

Communication Practices of Physicians With High Patient-Satisfaction Ratings

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Introduction

How do primary care physicians with outstanding patient-satisfaction ratings communicate with their patients? Which specific practices distinguish them from less effective communicators *on the basis of measured performance*? To answer this question, we videotaped 92 adult primary care visits in Southern California and Hawaii and interviewed both physicians and patients separately. Each participating physician and patient viewed the tapes of the visit and shared their perceptions of the communication aspects of the visit. We also audiotaped these debriefing sessions. To identify successful physician communication practices, exam room visit behaviors and comments from the postvisit debriefs were coded and compared with each physician's panel-level patient satisfaction. In the final section, we describe communication strategies reported by physicians with high patient-satisfaction ratings.

The quality of physician-patient communication in primary care visits is related to patient satisfaction,¹ adherence,^{2,3} litigation,⁴ quality of data collection,⁵ utilization patterns, and clinical outcomes.⁶ There is evidence that communications between physicians and patients are sometimes inadequate.⁷⁻⁹ In addition, disruptive communications reduce the quality of worklife for physicians. Thus, improvement in physician communication skills has great potential for both the quality of medical care and for the physician work environment.

Methods

Participants

Physicians: Fifty-five adult primary care physicians from Southern California and Hawaii Kaiser Permanente (KP) clinics volunteered to be videotaped with their patients (one to four patients per physician). The physicians were stratified into three groups on the basis of patient-satisfaction ratings obtained from their patient panel. *High Group* physicians had mean ratings in the upper third of physicians within their region. *Medium Group* physicians had mean ratings in the middle third of physicians, and the *Low Group* physicians had mean ratings in the bottom third of the distribution.

Patients: We videotaped 92 adult primary care visits with patients who were already scheduled to see these physicians during the time of filming. We invited patients to participate in a videotaped visit with their physicians. To respect privacy, the camera was covered

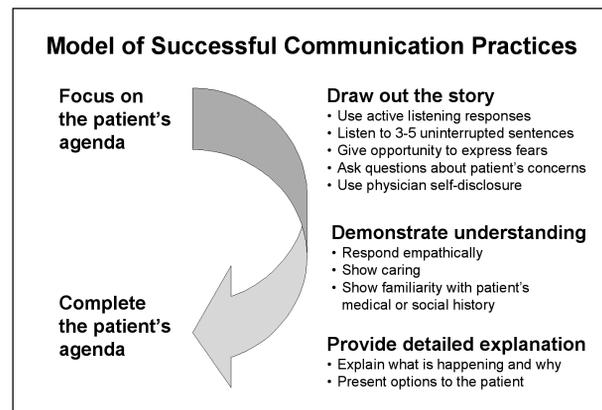


Figure 1. Model of the behaviors linked to higher patient satisfaction.

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during some physical examinations. Patients and physicians were informed that all comments would be completely anonymous.

Audiotaping of Postvisit Commentary

Following the exam room visit, the patients reviewed the videotapes of the visit with a research assistant to elicit comments on the visit (technique known as *stimulated review* or *grounded ethnography*¹⁰). We asked patients to describe aspects of the communication that they found to be “new, different, or anything [they] liked or disliked about the communication.” Using the same protocol, the physicians reviewed the videotapes and commented on the visit.

Narrative Analysis

A qualitative analysis of the audiotaped debriefing was conducted, guided by the principles of grounded theory.¹¹ Each tape was reviewed at least twice. Extensive notes were taken and potential coding categories were developed from the data using the constant comparative method.¹¹ All the physician and patient debrief audiotapes were reviewed (blind to the satisfaction rating of the physician) to identify communication practices for exploration and to develop a coding system for these practices. The goal was to identify communication practices that emerged from observed behavior rather than to test existing theories and then to assess the association between these observed practices and patient satisfaction ratings. Behaviors were rated as present (1), intermediate (0.5), or absent (0).

Up to three sources of data were used for coding: researcher, patient, and physician perspectives. When two or three perspectives were present, it was possible to assess multiple perspectives on the same visit, ie, a form of triangulation.¹² Sometimes the physician or the patient commented on a topic but not both. Occasion-

ally the patient and the physician both commented on the same issue, but disagreed. In these cases, discrepancies were typically resolved in favor of the patient's opinion. For example, if the patient believed the physician explained well, but the physician or the researcher did not, the patient's opinion was used. Some categories were coded on the basis of researcher observations, such as the number of consecutive sentences of storytelling. Additional detail on sources of data and priorities for resolving discrepancies are found in Table 1. Further details on the definition of the coded practices are included in the findings section. A large database was used to record notes, large sections of the visit dialogue, physician and patient comments, and to assign codes. The coder had no information on the physician's patient satisfaction scores when performing the coding. Later the performance data was added to this database.

Correlations Between Practices and Patient Satisfaction

Physicians in Southern California and Hawaii Regions were rated by their patient panels using different scales and the means of the distributions varied, plus the rankings were relative to other physicians in the same region. Thus the relative ratings from the two Regions were not directly comparable. The correlations were based on the High (3), Medium (2), or Low (1) Group classification within their respective Regions. One randomly selected visit was selected for each physician to adhere to the independence assumption of the statistical test. Nonparametric rank order Spearman correlations were calculated between the patient satisfaction data and behaviors coded as present (1), intermediate (0.5), or not present (0).

Results

Spearman rank order correlations between physician practices and patient satisfaction scores with correlations exceeding $r = 0.35$ ($p \leq .01$, $n = 45-55$) are presented in Table 1. Twelve coded practices met this criterion. These practices were examined to look for higher order commonalities. After several iterations, five major categories of practice emerged that described the behaviors that discriminated between High, Medium, and Low Group physicians. The resulting model and the relationships between the categories are illustrated in Figure 1.

The following sections describe the categories and practices found in Table 1. Quotations from the exam room visit are used to exemplify each practice found to be related to patient satisfaction.

The goal was to identify communication practices that emerged from observed behavior rather than to test existing theories ...

Table 1. Practices that discriminated between High, Medium, and Low Group physicians on the basis of panel level patient-satisfaction ratings

| Categories | Practices | Correlation (r =) |
|-------------------------------|--|-------------------|
| Focus on the patient's agenda | Focus on patient needs vs primarily clinical issues and/or time management ¹ | 0.65 |
| Draw out the story | Use simple, active listening responses during patient storytelling (eg, periodic statements of "okay," "uh-huh," etc) ¹ | 0.61 |
| | Listen to 3-5 uninterrupted sentences (which typically required less than 30 seconds) ¹ | 0.48 |
| | Give patient opportunity to express fears and concerns ¹ | 0.35 |
| | Ask probing questions, especially regarding patient concerns ^{1,2} | 0.47 |
| Demonstrate understanding | Use physician self-disclosure (for patient education) ¹ | 0.46 |
| | Respond empathically (showing understanding of patient's point or the implications of their situation) ^{2,1} | 0.54 |
| | Show caring (patient used the word "caring" or physician did something extra in terms of listening or helping) ^{2,1} | 0.59 |
| Provide detailed explanation | Show familiarity with the patient's medical or social history ^{1,2} | 0.43 |
| | Explain what is happening and why (eg, explaining etiology, genetic contributions, normalizing, using pictures, giving suggestions, explaining why new drug is important, problem solving, or giving handouts with explanation) ^{2,1} | 0.45 |
| Complete the patient's agenda | Present options to patients ^{2,1} | 0.37 |
| | Deliver what was promised or negotiate until later—issues of concern to the patient are addressed or at least acknowledged—(responding to patient questions, remembering the referral, phone number, medication, etc) ^{2,3,1,4} | 0.46 |

¹⁻⁴ Principal source(s) of information for coding practices and priority used in reconciling discrepancies (first listed is highest priority).
¹ = researcher observation of visit dialogue, ² = patient observations during debriefing session, ³ = physician observations during debriefing session, ⁴ = patients and physicians had access to information that was not available on tape regarding follow-up actions occurring after participants left the exam room.

Focus on the Patient's Agenda (Rather than Focusing Primarily on Clinical Issues or Visit Management)

The content of the physician debriefing sessions differed across the three groups. Even though the physicians knew the study was focused on communication, the Low Group physicians frequently talked at length about clinical issues, managing time, limited resources, and problems with systems, computers, and uncooperative patients. A few felt they didn't have time for minor medical problems and patient satisfaction. One said, *"I am here to keep multisystem patients out of the hospital. My time is for sicker patients. I am not here for a popularity contest. You need to prioritize. My patients come in [with multiple complaints]."*

In contrast, physicians from the Medium Group and, especially, High Group were focused much more on the patient. They attended fully to the patient's medical concerns, and also considered what the patient would need to move forward in the management of his/her condition(s). They were cognizant of the patient's history and barriers to progress. They assessed current patient concerns, affect, readiness for next steps, and tailored their actions to support the patient's development.

In effect, they helped the patient be an active participant in their care. For example, the first remark by one High Group physician was *"I do a lot of reassuring for this patient ... I think what she came in for is dialogue."*

Drawing Out the Story

Use Active Listening Responses During Patient Storytelling

Typical active listening responses used frequently by the High Group and Medium Group physicians included frequent utterances such as: "Uh huh ... uh huh," "Oh," "All right," "Okay," "I see," or "Hmm."

Some patients mentioned their physician's active listening responses

"I liked that he responds with 'uh-huh,' 'yes,' 'okay,' 'great,' 'good' ... It's like he has had some training in active listening."

Users of active listening responses were generally unaware that they were responding in this manner. When they listened to their videotapes, some were surprised that they were saying "okay" or "uh huh" so much. One physician wondered if it might annoy the patient, but none of the patients in the debriefing sessions indi-

... important storytelling did not always occur at the start of this visit.

cated dislike for these responses. To the contrary, during those sections of the visit, patients often mentioned that they appreciated that the physician was listening.

Active listening responses appear to serve several functions. They may:

- Indicate the physician is attending
- Give the patient permission to continue
- Keep the patient focused on the story

Low Group physicians were more likely to either be silent throughout the storytelling or they might interrupt the patient to start the biomedical questioning.

Listen to 3-5 Uninterrupted Patient Sentences

Low Group doctors were more likely to interrupt the patient after only one or two sentences were communicated. High Group physicians typically left room for patients to relate three to five consecutive sentences during storytelling. (Active listening responses were not counted as interruptions.) Typically, sufficient listening required less than 30 seconds, consistent with time frames reported in the literature.^{5,13} Note that important storytelling did not always occur at the start of this visit. Often the first minutes were used in rapid dialogue about lab or test results. One or more stories of interest to the patient often came up later in the visit.

Does length matter?

Patient satisfaction ratings were *not* significantly correlated with the length of the visit. This suggests improving communication does not necessarily require more time.

Some Low Group physicians could not tolerate non-pertinent “digressions.” The patient would respond to having their question ignored by repeatedly bringing up their issue, to which the physician would still not respond.¹⁴ This situation was unpleasant for both parties. One physician whose patient had multiple serious conditions objected, “This is a waste of time here. I just wanted the chronology.”

An interrupted story doesn't simply drift away.

It stays with the patient. Sometimes the patient's issue was not important medically, but it *so occupied the patient's attention* that the patient did not attend to what the doctor had to say.

Another consequence of failure to listen effectively was observed among some of the Low Group physi-

cians who failed to detect and/or address language barriers, cultural differences, or literacy problems that could have affected the relationship.

Listening did not always open a Pandora's Box. Only a few of the patients took advantage of physicians who were good listeners. Even an emotional story could conclude in good time when the patient felt heard and understood. In the following transaction, a High Group physician noted: “If patients have a chance to say what is on their mind, they often return to the medical issues on their own,” as illustrated in this dialogue with her patient.

Physician: “Well hello there. Good to see you.

How was your holiday?”

Patient: “We had a fire.”

Physician: “Oh my!”

Patient: “I am living with my niece now. I was going to move, then the fire.”

Physician: “Oh!”

Patient: “Everything turned out pretty good.

Everything is put in place now. So, what was my blood pressure?”

Physician: “It was 112. That is pretty good, much better ...”

Give Patients the Opportunity to Express Fears and Concerns

High Group physicians were more likely to hear patient worries about medical problems (beyond the presenting complaint), including concerns about the meaning of symptoms. Frequently patients wanted to determine if the symptoms were normal and why they occurred. They worried about abnormal test results sent in the mail, their family health history, pain or risks associated with procedures, and side effects of medicines. Some of their concerns were of a personal nature. Patients shared their embarrassment about symptoms they were having. They described struggles with weight, relationship problems, grieving, and health problems of family members, anger management, depression, sexual dysfunction, panic attacks, and suicidal cognitions.

Ask Probing Questions, Especially Regarding Patient Concerns

Patients expect detailed biomedical questions from their physicians. For patients, such questions indicate physician competence and even caring. Several patients said thorough probing was one of the things they liked about their physicians. They particularly wanted exploration of sufficient *depth around medical issues the patient raised during the visit*. The difference in the questioning was a mat-

ter of quantity of questions, not the quality.

Despite positive patient perceptions of medical questioning, some Low Group physicians felt uncomfortable about patient perceptions of probing questions. Some assumed that patients disliked medical questions because it seemed like they were “interrogating” the patient or being too “nosy.” Patients did not report objections to physicians asking questions.

Use Physician Self-Disclosure (for Patient Education)

Some of the High Group physicians were comfortable using self-disclosures to normalize, to teach, or to build a sense of commonality with the patient. For example, one physician shared that her husband was also on statins. She thought sharing that information would be more memorable than hearing a risk reduction percentage. Women physicians with children often shared this fact with patients. Patients often commented that they liked having their physician share personal information with them. These physicians were selective in their use of self-disclosure. The disclosures were always relevant to the patient’s development. For those who used this approach, it felt natural and they were confident doing so.

Demonstrate Understanding

Investing a little effort to build a strong relationship with patients was typical among High Group physicians. There were three practices related to this concept: empathic responses, demonstrations of caring, and familiarity with patient’s history.

Respond Empathically

Empathic responses were defined as remarks or actions that signaled to the patient that the physician understood what the patient was trying to communicate. The physician showed s/he heard the patient’s message and/or recognized the implications of the patient’s situation. Sometimes these were responses to patient’s emotional reactions, but more often the patient was trying to describe a situation, context, barrier, or symptom that the patient believed the physician needed to understand. Responsive actions showing understanding of the patient’s situation might be changes in body language, voice tone, deciding to order a test, or examining the patient.

The High Group physicians were more likely to 1) detect an opportunity to respond to an important patient thought or feeling and 2) to respond to the clue, proving to the patient that the physician under-

stands the patient’s experience. Sometimes they missed the opportunity during the visit, but detected it in the tape. In contrast, Low Group physicians generally did not detect missed opportunities. Other times, there was evidence of intellectual understanding of the patient’s situation, but they did not communicate the insight. For example, they might report their empathic understanding to the research assistant during the debrief, but did not share their insight and understanding with the patient.

- *Many empathic remarks are statements of the obvious*, but could still be quite important to share. The patient wanted to be certain the physician “got it.”

Physician: “You had a colonoscopy a few years ago. That was good ...”

Patient: “I don’t want to be on the receiving end of one of those again.”

Physician: “Worse than the sigmoid?”

Patient: “I handled that one better.”

Physician: “Okay then. We won’t be giving you another one of those!”

- A female patient described a family history of early onset heart disease and reported that her sister recently had a bypass performed. The patient was anxious. They worked on a treatment plan. The physician reinforced how serious she was about safeguarding the patient’s health, saying “We are doing this because this is a big concern with so *many* people in your family ...”

Handling Patient Fear

A patient who was very anxious about injections chose, after a persuasive argument about the benefits of having an injection vs taking pills, to accept the injection, but he was still frightened. In the past, he bit through the tongue depressor during a painful injection.

Patient: “I bit that thing in half. I broke out in a cold sweat.”

Physician: “You poor guy! What you have to put up with. This is not going to be nearly as bad.”

[The procedure went well. In the debrief, the patient said:]

Patient: “He explained everything. He gave me a choice. It was entirely my choice. There was more pain at first, but I don’t like to take pills. Exercise will keep them from popping out. We took care of the problem now and in three weeks I will come back and get exercise. We are taking care of things now and down the road.”

Patients often commented that they liked having their physician share personal information with them.

Show Caring

Patients sometimes described a physician as “caring.” Patients with serious conditions liked being told they could call the physician if problems arose. They felt cared about when the physician probed at length when the patient had a concern. They liked a physician who urged them gently to agree to important tests, medication, or procedures even though the patient was reticent. At critical times, a personal remark could move a patient forward, as evidenced in this attempt (not the first) to persuade a reluctant male patient to get a stress test.

Patient: “If you felt strongly, I would [do the stress test]. But, normally a company would be concerned about costs ...”

Physician: “I want to have this conversation ten years from now ... I need to help you to stay as healthy as possible ... If you were my father, I would have you do it ... If you leave it to me, I would schedule it.”

Patient: “I will take your advice.”

High Group physicians often made statements that suggested they were concerned about their patients as individuals. They liked to make small investments in the relationship when there were special opportunities to build trust and a relationship and to improve adherence *in the future*. Some of the High Group physicians discussed communication approaches that contribute to a strong relationship.

- “It is important ... to spend time not just on why they are there, but about who they are as people.”
- “He really needed to talk about his [epileptic] daughter. It had nothing to do with the visit. It is good for the relationship. It makes it easier next time. It is important he feels comfortable to come in if he has a side effect. I am a Family Practitioner.”

Great bedside manner—One patient’s description

“I have always enjoyed his bedside manner—such a pleasure. He stops doing what he is doing and watches and listens. So many doctors ... may listen, but they are not really there. They are cold and indirect. He makes your day brighter ... He can help you with a lot without sending you to someone else. I think that is a big plus. Others send out for nurses to do bandages, etc ... He makes jokes ... to take your mind off things. He keeps you entertained ... He will listen to your jokes too, even if they are bad!”

The Low Group physicians were less likely to effectively demonstrate their caring to patients. After viewing his tape, one physician expressed his disappointment

that he “didn’t seem warm and fuzzy” with the patient. He was unsure how he could change this perception.

Low Group physicians were also more likely to make remarks that were insensitive or otherwise detracted from the relationship. Some facts can be hurtful if shared insensitively. For example, one physician told his patient that she was 80 pounds overweight in an offhand manner on the way out the door. The patient reported her surprise and distress in the debriefing.

Show Familiarity with the Patient’s Medical or Social History

- The High Group physicians generally knew why the patient was in the office. These physicians did not recall extensive details, but they tended to remember a detail of importance to the patient, such as a recent vacation. One physician said, “I remember her hobbies ... I just remember these things. I am not flipping through the chart to find it.” Many patients mentioned they appreciated the physician who remembered to ask about the spouse’s last visit or last medical or personal problem. Remembering the issue of a spouse or child was endearing to patients. Low Group physicians were more likely to be confused about the reason for the visit or were incorrect about medical or personal history facts.

Provide Detailed Explanation

Explain What is Happening and Why

Patients of all educational levels sought detailed information about what was happening to them and why. “I’m lucky to get him back,” a patient of a High Group physician remarked. “You picked a good person to study. He takes the time to explain. Not all doctors are willing to do that.”

Medium Group and High Group physicians tended to offer more detailed explanation to patients *using simple language* than Low Group physicians. Some of their approaches are described below.

- Several physicians used the “What do you eat for lunch?” approach to explore eating habits. This method took time but provided an excellent teaching opportunity. Patients reported they welcomed such information.
- A number of High Group physicians worked with patients to help them remember to take medications and focused on ways to integrate pill taking into the normal day. They gave concrete suggestions like putting information on the refrigerator, or putting pills in a certain location to include in a daily ritual.

- Many of the High Group physicians discussed ways patients could add more exercise to their routine and helped them problem solve when problems emerged. For example, one doctor understood the patient's reluctance to exercise outdoors and shared her own strategy (exercising when she watches the television news).

Types of Information Sought by Patients

- Should I worry about my symptoms—are they normal?
- What was the doctor learning as the exam was being conducted?
- What is the cause of the symptom?
- Genetic contributions, including racial/ethnic predispositions to diseases
- Treatment options—including nonpharmacologic solutions
- Alternative medicine approaches
- Side effects of treatments
- Explanations using visual tools—illustrations, pictures, sketches
- What can I do to improve my condition?
- How can I overcome various barriers to change (primarily regarding exercise, taking medication, or healthy eating)?
- Handouts to supplement (but not replace) the physician's explanations

An Explanation of Joint Pain to an Overweight Patient

"When we were puppies, all our joints were lined with nice cartilage, all surfaces nice and smooth. As we put on some character, the cartilage started to wear down. It happens on both sides of the bone ... This is classical. You get stiff. As you get older, it deteriorates more, and it gets a gnarly appearance. It depends on the amount of weight you carry and how much you are on your legs. When you get up, it is going to hurt. Eventually there can be no cartilage, you get inflammation and can hardly walk ... Might need an artificial joint. Okay. You are at this stage [pointing to a drawing]. You are a pretty young guy. What would really help you is to bring your weight down. *And I know you are working on that.*"

A patient described how a High Group physician provided the "personal touch."

- *"She comes in and recaps what happened before. She explains the possible side effects. I know what*

to expect. I don't always read the pamphlets. ... She explained everything. I like knowing. Some would say she goes into a lot of detail. I don't mind it. I am interested. She mentioned my wife. She remembers. It is more the personal touch. You get that as opposed to someone you see for the first time. You feel more at ease. Even though this is an HMO. She knows your history. Knows the family history. It is nice to see one doctor all the time. She explains in a way that I can understand. She uses layman's terms. She makes sure I understand. She asks if I have any questions. At least I know. I don't have to worry."

Explaining well requires explaining effectively and handling all issues that the patient raises (although some issues were negotiated to a later visit for some patients).

- *"I had [another physician] that I didn't like. You just want to get out of his office. What is important is that [this physician] answers all the questions and covers all the material ... He is good at explaining things. If there is any doubt, he follows up on things. He cautions on the safe side. He covered all the points and explained what he was doing and what was coming."*

Present Options to the Patient

Full shared decision making was not frequently observed in these visits. However many patients mention liking their doctors because s/he gave them "options." In particular, patients were eager to learn about alternatives to medication. Many patients with chronic conditions were resistant to starting a new medication, especially if it was to be used long term.

High Group physicians typically built a case for a new medication over several visits and repeated information. Several physicians explained that patients want to understand why they need a medication or they would not take it. For example, one High Group physician worked with the patient as an advocate, empathically confirming that the patient did not like medication, and hoping that diet and exercise would work instead, then asking the patient's perspective. Patients complained about physicians who prescribed medication without explaining the reasons for the drug, the side effects, and/or did not seek their perspective. They reported that they did not use those prescriptions and they did not inform the doctor of their decision not to adhere to the plan.

One High Group physician was able to collaboratively work with a patient on psychosocial and health issues. After the patient complained about his relationship with his wife, the physician supported the patient's decision-making process.

Several physicians explained that patients want to understand why they need a medication or they would not take it.

Physician: Is this something you need help on?
 Patient: We tried that ... We saw a marriage counselor ... My wife is defensive. She says, 'He smokes too much; he drinks too much.' It didn't work.
 Physician: Right.
 Patient: Everything wrong is my fault. I can't get her to open up. We have various counselors. One said 'Get rid of her' ... quote unquote.
 Physician: What do you want?
 Patient: I can't afford to divorce.
 Physician: There is a person who comes here, if you want to start with yourself. And then she can recommend what comes next.
 Patient: Also I learned she hates to admit to doing something wrong.
 Physician: The problem is that all these stresses affect your overall health.
 Patient: I know where you are coming from ... [Other discussions followed, including smoking cessation.]
 Physician: So on the counseling, you want to hold off or try that?
 Patient: I have to do something. I am tired of being the bad guy ...
 Physician: See you back in four months.
 Patient: Check my ears for wax before you go? [quick exam]
 Physician: Bingo ... You have some now ... Use these drops.
 Patient: I think I covered all the bases. I accomplished a lot.

example with both the physician and patient comments on the interaction.

Physician: "When he mentioned the tingling, I thought carpal tunnel. He was worried about it being a side effect of the drug. I was sure it was carpal tunnel ... but I did the full exam and I think he is satisfied. He brought it up, so he is worried about it."
 Patient: "He has a lot of knowledge and he expresses it to help you know what is going on ... It's great ... He sets my mind at ease. Either it is not as bad as I think it is or I am not thinking right. I was worried that I was doing more damage ... He explains things in detail ... Nothing is left out ... I bring a list usually and we go down the list and he and I discuss everything on the list ... I like that he spends enough time on each issue and does not push you through. He makes you aware of what he is going to do. You feel a little more at ease."

Factors Not Correlated with Performance

- Length of the visit
- Asking open-ended questions at the start of the visit (almost all physicians do this, so there is no variability)
- Heavy use of closed-ended questioning vs mixed open- and closed-ended questions
- Attitudes toward the use of a computer in the exam room
- Reassurance

Complete the Patient's Agenda Delivering what was Promised; Responding to Questions

Some of the visits with Low Group physicians were incomplete with respect to the patient's agenda. The promised prescription was overlooked or promised materials were not provided. A lab or a referral might not be ordered. Either the patient or the physician noted this in the debrief. If the patient objected in the debrief that a topic was not adequately addressed, the patient's agenda was recorded as not *covered*. A patient concern that was negotiated to a future visit was considered to be *covered*. High Group physicians generally overlooked fewer items and were more likely to mention omissions in the debrief.

Patients were pleased when the physician agreed to pursue an issue that was of interest to the patient, but not the physician. The following is an

In another visit, a male patient asked his doctor about his father's (a previous patient) problem with blood in the urine. The physician took a minute to share some advice. The patient thought highly of his doctor for taking the time to help him understand. The patient said, "*I appreciate her answering my question about him, her explaining the reason. She seems quite concerned. I am very comfortable with her.*" The physician remarked, "*I spent time on this issue. His father used to be my patient. Men don't talk about these things. This must bother him a lot to share this with me.*"

High Group Physicians Describe Their Communication Strategies

During the debriefing sessions, the physicians were not asked about their philosophies of patient care or strategies for interacting with patients, but many of the High Group physicians volunteered general approaches

to working with patients. As a group, the Low Group physicians offered little information about their communication strategies. The approaches they did mention seemed to be less differentiated. For example, some emphasized only the importance of maintaining eye contact with the patient. Some of the Low Group physicians believed that when they had problems communicating with patients, they should be more direct with patients.

In the previous section, the practices that correlated with patient satisfaction were discussed. The following section summarizes the communication strategies volunteered by the High Group physicians. The following is a list, not ordered by frequency of mention by the physicians. Use of these practices may or may not be correlated with patient satisfaction. The High Group physicians mentioned the following approaches to interviewing patients:

Personalized Greeting

As one physician explained, “I spend time greeting and acknowledging each patient. You have to look at each person. Each person is a little different.”

Listening

Listening was widely believed to be a fundamental tool for effective data collection and building a relationship. They mentioned their efforts to:

- Listen with eye contact and full attention
- Give the patient time to explain without interruption
- Acknowledge when the patient is concerned about something
- Try to “catch opportunities to give an empathic response” when the patient has suffered or is worried.

Individualized Approaches

“This [patient] is different. She expects me to take the lead. She was open ... She lets me guide. She is different from other patients. I feel out each patient. Her concern was the heart, so we talked about that.”

“Seeing patients is the best part of the day. I fix every problem I can on each visit. I do not like to bring them back for less important things. *You don't want to prioritize the schedule instead of the patient.*”

Feedback

Many High Group physicians believed it was important to provide generous feedback to the patient about the status of various systems as they progress through the examination. For example, how do the lungs sound? How does this part look? Is it normal?

Being Responsive/Flexible

The High Group physicians tried to respond to inquiries that were important to the patient (even if these were not the most pressing clinical issues)

- They wanted to understand why the patient came in
- Some reported that they modified their own style/approach to each individual patient
- Cultural expectations were salient to some physicians.

Teaching and Explaining

Some of the educational strategies mentioned by High Group physicians included:

- Examining self-monitoring notes that patients do at home—“*If I don't acknowledge their blood pressure readings, then they will stop doing it.*”
- Preparing patients—Helping patients understand why they need to change behavior, why they should take medication, why the treatment is necessary, or why they should submit to a procedure
- Reiterating important messages
- Using visual aids (patients reported this was very helpful)
- Writing things down for the patient. “*She is bright, but she asked several times. I will write it down for her.*”
- Summarizing the plan at the end of the visit
- Seeing patients in the office after the exam, creating a relationship of equals.

Using Pictures: A Powerful Tool

“Most people have no idea of what their bodies are like under the skin.

Every chance I can I use an illustration or drawing. It's one of the most valuable things we have to make things clear to the patient. ... It makes a big difference.

When you make things clear to the patient, he has a better understanding. He knows it is normal and it's progressive. He will be okay ...

It gives them the confidence that, first, I know what I am talking about, and second, that the treatment is aimed at resolving the issue.”

High Group physicians generally overlooked fewer items and were more likely to mention omissions in the debrief.

Covering Topics of Interest to the Patient

High Group physicians tried to be comprehensive, covering questions that were important to the patient, even though these might not be the most pressing clinical issues.

Handling Psychosocial Issues

Many of the High Group physicians wanted to be sensitive to patient fears and work to help patients with their concerns. Approaches to psychosocial issues included: active listening, reassuring, and reviewing what has been done and what actions can be taken.

One physician discussed how a depressed patient was handled.

“Her husband died a couple years ago. They were childhood sweethearts, married since their teens. He died of cancer ... She has been depressed since the death. She was hesitant to try antidepressants. We clarified some issues through talking about her daughter (who is doing well on antidepressants). It was a window of opportunity. There were many fears to address.

“As a physician, you may think you have it all wrapped up. But there is what we know and there is communicating it to the patient. We are educators and we are like salespeople. I think it will make her feel better. This is trying to change behaviors. I am trying not to seem judgmental. She feels guilty about being depressed. It took a lot for her to come in today with all that is going on ... I am sharing what I hear her saying. I acknowledge the pain. There are options [for her].”

Nonverbal Communication

Some High Group physicians were conscious of the nonverbal communication (body language) of both patients and themselves and tried to respond in a positive manner.

Touch

“It conveys I am not afraid to touch them ... More so for kids, the middle-aged, older people, or the sick.”

A patient of a different physician remarked, “The doctor never even physically touched me. That doesn’t instill a lot of confidence.”

Patients often expected a physical examination. Some of the High Group physicians believed that touching was a natural and important element of communication for them. They touch patients on the arm, hand, or shoulder or hug them. One physician explained, “*I use a lot of hand gestures. I am not just talking. Otherwise, they lose interest. It helps.*”

Physicians were sometimes surprised how much they gestured. Patients seldom mentioned gestures, but they

did notice whether the physician was looking at them and sitting down in contrast to standing over them or reaching for the door.

Use of the Exam Room Computer

“The computer changes things.” Many High Group physicians struggled with the positioning of the computer in the room. They disliked being positioned with their back to the patient and wondered about the affect on patients. (The patients in this study did not complain about the computer.) Some reported they tried to finish the notes while the patient is still in the room, although it was not always possible. After reviewing her videotape, one High Group physician decided to stop typing and not look at the computer when giving advice.

Huddling with the Computer to Avoid Having Your Back to the Patient

“I say to the patient, ‘You can watch if you want and make sure I’m typing it right ...’ Patients love it.”

Discussion

The importance of physician-patient communication is well established. From our analysis it is clear that High Group and Low Group physicians communicated differently with their patients and that these differences are noticeable to patients and clinicians.

The findings suggest an approach to improving physician communication with patients. The general theme emerging from this research is the importance of the patient’s agenda. First, identifying the patient’s agenda needs to be part of the physician’s agenda. The physician draws out the patient’s agenda with active listening responses, allowing the patient time to describe their concern(s) and to express their fears, and then asks the patient questions. During this time, a personal connection can be built using empathic statements and showing familiarity with the patient’s history, both of which tend to add depth to the relationship and contribute to the patient’s perception and feeling of being cared for. Next the physician returns to the patient with details to normalize or explain the reasons for the problem and how it might be addressed. The physician explains any options for managing the problems. Finally, the physician verifies that the items in the patient’s agenda were addressed or negotiated to a future visit. Neglected issues interfere with the relationship and the flow of the visit and frustrate the patient and physician.

These findings are compatible with the Four Habits

... identifying the patient’s agenda needs to be part of the physician’s agenda.

Model,^{15,16} which has been widely used within KP to train providers in physician-patient communication skills. The four major categories of the model (invest in the beginning, elicit the patient's perspective, demonstrate empathy, and invest in the end) are well represented in the study's correlational findings and in the communication strategies shared by the High Group physicians. The study findings show specific ways that KP physicians apply the Four Habits.

Sources for Improving Clinician-Patient Communication Skills

- KP Clinician-Patient Communication Intranet Web site <http://kpnet.kp.org/cpc/>
- KP regional programs: Conversations at the End of Life, Communicating Unexpected Adverse Outcomes, Three-Day Intensives, Individual Observation and Coaching, Integrating Communication Skills into HealthConnect Training
- KP Care Management Institute: Health Literacy
- KP National Diversity
- National Institute on Aging: Communicating with Older Adults
- The American Academy on Communication in Healthcare <http://AACHOnline.org>.

Additional research with a narrower focus could be conducted to replicate specific findings of interest suggested by this exploratory research. ❖

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"Narrative is ever present in medicine and is an integral aspect of the doctor and patient relationship ... If the patient's narrative is not heard fully, the possibility of diagnostic and therapeutic error increases, the likelihood of personal connections resulting from a shared experience diminishes, empathic opportunities are missed, and patients may not feel understood or cared for."

— Creswell. Cited in *New England Journal of Medicine*. Book Review. 353: 15, p 1637, Oct 2005, (Progress in Pain Research and Management. Vol 34.) Eds Daniel B Carr, John D Loeser, and David B Morris. Seattle, IASP Press, 2005