2012 David Sun Lecture: Helping Your Patient by Helping Yourself—How to Improve the Patient–Physician Relationship by Optimizing Communication Skills

Douglas A. Drossman, MD[1]

Am J Gastroenterol 2013; 108:521–528; doi:10.1038/ajg.2013.56; published online 19 March 2013

I am honored to have given the 2012 David Sun Lecture on communication skills and the patient–doctor relationship (http://universe.gi.org/viewpres.asp?c=11017) and now to have the opportunity to elaborate further on this topic in the American Journal of Gastroenterology. Over the years, I have become convinced of the value of these skills as a means to increase personal and patient satisfaction as well as improving clinical outcome. So this article is a primer of sorts from research and my 35 years of clinical experience on ways to improve medical communication and the patient–doctor relationship.

THE IMPORTANCE OF COMMUNICATION SKILLS IN MODERN MEDICAL PRACTICE

To begin, we should consider why is it important to improve one's skills in this area. I believe the benefits affect us personally as well as to the health-care system. As practitioners of modern Western medicine, we diagnose and manage patients by ordering increasingly expensive and often unnecessary tests that lead to increases in health-care costs. This is particularly so with chronic or functional gastrointestinal (GI) conditions. This may be occurring because we are no longer comfortable with our clinical judgment and diagnostic skills, we approach human illness from a dualistic (i.e., organic vs. functional) (1) perspective, feeling compelled to "rule out organic disease", the tests are easy to obtain and are perceived as clinically helpful, and we also succumb to practicing defensive medicine in a litigious society. All of these premises, I believe, are disruptive to good care and not necessarily correct (2). In fact, malpractice suits relate more to poor patient–doctor communication and lack of caring than to not doing the right tests (3,4). But clearly these behaviors are enabled by third-party payers who readily reimburse for procedures.

In addition, we note that doctors in academia are becoming more dissatisfied within their careers and find their work less meaningful (5). Within private practice, physicians feel besieged by the changes in the structure and process of health care. This has resulted in higher burnout rates, earlier retirements, and increasing numbers of physicians are leaving health care for other pursuits (6). Notably when asked, practicing doctors disclose that what is meaningful to them are the humanistic interactions with patients: "… when crossing from the world of biomedicine into their patient's world" (6), and these experiences seem to be dissipating. Some have proposed that the human interaction is therapeutic for physicians as well as patients (7). So perhaps in modern health care, we as physicians are losing what is most needed, communicating effectively with patients and enjoying the process.

Given this prospect, the clinician's interest to conduct a carefully constructed medical interview and actively engage with the patient seems to be on the decline. Teaching the medical interview is occupying less time in medical school curricula, and both doctors and patients have become dissatisfied with the utility of the patient–doctor interaction itself. Some perceive that ordering studies can substitute for a good history. Yet, Sir William Osler who is considered the Father of Modern Medicine said: *"Listen to your patient, he is telling you the diagnosis,"* and emphasized that 90% of the diagnosis comes from the medical interview. The shifting of priorities from one-on-one interaction to test ordering probably occurs due to time constraints, poor reimbursement for these services and the inevitable directive to obtain and enter information using the computerized electronic medical record. However, without the human interaction to gather the patient's life history, personal perceptions, attitudes, and behaviors surrounding the medical data, we lose the capability to understand the full picture of the patient's illness, make proper clinical judgments, or develop a gratifying therapeutic relationship (2).

One of the key benefits of having good communication skills is increasing patient satisfaction, and clinicians are now being evaluated for this. There are patient-directed internet evaluation sites of physicians (e.g. Vitals.com, Healthgrades.com) and hospitals and

[1]Drossman Center for the Education and Practice of Biopsychosocial Care, Adjunct Professor of Medicine and Psychiatry, UNC Center for Functional GI and Motility Disorders, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA. **Correspondence:** Douglas A. Drossman, MD, Drossman Center for the Education and Practice of Biopsychosocial Care, Adjunct Professor of Medicine and Psychiatry, UNC Center for Functional GI and Motility Disorders, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina 27517, USA. E-mail: drossman@med.unc.edu

A video of the lecture can be found at http://universe.gi.org/viewpres.asp?c=11167

Received 28 December 2012; accepted 31 January 2013

clinics increasingly rely on patient-based satisfaction benchmarks (e.g., Hospital Care Consumer Assessment of Healthcare Providers and Systems—HCAHPS). Many hospitals focus now on finding ways to move the satisfaction score up a few points to help generate more income, but in my opinion they need to gain insight as to the best ways to accomplish that.

I believe it is sufficient to say that improving communication and the patient–doctor relationship improves satisfaction with care and may help reduce unnecessary health-care costs, though the latter needs to be proven. These are teachable skills (8), and an unanticipated benefit is that when doctors learn and apply good communication skills they also like their patients and job more (9). Finally, the positive impact of good communication skills relates to many other important clinical benefits: the disclosure of more meaningful information, greater patient adherence to treatment, reduced symptom severity and emotional distress, improved physiological parameters, and overall better clinical outcomes (9–16).

EVIDENCE TO SUPPORT THE VALUE OF GOOD COMMUNICATION SKILLS

By the end of the twentieth century, the use of technology in medicine had grown rapidly. Many thought technology would dramatically help to diagnose medical disease, and for some diseases this has been the case. Yet, for functional GI complaints and non-specific chronic symptoms, these improvements in technology have mostly served to exclude other diseases. Indeed, many academic educators and seasoned clinicians extolled the virtues of good communication skills to understand human illness (the patient's experience of ill health and disease) and improve the patient–physician relationship. This included experts in gastroenterology (17–22) and internal medicine (11,23–29). These data were primarily experiential but they shared the common themes.

Then in 2001, the Institute of Medicine published a report designed to set guidelines to improve the quality of health care delivered to Americans: *Crossing the Quality Chasm: A New Health System for the 21st Century* (30). They stated that the health-care system is deficient in meeting the needs of Americans, and there is not just as a gap but a chasm between what exists and could exist. To improve on this, one important directive was to provide patient-centered care. This is care that is be respectful and responsive to patient's preferences and needs, with the patient's values guiding clinical decisions. This is a radical departure from previous concepts of physician-centered care and is consistent with the recommendations being made by the educators in medical communication. The committee also identified 10 rules for redesign and five of them specifically relate to the current discussion: *1. Care is based on continuous healing relationships, 2. Care is customized according to patient needs and values, 3. The patient is the source of control, 4. Knowledge is shared and information flows freely, and 5. The (patient's) needs are anticipated.* This document has served as a template for later attempts to improve health care.

About the same time, a panel of experts seeking to improve the clinical interaction between patient and physician created the Kalamazoo Consensus (31). The document delineated several key components of good communication and patient-centered care: *(1) allowing the patient to complete his or her opening statement, (2) eliciting concerns and establishing a rapport with the patient, (3) using a combination of open-ended and closed-ended questions to gather and clarify information, (4) identifying and responding to the patient's personal situation, beliefs and values, (5) using language that the patient can understand to explain diagnosis and treatment plans, (6) checking for patient's understanding, (7) encouraging the patient to participate in decisions and exploring the patient's willingness and ability to follow care plans; (8) asking for other concerns that the patient might have, and (9) discussing follow-up activities expected of the patient before closing the visit.*

A year later, several investigators published a systematic review of the literature on physician–patient communication from the 26 studies that met their inclusion criteria. They delineated verbal and non-verbal behaviors associated with positive health outcomes: patient satisfaction, adherence to treatment, and patient comprehension (32). The key verbal behaviors positively associated with these outcomes included: *empathy, reassurance and support, patient-centered questioning, explanations, humor, psychosocial discussion, providing health education and information sharing, friendliness, courtesy, orienting the patient during the physical examination and summarization and clarification*. Non-verbal behaviors associated with good outcomes included: *head nodding, forward lean, direct (frontal) body orientation, uncrossed legs and arms, and symmetry (patient and clinician holding similar positions).*

Over the past decade, interest has also focused on understanding patient–physician communication in the age of the internet (33) and with cell phones (34). Within psychiatry, psychology, and primary care, communication skills have evolved into treatment for patients with chronic diseases using Motivational Interviewing. Motivational Interviewing seeks to create a collaborative patient-centered communication that strengthens the patient's motivation to change unhealthy behaviors and resistances to treatment. The strategy has been used for drug addiction, dietary change, medication adherence, and management of chronic medical disorders. The concepts of Motivational Interviewing can also be applied to patients having difficult to manage functional GI or other chronic GI disorders. The concepts include: *(1) fostering patient-centered care, (2) creating a sense of collaboration through empathy, support, and shared-decision making rather than promoting the clinician's sense of "right," (3) enhancing rapport by using open-ended questions with well-timed affirmations and skillful reflective statements, (4) strengthening patient motivation toward behavioral changes that improve health, and (5) avoiding confrontational interactions* (35–39).

RECOMMENDATIONS TO IMPROVE COMMUNICATION SKILLS AND THE PATIENT–DOCTOR RELATIONSHIP

What follows are recommendations compiled from these and other published data and consensus documents along with personal experience. They require a proper patient-centered interview technique utilizing core concepts, verbal statements, and the

context within which they are said and non-verbal behaviors that create a partnership of care. Although much of gastroenterology has become procedure-oriented, clinicians still spend considerable time in consultation or ongoing care of patients with chronic illnesses, unexplained symptoms, and difficult-to-manage functional GI disorders. **Table 1** summarizes many of the points listed below.

CORE CONCEPTS

The core concepts provide the framework for conducting the medical interview. Some may be more applicable than others depending on the clinical situation. Further information can be found from standard textbooks (23,40). A video demonstration of these concepts particularly as related to understanding and managing patients with functional GI disorders can be found at http://www.youtube.com/watch?v=IDaG0rIR-ho.

1. **Listen actively.** The clinical data is obtained through an active process of listening, observing, and facilitating. This is different from some social situations where "collective monologue" occurs: individuals hardly listen to others and wait for a moment to communicate their ideas to them. With active listening, questions are constructed based on what the patient says, rather than from a personal agenda.
2. **Accept the reality of the disorder**. Some clinicians have difficulty accepting functional GI or other somatic symptoms as *bona fide*, as there is no biomarker or specific diagnostic test. This can drive the frequent ordering of tests and lead to communicating uncertainty to the patient. Yet, patients desperately want to be believed. The solution is to accept and acknowledge the symptoms as real and focus on working with the patient on the management of the disorder. Patients with chronic illness are not looking for cure as much as wanting the clinician to listen, show interest and concern, to not abandon them, and to offer support and a sense of hope.
3. **Stay attuned to questioning style and non-verbal messages**. Often, it's not what you say but how you say it that makes the difference. **Table 1** gives examples of verbal and non-verbal behaviors that either facilitate or inhibit the acquisition of data from the patient and help develop clinical rapport and engagement. For example, methods that engage the patient in the care process include: good eye contact, affirmative nods and gestures, a partner-like relationship, closer interpersonal distance, and a gentle tone of voice. These items improve clinical outcome, treatment adherence, reduce symptoms and need for pain medication, and shortened hospital stay (26,41). In general, these behaviors are quadratic in effect, so too much or too little may be non-facilitative (e.g., eye contact). These facilitative techniques are, to some degree, intuitive but improve with training and experience.
4. **Elicit the patient's "agenda".** The clinician needs to identify how the patient understands the illness from their personal and sociocultural perspective. In doing so,

Table 1. Verbal and non-verbal behaviors affecting communication

Behavior	Facilitates	Inhibits
Non-verbal		
Clinical environment	Private, comfortable	Noisy, physical barriers
Eye contact	Frequent	Infrequent or constant
Listening	Active listening—questions relate to what patient says	Distracted or preoccupied (e.g. typing)
Body posture	Direct, open, relaxed	Body turned, arms folded,
Head nodding	Well timed	Infrequent, excessive
Body proximity	Close enough to touch	Too close or too distant
Facial expression	Shows interest and understanding	Preoccupation, boredom, disapproval
Voice	Gentle tone	Harsh, rushed
Touching	Helpful if well timed and used to communicate empathy	Insincere if inappropriate or not properly timed
Synchrony (arms, legs)	Concordant	Discordant
Verbal		
Question forms	Open ended to generate hypotheses	Rigid or stereotyped style
	Closed ended to test hypotheses	Multiple choice or leading questions ("You didn't … did you?")
	Use of patient's words	Use of unfamiliar words or jargon
	Facilitates patient discussion by "echoing" or affirmative gestures	Interruptions, undue control of conversation
	Uses summarizing statements	Not done
Question/interview style	Non-judgmental	Judgmental
	Follows lead of patient's prior comments (patient centered)	Follows own preset agenda or style
	Use of a narrative thread	Unorganized questioning
	Appropriate use of silence	Interruptions or too much silence
	Appropriate reassurance and encouragement	Premature or unwarranted reassurance or encouragement
	Communicates empathy	Not provided or not sincere
Recommendations	Elicits feedback and negotiates	No feedback, directly states views
Asks/provides medical information	As appropriate to the clinical issues	Too many bio-medical questions and too detailed information
Asks/ provides psycho-social information	Elicits in a sensitive and non-threatening manner	Ignores psychosocial data or asks intrusive or probing questions
Humor	When appropriate and facilitative	None or inappropriate humor

the dialog can evolve to a mutually specified set of goals. Several questions can be routinely asked to understand the patient's agenda:

a. *"What brought you here today"*. With chronic illness, there can be many reasons for a visit: symptoms are worse, major psychological stress occurring, worrying about cancer (e.g., family member with similar symptoms), insurance issues, being urged by family, etc. Knowing the reason can help gauge the conduct of the visit.
b. *"What do you think you have"*. Patients have certain concepts or "schema" that are personal, familial, or cultural. They need to be understood and acknowledged before any re-education, if needed, can be done.
c. *"What worries or concerns do you have"*. Patients may not say they are afraid of cancer or that a close family member died of the same disease. By offering the opportunity to express their concerns, the patient is more receptive to hear the clinician's perspective on the matter.
d. *"What are your thoughts of what I can do to help"*. A patient may come for a consultation expecting cure, yet the clinician sees this as a chronic management issue. Thus, after a few months of care, the patient becomes dissatisfied because the expectation for cure, although not discussed, was not met. However, if such differences in expectations are discussed on the first visit, some resolution can be achieved through mutually planning the goals of care.

5. **Work to improve patient satisfaction**. Patient satisfaction relates to the patient's perception of the doctor's humaneness, technical competence, interest in psychosocial factors, and his/her provision of relevant medical information. However, too much focus on biomedical issues can have a negative effect (42,43).
6. **Offer empathy**. Empathy means to demonstrate an understanding of the patient's pain and distress, while maintaining an objective and observant stance. An empathic statement would be: "I can see how difficult it has been for you to manage with your symptoms" or "I can see how much this has affected your life". Communicating empathy among medical students has been reported to decline upon entering the third year of training (44). However, empathy can be taught, and when this is done patient satisfaction and adherence to treatment improves and malpractice lawsuits are reduced (20,45).
7. **Validate the patient's feelings**. Patients may experience shame or embarrassment when about to disclose personally meaningful information. Clinicians not sensing this may respond to the patient's opening statements with judgments, a quick reassurance, or a solution all of which unwittingly tends to shut down communication. Therefore, the clinician needs to provide an air of openness and acceptance and seek to validate the patients' feelings (11). For example, a validating statement to a patient who is feeling shamed or stigmatized by others who say the problem is due to stress would be: "I can see you are upset when people say this is due to stress and you know it's real". This statement can also open the door to further dialog about the role of stress in illness.
8. **Be aware of personal thoughts and feelings or stereotyping that may lead to unequal treatment**. Patients may interact in ways that seem overly cautious and "resistant" to recommendations, or even demanding or adversarial. This may relate to undisclosed previous life experiences, including in early life or with their health care. Some clinicians may react defensively by getting angry, doing unnecessary studies, or overmedicating. The clinician needs to understand these behaviors as responses to factors that need to be understood. In addition bias and stereotyping, although not necessarily conscious, may lead to ethnic disparities and unequal treatment. This may more likely occur in situations of clinical uncertainty or time pressure.
9. **Set realistic goals**. Patients may come to the doctor with expectations for a rapid diagnosis, perhaps of a structural disease, and for a cure. However, the clinician may see this as a chronic disorder requiring ongoing management. So often these differing goals are not articulated at the outset, so the patient may return several months later feeling dissatisfied that the goals were not met. Therefore it helps to clarify the patient's goals and reconcile them to achieve a consensus for the care. For example, the clinician might say: "I can understand how much you want these longstanding symptoms to go away, but realistically we need to find better ways to manage them, just like arthritis or migraine headaches. If you could reduce your symptoms by 30% or 40% would that help?" In this way, the patient is introduced to the idea of management of a chronic illness and of setting realistic goals.
10. **Educate.** Patient's education is required for any visit and is an iterative process. It involves: (1) eliciting the patient's understanding, (2) addressing misunderstandings, (3) providing information that is consistent with the patient's frame of reference or knowledge base, and (4) checking the patient's understanding of what was discussed. Explanations for pathophysiology of symptoms and treatments must be understandable and relevant to the patient's beliefs. For example, when discussing the basis for irritable bowel syndrome pain, one can explain that it relates to an oversensitivity of the nerves in the gut (e.g., due to visceral sensitization, altered microflora, immune dysfunction) and/or in the brain's failure (e.g., via stress mediated pain modulatory center) to "turn down" the pain signals coming from the gut. This plausible hypothesis can open the door to further discussion about testing and treatment options (e.g., psychological treatment or antidepressants).
11. **Reassure**. Patients often fear serious consequences of their disease and may feel helpless, vulnerable to their condition, and out of control. Reassurance occurs

by: (1) identifying the patient's worries and concerns, (2) acknowledging and validating them, and (3) responding to their specific concerns. It's important to avoid premature or "false" reassurances (e.g., "Don't worry, everything's fine") particularly before the medical evaluation is completed. Although perhaps well meaning, these statements can have negative effects on patients who may view them as dismissive or diminishing what they have as not important.

12. **Negotiate**. The basis for patient-centered care is that patient and physician must mutually agree on diagnostic and treatment options. The doctor should ask about the patient's personal experience, understanding, and interests in various treatments, and then provide choices (rather than directives) that are consistent with the patient's beliefs. Consistent with the IOM guidelines (30) the patient needs to make the final decision in these options.
13. **Help the patient take responsibility**. Many patients may respond to their illness by feeling helpless and dependent on the clinician, thus abrogating their responsibility. However, patients with chronic illness do better when they take responsibility for their care and the clinician must encourage this. As an example, rather than asking the patient: "How is your pain doing?" one might say: "How are you managing with your pain?" The former question tends to leave the responsibility for dealing with the pain with the physician, while the latter acknowledges the patient's role. This also offsets any negative feelings by clinician's who feel pressured to take more responsibility than needed. Another method includes offering any of the several treatment approaches with a discussion of their risks and benefits, so that the patient can make the choice.
14. **Establish boundaries**. For some patients, it is important to establish and maintain "boundaries" related to frequent phone calls, unexpected visits, a tendency toward lengthy visits, or unrealistic expectations for care. The clinician needs to present expectations in a way that is not perceived as rejecting or belittling to the patient yet is also consistent with personal needs. For example, if a patient calls by phone during off hours when not on call, the clinician can gently remind the patient that it would be better to have the discussion in the office or at the next visit. Here it is important not to try to address the issue on the phone as that might encourage further phone calls.
15. **Be aware of time constraints.** It is a given that clinicians have less and less time to spend with patients. Learning high quality skills can actually save time by establishing a satisfying relationship with only a few simple techniques as noted. For example, some patients may desire more time or make frequent phone calls. Setting limits on time can be accomplished by scheduling brief but regular appointments of a fixed duration, rather than attempting to extend the time of a particular visit.

VIDEO DEMONSTRATIONS ON COMMUNICATION SKILLS AND THE PATIENT–DOCTOR RELATIONSHIP

The techniques listed above do not need to take time. Rather, they can accomplish more in less time. Please review how these principles are demonstrated through two vignettes demonstrating ineffective and effective approaches with the same patient and in approximately the same time. The following link: http://www.vimeo.com/59259673 (password: DCP001), includes the two interviews and a discussion of the communication skills being demonstrated in the vignettes. The reader can also review the dialog of this video in the Appendix. In addition, the application of the core concepts of understanding and managing patients with functional GI disorders is discussed at http://www.youtube.com/watch?v=IDaG0rIR-ho.

REVIEW

CONFLICT OF INTEREST

The author declares no conflict of interest.

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APPENDIX—CLINICAL DIALOG

EXAMPLE OF INEFFECTIVE PATIENT–PROVIDER DISCUSSION

Narrator: "So much of the provider–patient relationship is not "what you do" but "how you do it". Let us have a look at the two approaches to a patient seeing a gastroenterologist for her symptoms. Ms. Simpson is a 38-year-old woman with a history of several years of abdominal pain and bowel difficulties. Blood studies, barium enema, and CT (computed tomography) done in the past few years are negative. She has been on numerous medications, including antispasmodics, fiber, probiotics and antibiotics, and has not responded. She has become depressed and frustrated and asked her doctor to refer her for a second opinion."

Dr (patient enters and sits in chair, doctor seated at computer, briefly looks up) "How can I help you?" (Looks back to computer typing)

Pt. "Well, when I came back from vacation, I got a flare up of whatever it is I have … nausea, diarrhea fatigue, and stomach pain,… (*pause*) …. So Doctor Jones thought I should see you …"

Dr (*interrupting*)" Was this like something you've had before?"

Pt. "Well, Yes, but … it's never been this bad"

Dr "Is it made worse by food?" (*Looks up*)

Pt. "No, well, maybe, but I don't eat much when it gets bad. Do you think it's something I ate?"

Dr "I don't know yet. (*Turns to patient*) Did you have diarrhea, or fever?"

Pt. "I think so … but I didn't take my temperature"

Dr "So you have diarrhea and fever?"

Pt. (*leans back*) "Uh no, I get constipation too …. But that's normally when I'm not eating well. I know some diets can help, and it's important to eat regular meals right? (*Dr briefly acknowledges*) I do know that if I eat fatty foods I get pain and I feel queasy right here (*pointing to epigastrium—not looking at doctor who ignores as typing on computer … pause, patient starts to look concerned*) Dr I'm really worried about this."

Dr (*Ignores affect, looks back at patient*) "I'm sorry I'm not quite following. What type of bowel problems did you say you are having?"

Pt. "(*Folds arms*) Normally I get constipation but when it's really bad I have diarrhea too."

Narrator: "This is not going too well—can you see some reasons why?"

Dr (*looking frustrated*) "OK, OK, I want to do a physical examination and then maybe we can talk about the plans OK? (*Patient looks dissatisfied*)

[FADE OUT FADE IN—AFTER PHYSICAL EXAM]

Dr Well everything seems ok. What I'd like to do is a blood test for celiac disease and then I'd also like to do a colonoscopy. (*Patient looks surprised)* No, it'll probably be ok, this way we'll be sure there is really nothing to worry about. So don't worry."

Pt. "Doctor, What is it that I have? You know I've been reading online about patients that have the same symptoms that I do and they call it irritable bowel syndrome. Is that what I have?

Dr "Perhaps, but I think we first need to rule out anything organic.

Pt. "What's 'Organic'"?

Dr "I mean something specific that we can treat. If the studies are negative then what I'd like to do is put you on an antidepressant and that will make you feel more comfortable with your symptoms."

Pt. (*looking confused*) "Doctor I'm not depressed …. I just can't deal with the pain. I …."

Dr (*interrupting, turns back to patient*) "No, I'm sorry; I didn't say you were depressed. These medications can help your symptoms … Look, let's just see what the tests show and then we can take it from there, OK? (*Patient looks disappointed*)"

Narrator: "There are several observations to address in this dialog. The dialog did not disclose much relevant clinical content; it demonstrated ineffective communication skills and did not enhance the physician–patient relationship.

1. The body language interfered with good communication
   a. He did not introduce himself to the patient
   b. There was little eye contact
   c. The doctor faced away from the patent and looked at the computer most of the time
2. The interview method was non-facilitative and did not disclose helpful information
   a. The doctor was not actively listening and spoke from his agenda rather than the patient's
   b. He asked closed ended, at times multiple-choice questions and frequently interrupted
   c. His voice was clipped and rushed and he seemed frustrated when not understanding the interview.
3. After the physical exam, the education and treatment plan was ineffective
   a. He recommended tests without summarizing his observations, making a diagnosis or offering education
   b. He attempted to reassure that the test would be normal and not to worry; this ended the discussion and left the patient disappointed
   c. He delegitimized irritable bowel syndrome as a possible diagnosis
   d. In a dualistic fashion, the doctor sought to identify "organic" conditions which he presumed are more treatable.
   e. His suggestion to take an antidepressant to be more "comfortable" was rejected by the patient who assumed it was given for depression, which she did not believe she had."

EXAMPLE OF EFFECTIVE PATIENT–PROVIDER DISCUSSION

[Narrator—Let us see how a more effective interview technique can be applied with the same patient]

Dr (*at computer, turns to greet patient*) "Hi, Ms. Simpson, I'm Dr Drossman, How can I help you?"

Pt. "Well, I came back from vacation, and I got a flare up of whatever it is I have … stomach pain, nausea, diarrhea, fatigue, … (*pause*) I just got this new promotion at work to floor supervisor, and then all this happened … It started with the muscle ache and then fatigue … and then I started getting queasy and having pain. It was worse after I ate …. it was kind of like a stomach virus, I felt warm, I didn't take my temperature, so I don't know, but … It was definitely getting worse. I went to see Dr Jones and I asked him what he could do to help me and he thought I should come see you"

Dr "Tell me more about the symptoms, like what makes it better or worse?"

Pt. "Well it's definitely better after a bowel movement, and its worse after I eat, or when I'm upset. (*Pause*) I'm really starting to worry about this.

Dr "I see …. (*Pause*)

Pt. "(Continues) … I don't feel like I can go work out, or go out to eat … and I just got this job, and I'm just worried, what if I can't do it? And at home I just don't feel I'm doing a good job there either. My kids are great, you know, they help out and all but ….. I just don't know."

Dr "I can really see how this is affecting your life"

Pt. "Sometimes I feel like no one understands.

Dr" It's gotta be hard when people don't really understand what you're going through. (Pause) … So what do you think is going on?"

Pt. "I don't know …. I have been reading on the internet and it seems there are other people that have the same symptoms, and they call it 'Irritable bowel syndrome."

Dr Yes, Irritable bowel is a possibility, and if that's what you have I want to be sure you get the right information. You know there is a lot of research going on now to help find better ways to treat that condition (*patient nods*). So these are one of the things we'd be thinking about … we want to do some other tests and then we can take it from there.

[FADE OUT AS DISCUSSION CONTINUES AND FADE BACK IN]
Dr Well, this has certainly been helpful. So what I'd like to do is why don't you get into a gown and we'll go ahead and do a physical examination and then we'll come back and take it from there.

[FADE OUT FADE IN]
Dr (*after examination*). Well you know I can see that you've had two extensive medical evaluations, and between that, the fact that your symptoms haven't changed any, and from our medical evaluation, I do believe you have irritable bowel syndrome *(patient nods in agreement*). So I think I'd like to work more on managing your symptoms rather than doing other tests that may not be necessary *(patient nods in agreement)".*
Pt. "So … what do we do?
Dr "Well there is no magic pill, I think you know that, but we can work on this. I can see that these symptoms have had more effects than just the pain. This affected your quality of life, your relationship with others (*patient nods*) … so, while we are working on your symptoms I'd like to have Dr Johnson, who is a colleague of mine, a psychologist help you develop coping strategies to help you get back to a more normal lifestyle."
Pt. But you'll still see me too, right?
Dr "Oh yes of course. Dr Johnson will be part of our health-care team, and we'll be focusing more on the medical management. And in that regard, you've been on a lot of medicines that haven't been very effective. I'm thinking we might want to get something that might work a little bit better for you … it's a type of antidepressants that helps with pain.
Pt. "(*looks confused*) Do you think I'm depressed?"
Dr "What are your thoughts about that?"
Pt. "Well (*pause ... thinking*) maybe, because of the symptoms?"
Dr Well you know medications have different effects. Aspirin for example can be used to treat pain but they also can prevent a heart attack. And just like that the antidepressants in addition to treating depression can actually act as pain modulators. (*Uses diagram of brain–gut axis*) They can block pain signals going from gut to the brain and in blocking the pain; it can raise your pain threshold. That's in addition to … if you are having any depressive symptoms, it could help that as well. But whatever you decide we'll be working together on this to modulate your symptoms and get you to a better place."
Pt. "Okay. I'll give it a try. Thanks doctor." (Patient smiles)
[Narrator] "Although the number of iterations for these dialogs are almost the same, the second one discloses more relevant clinical content, demonstrates good communication skills and enhances the physician–patient relationship.

1. The body language facilitated to good communication.
   a. The doctor greeted the patient with a handshake and maintained an open posture.
   b. He engaged with the patient with more affirmative head nods, good eye contact, a gentle tone of voice and close interpersonal distance.
   c. Then the patient showed acceptance and satisfaction rather than confusion and discomfort as occurred in the first interview.
2. The interview method was more facilitative
   a. The doctor gave the patient the opportunity to tell her story in her own way
   b. He expressed empathy for her concerns and validated her beliefs.
   c. Then the patient disclosed about stresses contributing to her symptoms and how the illness might further affect her ability to handle her job after being promoted.
   d. Education was provided as a dialog, as he asked for the patient's ideas.
   e. The doctor listened actively: his questions and responses were based on what the patient said rather than any personal agenda.
3. After the physical exam, the education and treatment plan was more effective
   a. The doctor summarized his observations,
   b. And affirmed the diagnosis of irritable bowel syndrome
   c. He recommended the psychologist as part of a team approach to care.
   d. Then using a diagram, he recommended the antidepressant as a way to treat the pain.
   e. At the end, the doctor offered to work collaboratively and with an interest to continue the care in a partner like relationship"