMA 236:861, 1976
2. Ley P, Spelman MS: Communicating with the Patient. St. Louis, Mo, Warren H Green, 1967
3. Bates RC: The Fine Art of Understanding Patients. Oradell, NJ, Medical Economics Book Division, 1968, p 1
4. Schochet BR: The difficult patient in the general hospital. Am Fam Physician 7:95, 1973
5. Enelow AJ, Swisher SN: Interviewing and Patient Care. New York, Oxford University Press, 1972, pp 29-50
6. Snyder D, Lynch JJ, Gruss L: Doctor-patient communications in a private family practice. J Fam Pract 3:271, 1976
7. Matthews D: The non-compliant patient. Pri Care 2:289, 1975
8. American Medical Association: Special requirements for residency training in family practice. In Essentials of Approved Residencies. Chicago, American Medical Association, 1968
9. Schwab JJ, Fennell EB, Warheit GJ: The epidemiology of psychosomatic disorders. Psychosomatics 15:88, 1974
10. Marsland DW, Wood M, Mayo F: Content of family practice. J Fam Pract 3:37, 1976
11. Glasser M: Incidence of psychiatric problems in one family physician's office. J Fam Pract 3:558, 1976
12. Gardner EA: Emotional disorders in medical practice. Ann Intern Med 73:651, 1970
13. Thomas RB, Wessinger WN: A descriptive assessment of the psychiatric practice of nonpsychiatric physicians in South Carolina. South Med J 66:221, 1973
14. Kiely WF: Psychiatric syndromes in clinically ill patients. JAMA 235:2759, 1976
15. Society of Teachers of Family Medicine: Guidelines for residency objectives. Kansas City, Mo, Society of Teachers of Family Medicine, 1972
16. Rogers CR: The necessary and sufficient conditions of therapeutic personality change. J Consult Psychol 21:95, 1957
17. Carkhuff RR, Berenson BG: Beyond Counseling and Therapy. New York, Holt, Rinehart, and Winston, 1967
18. Gazda GM, Walters RP, Childers WC (eds): Human Relations Development—A Manual for Health Sciences. Boston, Allyn and Bacon, 1975
19. Deneen LJ: The Effects of Systematic Human Relations Training on the Interpersonal Functioning of Dental Students and the Characteristics of High and Low Functioning Students, thesis. University of Georgia, Athens, 1973 (Available from University Microfilms, Ann Arbor, Michigan)
20. Gazda GM: Basic Approaches to Group Psychotherapy and Group Counseling. Springfield, Ill, Charles C Thomas, 1968