Concise Review for Clinicians

Two Words to Improve Physician-Patient Communication: What Else?

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The medical interview is the physician's initial and perhaps most important diagnostic procedure, but physicians vary in their abilities and skills in physician-patient communication. Information gathering, relationship building, and patient education are the 3 essential functions of the medical interview. A physician-centered interview using a biomedical model can impede disclosure of problems and concerns. A patient-centered approach can facilitate patient disclosure of problems and enhance physician-patient communication. This, in turn, can improve health outcomes, patient compliance, and patient satisfaction and may decrease malpractice claims. Physicians can improve their communication skills through continuing education and practice.

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The history and physical examination are completed and tests ordered. The diagnosis has been discussed with the patient. The patient has prescriptions and instructions for a follow-up visit. While the physician and patient are walking to the examination room door, the patient says, "Oh, by the way, Doc…."

Now the patient's most important concern is expressed, and the real reason for the visit is revealed. The physician often must start over despite the previous work and time invested. Why does this happen? Frequently this occurs because of what the physician does and fails to do during the medical interview. This can be avoided in most situations if the physician uses a more patient-centered approach to the medical interview.

WHY SHOULD PHYSICIANS BE CONCERNED WITH PHYSICIAN-PATIENT COMMUNICATION?

Learning about the true chief complaint at the conclusion of a patient visit is not only inefficient but also impedes proper diagnosis and treatment. Poor communication also negatively affects patient compliance and outcomes. Patients complain that physicians do not listen, are hurried, and do not allow them to participate in their care. In this managed-care era, physicians complain that they are hurried and hassled and have insufficient time with their patients. Obtaining the patient's medical history is the most frequent and the most important procedure that physicians perform. Eliciting a complete and clear medical history depends on good physician-patient communication skills. Natural communication skills in physician-patient communication vary as do the quality and quantity of training in medical school and residency. Physician communication skills can improve with attention and practice.

In an editorial, Dr F. Daniel Duffy[1] of the American Board of Internal Medicine cited the many advances in communication skills that are used by politicians and advertisers to exert influence. Physicians and behavioral and social scientists have also been carefully studying the medical interview. Dr Duffy indicated that physicians must be as attentive to developing and refreshing communication skills as they are to developing and refreshing diagnostic and therapeutic skills.

FUNCTIONS OF THE MEDICAL INTERVIEW

The American Academy on Physician and Patient (AAPP) adopted a functional framework for the medical interview.[2] Within this framework, the 3 functions of the medical interview are information gathering, relationship building, and patient education.

In the Kalamazoo consensus statement, the elements of physician-patient communication are expanded to 7 essentials.[3] The key element is establishing a relationship by opening the discussion, gathering information, understanding the patient's perspective, sharing information, reaching agreement on problems and plans, and providing closure.

All 3 functional aspects occur concurrently during a medical interview. One function may predominate in any given interview depending on the nature of the visit, but all are interdependent and essential.

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A question-and-answer section appears at the end of this article.

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Information Gathering

Shifting from a physician-centered to a patient-centered interview style will improve the efficiency and effectiveness of the medical interview. An example of one style of interviewing is as follows.

Physician: What brings you here today?
Patient: I have headaches.
Physician: Where are the headaches? How long do they last? What do you do to relieve them?

This interview follows a physician-centered and biomedical model pattern. In an analysis of interviews in a primary care practice, Roter et al[4] identified 5 communication patterns: narrowly biomedical, expanded biomedical, biopsychosocial, psychosocial, and consumerist. The narrowly biomedical pattern was highly physician controlled, while the expanded biomedical pattern included some psychosocial dialogue but was still highly physician controlled. The biopsychosocial pattern was a balance of physician and patient control and biomedical and psychosocial information exchange. The psychosocial pattern was highly patient controlled and was the most satisfying to patients. The consumerist pattern was controlled by patient questions with the physician supplying information. In this study, 65% of the visits consisted of either the narrowly biomedical or the expanded biomedical pattern.[4] The lowest level of patient and physician satisfaction was with the narrowly biomedical pattern.

Contrast the previous interview with the following interview.

Physician: What brings you here today?
Patient: I have headaches.
Physician: What else?
Patient: Well, I have problems sleeping.
Physician: What else?
Patient: I am very worried about my son. He is using drugs.

This interview follows a patient-centered and biopsychosocial pattern facilitated by the use of what Beckman and Frankel[5] term a *continuer*—a linguistic expression that allows the patient to reveal all his or her concerns at the beginning of the interview. In their classic analysis of recorded primary care office visits, Beckman and Frankel[5] found that physicians interrupt patients an average of 18 seconds after the patient begins to speak. Patients rarely continued to express all their true concerns once they were interrupted. They also found that when patients were allowed to express all their concerns at the beginning of the interview, no more than 150 seconds was needed. Interrupting the patient with questions about the first complaint (not necessarily the chief complaint) and developing the history of that first complaint is the approach that most physicians learned in medical school. When a physician asks a question such as "What else?" or "Anything else?" the patient is allowed to share all his or her concerns at the beginning of the interview. Physicians may think that once the patient has shared all concerns, the 15- to 30-minute visit will become a full general medical examination; however, this need not be the case. Once all concerns are expressed, the physician and patient can set an agenda for the current visit and then arrange subsequent visits to address the less pressing issues.

After the patient has expressed all his or her concerns and an agenda has been set, the physician can explore the complaints. Again, a patient-centered approach yields the best information. The physician should allow the patient to tell the story and guide the patient to provide pertinent details by using open-ended (eg, tell me more about this) phrases and questions as well as specific closed questions. Summarizing what the patient has shared is important to ensure that the physician understands the patient's descriptions and meanings. Summaries can be done during the interview or at the conclusion of the interview before the physician begins the examination or other procedures.

Relationship Building

Along with information gathering, the medical interview functions to help the physician establish a relationship with the patient and often with the patient's family or other support system.

This relationship may be brief, such as occurs in an emergency department or urgent care center visit. In other situations, relationships may develop and continue over a long period. The manner in which the physician begins the interview may determine the relationship. Using phrases such as "What else?" that allow the patient to tell the whole story can certainly build a positive relationship at the outset. The patient-centered interview style also allows the physician to be more attentive to both verbal and nonverbal cues that the patient is expressing. Attention to nonverbal patient behavior can be important in determining the true issues and factors affecting the patient's symptoms, compliance problems, etc. Such things as eye contact, posture, flushing, handshake, and pace of speech reveal a substantial amount of information about the patient's concerns and emotional state.

Although physicians usually recognize the patient's nonverbal cues, they often ignore them or respond with more questions or information. The AAPP recommends responding with a statement rather than a question. For example, the aforementioned patient with headaches also speaks softly and makes poor eye contact. Using a physi-

cian-centered approach, the physician would continue to ask questions about the headache or discuss treatment options for headaches. Using a patient-centered approach, the physician would use a phrase that builds a relationship, such as "You seem very sad (angry, upset, tired, etc)." This acknowledges the patient's emotions and allows the patient to reveal more information. The AAPP suggests the mnemonic PEARLS for this relationship-building aspect of the medical interview: *P*artnership, acknowledges that the physician and the patient are in this together; *E*mpathy, expresses understanding to the patient; *A*pology, acknowledges that the physician is sorry the patient had to wait, that a laboratory test had to be repeated, etc; *R*espect, acknowledges the patient's suffering, difficulties, etc; *L*egitimization, acknowledges that many patients are angry, frustrated, depressed, etc; *S*upport, acknowledges that the physician will not abandon the patient.

Platt et al[6] suggest that physicians need to express "respectful attention" nonverbally and that this is the most powerful way to build a relationship with patients. They expanded the patient-centered interview to include language that can help clinicians learn more about their patients: tell me about yourself—to gain basic psychosocial background; tell me what you expect from this visit—to clarify patient expectations; tell me how this illness has affected you—to determine how the patient perceives the problem; tell me what you think is causing the problem—to learn about the patient's idea of illness; tell me how you feel about this problem—to learn some of the emotional connections.

By using PEARLS and the aforementioned examples, physicians can gather helpful information and build positive relationships with their patients. These 2 factors can result in more accurate diagnoses, patient compliance, and more successful outcomes.

Patient Education

The third function of the medical interview is to give the patient information about diagnosis, further testing, treatment, and prognosis. The relationship built earlier in the interview substantially affects the information-giving aspect of the interview. Keller and Carroll[7] point out that giving information is not the same as educating the patient about the meaning of that information. Education is the complex process through which physicians explain the meaning of the diagnosis, treatment, and prognosis for the patient in the context of his or her life functions and determine the patient's understanding of this information. Because of easy access to the Internet and other sources, Keller and Carroll reiterate that patients usually come to the visit with a substantial amount of information about what they believe their problem is and how it should be approached. Part of the information-giving task is to ask the patient what he or she already knows and thinks about the problem.[7] Clarifying the patient's perspective early can help the physician tailor explanations and enlist the patient in the management process to improve compliance and outcome. Physicians can assume that patients usually have questions but many will not ask questions unless invited. The AAPP and Keller and Carroll suggest an "ask-tell-ask" framework. The physician begins by asking the patient about his or her understanding of the diagnosis and expectations for outcomes with treatments. Then the physician tells the patient the diagnosis and management plan, asks the patient again about understanding, and invites the patient to ask questions. The physician gives the patient the information requested and addresses concerns. The physician again asks for questions, concerns, and understanding until both the physician and the patient have reached a point of understanding and can proceed to treatment, follow-up, etc. This approach is analogous to the "What else?" question used during the interview. It enables the physician to enlist the patient in management, to clarify perceptions and expectations, and to improve compliance.

DOES THE PATIENT-CENTERED APPROACH MAKE A DIFFERENCE?

There is evidence that physician-patient communication can affect patient satisfaction, outcomes, compliance, and malpractice claims. Levinson et al[8] identified differences in communication between primary care physicians with and without malpractice claims. They found that primary care physicians who had no malpractice claims provided more information about the visit, allowed patients to express all concerns and tell their story, checked their understanding of patients' concerns, asked patients what they thought, and expressed warmth, friendliness, and humor. Stewart and colleagues[9,10] reviewed 15 years of literature (1983-1998) to assess articles that analyzed patient outcomes relative to physician-patient communication by using either randomized controlled trials or analytic studies. Of the 22 articles reviewed, 16 indicated positive effects on patient health. These investigators concluded that good physician-patient communication in the medical interview improves patient health by positively affecting emotional health, symptom resolution, function, physiologic measures, and pain control. When patients are not allowed to express their concerns or clarify their understanding, outcomes can be adversely affected. Poor communication during the medical interview can cause a physician to overlook a psychiatric diagnosis or an important psychosocial problem underlying the patient's complaints. Conversely, Stewart and colleagues conclude that outcomes are improved when patients are given the opportunity to tell their story, the physician expresses empathy and understanding, the physician's and the patient's

perceptions and expectations are clarified, and the physician and patient agree on the agenda and goals.

SUMMARY

The medical interview is the most common and critical procedure that physicians perform. The ability to perform the 3 functions of the medical interview—information gathering, relationship building, and informing and educating patients—is enhanced by using a patient-centered approach. This begins at the start of the interview with the physician using language (eg, "What else?") that allows patients to express all their concerns rather than interrupting patients after their first statement. When all issues are expressed, the physician and patient can determine the agenda for this and subsequent visits. Expressing empathy, respect, and support builds positive relationships with patients that facilitate patient education. Physicians can get intensive practice in these communication skills through workshops conducted by groups such as the AAPP and the Bayer Institute for Health Care Communications. Ultimately, better physician-patient communication can increase patient and physician satisfaction, improve efficiency, enhance compliance, and improve patient health outcomes.

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Questions About Physician-Patient Communication

1. Which <u>one</u> of the following is <u>true</u> about a patient-centered interview?
   a. It takes more time than a physician-centered interview
   b. It elicits only psychosocial information about the patient
   c. It uses continuers to allow patients to express all their concerns
   d. It is applicable only to an extended visit, such as a general medical examination
   e. It means only the patient determines the agenda
2. Which <u>one</u> of the following <u>best</u> describes why the physician interrupts the patient during a physician-centered interview?
   a. The patient has disclosed all his or her concerns
   b. About 18 seconds of the interview has passed
   c. The patient is rambling
   d. The physician wants to clarify and check understanding of information
   e. The physician wants to express empathy and concern
3. Which <u>one</u> of the following describes the <u>key</u> functions of the medical interview?
   a. Diagnosis and treatment
   b. Information gathering and patient education
   c. Information gathering, relationship building, and patient education
   d. Information gathering and patient partnership
   e. Diagnosis and patient compliance
4. Which <u>one</u> of the following is the <u>optimal</u> approach for giving the patient information during the medical interview?
   a. Provide printed material about the patient's condition
   b. Explain the condition and treatment carefully
   c. Answer the patient's questions carefully
   d. Use an ask-tell-ask format
   e. Be brief and concise
5. Which <u>one</u> of the following is <u>true</u> regarding the patient-centered interview?
   a. It has no effect on malpractice claims
   b. It can improve health outcomes
   c. It improves patient satisfaction but not physician efficiency
   d. It is a consumerist approach
   e. It does not affect patient compliance

Correct answers:
1. *c*, 2. *b*, 3. *c*, 4. *d*, 5. *b*