ABSTRACT

Effective patient-provider communication is essential to ensure the best possible treatment outcomes for patients with HIV and other chronic diseases. Patients with HIV who report better relationships with their providers are more likely to begin antiretroviral therapy and to remain adherent to long-term care. Many studies have shown that healthcare providers interact differently with their minority patients, who in turn report lower levels of satisfaction with the healthcare that they receive. In their conversations with minority patients, providers are more likely to restrict themselves to biomedical issues, to engage less on interpersonal or psychosocial topics, and to exert greater verbal dominance. Communication problems are especially challenging for patients with language barriers, who are less likely to access a variety of healthcare services. Reliance on family members or other ad hoc translators often results in incomplete transmission of health information between patient and provider. Regardless of the patient’s language or culture, it is essential to understand the patient’s perspectives toward HIV infection and treatment in order to identify and overcome barriers to treatment. Providers often fail to engage the emotional concerns of their patients, either because they do not recognize statements about emotional well being, because they do not feel competent to engage patients on these topics, or for other reasons. Several practical steps can help providers to improve their use of empathy in patient-provider communication. (Adv Stud Med. 2010;10(2):49-52)

Strategies to improve patient-provider communication have been associated with better treatment adherence, patient satisfaction, understanding and recall of health information, and health outcomes in many chronic diseases. Effective communication is important to provide patients with the information they need to manage HIV and other conditions on a day-to-day basis, to build patient trust, and to assure patients that treatment recommendations are in their best interests. In studies of patients with HIV infection, those who report better relationships with their healthcare providers are more likely to remain adherent to antiretroviral therapy. Patients with HIV who agree that their healthcare provider “really knows me as a person” are significantly more likely to use highly active antiretroviral therapy (HAART), to remain adherent to HAART, and to achieve an HIV viral load of less than 400 copies/µL HIV RNA, even after controlling for potentially confounding factors such as longer time in therapy, older age, social stress, and beliefs about HIV treatment.

Several studies have found that patient race and ethnicity significantly influence many aspects of patient-provider communication, including physician empathy, concern, courtesy, information-giving, and
nonverbal attention. When interacting with black patients, physicians may be more likely to adopt a more narrow "biomedical" communication style and to employ less patient-centered communication. Studies also have demonstrated lower rates of satisfaction with patient-provider communication among black and Asian patients. The impact of race and ethnicity on patient-provider communication patterns has been examined in several recent studies in which patient visits for HIV treatment were audio recorded, and every statement made by the provider and the patient was coded using an exhaustive conversation classification system. In one study, provider verbal dominance (the total number of provider statements divided by the total number of patient statements) was significantly higher when providers spoke with black patients than with white patients. Greater verbal dominance by providers was due to a lower number of statements by black patients than white patients during clinic appointments, rather than to differences in the number of statements made by providers. Other measures of communication, such as the total visit length and patient ratings of communication quality, were generally similar for black or white patients. In a similar study that compared communication patterns for Latino versus white patients, verbal dominance scores did not differ when providers talked with the 2 patient groups. However, a score of the patient-centeredness of the visit was lower for visits with Latino patients, with fewer patient questions and less discussion of psychosocial issues.

**IMPROVING PATIENT-PROVIDER COMMUNICATION**

Some of the essential goals for improving cross-cultural patient-provider communication include addressing language barriers, exploring patient perspectives, and expressing empathy.

**Address Language Barriers**

- In 2000, it was estimated that nearly 47 million US residents—or approximately 18% of the US population—spoke a language other than English at home. Nearly 50% of these individuals (21.4 million) had some difficulty speaking English. Patients with language barriers are generally less satisfied with the quality of patient-provider communication, less likely to have regular sources of care, and are less likely to receive a range of healthcare services, including eye, dental, and preventive treatments. These individuals are also more likely to experience medication complications.

Among minority patients with HIV infection, studies have demonstrated that limited English language proficiency is a significant barrier to medical care. For example, studies of Hispanic patient populations in the United States have found that Spanish-speaking patients have less accurate knowledge about HIV factual information than English-speaking patients. Among Asians and Pacific Islanders with HIV/AIDS, those with English as their primarily language received more primary care services and experienced fewer barriers to care (eg, language, treatment costs, knowledge about where to obtain services, and confidentiality). Although patients often rely on family members or others from their own communities to interpret, the use of these ad hoc interpreters often presents several potential obstacles to optimal care of patients with HIV, including withholding information from either the patient or the provider, editorializing with their own perspectives, and misinterpreting medical terminology. The United States Department of Health and Human Services has established, in its National Standards for Culturally and Linguistically Appropriate Services in Healthcare, 4 federally mandated language access standards for healthcare settings:

- Right of every client to have access to qualified language assistance if needed
- Notice to consumers that they have that right
- Ensuring that interpreters are qualified to perform that role
- Ensuring that written materials and signage are translated into the most commonly encountered languages in the service area

**Explore Patient Perspectives**

When language barriers have been addressed, exploring patient perspectives is important to understand potential obstacles to HIV treatment. Patients should be directly questioned about the impact of illness on their lives and the lives of their family and friends, the explanatory framework they use to interpret their symptoms or illness, the advice they have previously received from other healthcare profession-
als, their worries or concerns, their expectations about treatment, and their beliefs and opinions about treatment. Sample questions to explore patient perspectives about HIV infection and its treatment are shown in Figure 1. Questions such as these can help to establish rapport with the patient and to provide important information about treatment strategies that might be effective for the individual patient.

**Express Empathy**

Empathy may be defined as a response that demonstrates an accurate understanding and acceptance of the patient's feelings and concerns. One of the key concerns in improving patient communication is the missed empathic observation, as illustrated in Figure 2. The patient has expressed an emotion, while the provider is focused on the patient's physical symptoms and does not detect or respond to the expressed emotion. Studies of patient-provider encounters have found that providers missed empathic opportunities in 72% of patient visits. There are several provider barriers that contribute to the high incidence of missed empathic opportunities in medical care. Many clinicians may avoid engaging with patients about their hopes or fears because of the concern that to do so will require more time than is typically available during an office appointment. However, in one study that evaluated physician empathy, visits in which there were missed empathic opportunities lasted an average of 3 minutes longer than visits in which empathy was expressed. When the investigators examined this phenomenon in more detail, they found that patients often repeated a concern when it was not initially addressed. In 53% of visits with missed opportunities, the patient brought up the same concern more than once. In addition, many clinicians are more focused on biomedical issues and are less comfortable dealing with strong emotions, they may view emotional issues as beyond the typical concerns of the physician, or they may feel that they lack the skills to engage effectively with patients on emotional issues. Clinicians often feel that detached concern, rather than emotional engagement, is better for solving medical problems. Finally, many clinicians simply fail to recognize an opportunity to engage with the patient.

There are several practical steps by which clinicians may improve their use of empathy in patient-provider communications. Some of these techniques include:

- Framing or sign-posting:
  - “Let me see if I have this right . . .”
  - “So it sounds to me like . . .”
- Reflecting the content back to the patient:
  - “So if I’m hearing you right, comfort food during the winter would be hardest to give up.”

**Figure 1. Exploring Patient Perspectives**

- Impact of illness on life and family/friends
  - How has this affected your relationship with your partner?
  - How hard is it to tell your friends?
  - You mentioned once that you felt guilty about having HIV—how are you thinking about that now?
- Explanatory framework for symptoms/illness
  - What do you think is going on?
  - Have you done to treat this illness so far? How does that treatment work?
- Prior advice received
  - Have you seen other health professionals? What have they told you?
  - What advice do your friends with HIV give you?
- Worries/concerns/fears
  - What worries or concerns you most about this symptom?
  - Is there anything you are particularly afraid of?
- Expectations
  - How were you hoping I could help you most?
- Opinions
  - How do you think these medicines are working for you?
  - What do you think we should do?

**Figure 2. A Missed Empathic Opportunity**

Patient: After I had my hysterectomy, I was taking estrogen, right?
Provider: Yeah?
Patient: You know how your breast gets real hard and everything? You know how you get sorta scared?
Provider: How long were you on the estrogen? [Missed empathic opportunity]
Patient: Oh, maybe about 6 months.
• Calibrating the emotion:
  • “I have the sense that you feel strongly, but I’m not sure I understand exactly what the feeling is. Can you tell me more?”

CONCLUSIONS

More effective patient-provider communication is clearly associated with better clinical outcomes and higher patient satisfaction in a variety of healthcare settings. Minority patients with HIV face significant barriers to patient-provider communication, including differences of language, culture, and provider communication styles. Improving communication with minority patients requires not only addressing language barriers, but also striving to understand the patient’s perspective to HIV infection and its treatment.

REFERENCES