

5 Questions: Dean Pizzo on doctor-patient communication

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For all the technological advances that enable today's physicians to get a better view of what's going on inside their patients, many neglect one key source of insight — direct and engaged conversation. Philip Pizzo, MD, dean of the School of Medicine, wants doctors to improve physician-patient communication as a way to better “fuse the art and science of medicine.” Pizzo wrote about the topic in a commentary published May 4 in the Journal of the American Medical Association and co-authored by Wendy Levinson, MD, professor and chair of medicine at the University of Toronto. He discussed the obstacles and possible solutions to better physician-patient communication with Inside Stanford Medicine writer Susan Ipaktchian.

Q: Despite the attention this issue has received over the years, you note that patients still often feel that their physicians are “too busy to listen and too distant to care.” What do you see as the main reason for the lack of progress?

Pizzo: Multiple factors impact the effective communication between a doctor and patient, but a central issue is the lack of time — both real and perceived. Of course, it is true that even under ideal circumstances some physicians have better “bedside manners” than others, but it is also true that the communication gap between doctors and patients has been aggravated by many of the pressures of current medical practice. For

example, physicians are expected to see more patients over shorter periods of time, and the need for efficiency is sometimes confused with avoidance of open-ended communication between the doctor and patient. This can be made worse by the use of technologies, such as the electronic medical record or imaging, that permit the doctor to view the patient through a different lens, the net result of which is less direct and personal contact and connection. Medical practice has also shifted to physician work schedules that sometimes impact continuity or doctors' ability to form a personal relationship with her or his patient. Further, physicians in training don't necessarily have good role models or teachers about the art of medicine (which includes listening and communicating). Generational differences in how [doctors](#) carry out their work and how they view medicine as a profession or a job add to the mix of issues and complexities. Listening to the patient is not the same as simply asking questions and getting answers. It begins with allowing patients to tell their stories — and to have the time to do so.

Q: You write that academic medical centers “almost worship technology,” and that some faculty and clinicians put a higher premium on tests and imaging than on interacting face-to-face with the patient. What role should the nation’s academic medical centers play in closing the communication gap between patients and physicians?

Pizzo: We need to rediscover — and to teach — that the vast majority of medical diagnoses can be made with a well-done history, complemented by a physical exam and supported by selected laboratory and imaging studies. This simple concept needs to be given much more value and attention in the education of medical students and postgraduate trainees. During the last decades, too much emphasis has been placed on getting

as many tests as possible to rule in or out various diagnoses rather than seeking the simplest and most cost-effective way to making a diagnosis.

Q: The School of Medicine has been working to improve the patient-interaction skills of its medical students. Has it begun to yield results yet?

Pizzo: A number of educational programs are in place to guide our Stanford medical students and trainees. One of the most notable and important programs is the Educators-4-Care program that was launched just a couple of years ago by Dr. Charles Prober, senior associate dean for medical student education. This program aligns outstanding clinicians and teachers to work longitudinally with small groups of students (six students/class) to teach them practice-of-medicine skills and mentoring. This is one way of humanizing medicine. Coupled with this is interaction with outstanding clinicians like Dr. Abraham Verghese as well as with the use of technology and simulation devices that focus on humanism as well as technical proficiency.

Q: Is there an instance from your own experience that illustrates the need for good communication with a patient?

Pizzo: As a medical student (at the University of Rochester) I was taught how to listen to a patient's story and perform physical examination in a manner that emphasized humanism along with science. It followed an approach to medicine now referred to as the biopsychosocial model that connects an individual's biological makeup with one's personal reaction to health and disease within a societal and environmental context. These skills have been important to my medical practice over the past decades — which continue through today. This is also evidence that

communication skills as well as professionalism and humanism can be taught — as well as learned and sustained.

Q: There may be a widespread perception among patients that physicians' bedside manner has grown worse in recent years. But is there any objective way to measure this? And if it has happened, is it a change that is particular to physicians or is it part of a broader shift in a society that has come to value less-personal interactions?

Pizzo: There are many ways of assessing and evaluating bedside manner — at least as seen through the eyes of the patient. In fact, we are currently providing feedback to our physician faculty at Stanford in how they have performed in aspects of the doctor-patient relationship. We hope that this feedback will provide a compass for self-improvement. We can all benefit from feedback, especially if we use it to improve our practice of medicine. That is our goal — on both an individual and institutional level

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