A PIECE OF MY MIND

Questioning a Taboo
Physicians' Interruptions During Interactions With Patients

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A seminal event occurred in 1984. Howard Beckman, MD, and Richard Frankel, PhD, published a study[1] reporting that physicians interrupt patients, on average, after 18 seconds during an encounter. According to Google Scholar,[2] this study has been referenced 1115 times in academic journals and books, 50 times alone in 2016. The mainstream press picked up on this study with titles such as "Study Finds Doctors Aren't Good Listeners" or "Prescription for Doctors: Listen More."

In light of the 1984 finding, how many students, residents, and practicing physicians in the last 30 years have been told not to interrupt patients? This admonishment is well intentioned. Most people associate interruption with rudeness, often leading to patient complaints. Skillful listening is essential to accomplish critical health care functions such as identifying the reasons patients request care, making accurate diagnoses, conveying empathy and support, exploring self-management challenges, and more. Yet there is a nagging question: Should physicians never interrupt their patients?

Over the years I have asked scores of physicians and many psychotherapists, "Do you ever interrupt your patients?" I have received two answers: "Yes" and "Of course." Frequently the respondent laughs sheepishly as if to say, "I know I'm breaking a rule." What does the literature tell us about interruption in the medical encounter? Early research examining interruption of patients stressed physicians' tendency to assert and retain power in the relationship. Subsequent studies provide a broader, more nuanced view. Physicians and patients interrupt one another often, and patients interrupt at least as frequently as physicians.[3] Not all interruptions are intrusive, competitive, or power-claiming.[3] While some interruptions are classified as neutral, others build rapport, offer support, and express cooperation.[4] The frequency of interruption varies among visit phases.[5] The first phase combines rapport building and agenda setting. A middle phase focuses on diagnostic inquiry and hypothesis testing. The final phase is treatment planning. Physicians tend to interrupt in the earlier phases of the visit using questions to clarify symptoms or concerns. Later in the interview, patients may interrupt more often using statements more than questions.[3]

Despite this research, writings and teachings claim that interrupting patients is taboo. Can some interruptions improve the quality of care and help the patient and physician make better use of time? I believe the answer is yes. Allow me to share a few examples from different situations when interruptions might improve health care efforts and decrease physician stress.

Let's start with the critical, agenda-setting phase, when patient and physician should identify and prioritize issues to address during the visit. A physician who understands the 18-second interruption study[1] may be more effective at agenda setting. Beckman and Frankel classified four physician behaviors as interruptions when used during the opening moments because these behaviors distracted the patient from sharing additional concerns. The first form of interruption is an "interrogative" or closed-ended question, such as "How long have you had this pain?" This interruption inaugurates a string of diagnostic questions that are virtually automated behaviors rooted in medical training. Second, an "elaborator" encourages a patient to continue speaking on a topic. For example, "Tell me more about your pain." A third form is a "recompleter," a way of reflecting or confirming the patient's statement. For example, "So, your pain is waking you at night." Both the elaborator and the recompleter encourage patients to go into greater depth on a single issue. Fourth, a statement such as "Let's figure out what is going on" interrupts the patient from naming new concerns. While all of these physician comments may be helpful later in the visit, when used early they interrupt the process of agenda setting.

Beckman and Frankel did not code asking "anything else" as an interruption because it prompted the patient to name other concerns, even though it may have "interrupted" some patients from sharing more details about their first concern. Beckman and Frankel's rationale made sense then as it does now. The first reason for the visit may not be the only or most important concern. Knowing about all the concerns at the outset of the visit helps the physician develop hypotheses, plan time use, and significantly decrease the chance that the patient or the physician will raise "Oh, by the way" concerns late in the encounter.[6] To help physicians with agenda setting, I teach a more elaborate form of asking "Anything else?"

Excuse me for a moment. Your knee has been painful. Before we talk further about this pain, I'd like to know if you have something[7] else important to address today. This way you and I can figure out how to make the best use of our time.

In teaching this verbal script, I make it clear that it does "interrupt" the telling of a story in favor of determining if there are other stories that the patient wants to reveal. Once planning the visit is complete, the Beckman and Frankel interruptions become desirable skills to help patients tell their most important stories.

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A frequent source of frustration for physicians occurs when patients speak tangentially, bringing up a new topic. This common occurrence can pull the interaction off course, resulting in lengthened visits, inefficiency, and compromised quality of care. Respectfully phrased reassurance and recognition combined with an interruption to redirect the patient can be helpful. A behavioral health colleague compared the use of interruptions when patients shift topics to extending the bumpers in a bowling alley. Just as bumpers help the bowler hit the pins, interruptions can help patients stay on topic. What might a topic tracking[8] interruption sound like?

Excuse me, your back pain sounds distressing, but we were only part way through addressing your asthma. How about we finish the asthma and then see if there is time for your back pain?

Another example of helpful interruption is when a patient "drops" a verbal or nonverbal cue deserving exploration. Evidence suggests that investigating a cue is associated with shorter visits[9]:

Excuse me, before we continue, you just mentioned something that sounded important. Tell me more about … that you do not always feel comfortable at home … that you do not trust your most recent blood sugar results.

The reader is no doubt wondering about the patient who is repetitive, disorganized, or circumloquacious.

Forgive me. You are sharing a lot and I can see you are really bothered about … your headache, fatigue, allergy, stomach pain … and this is frustrating and scary for you. I would like to switch gears and ask several specific questions, then do an exam to make sure we develop a plan that works best for you.

The interruption examples above have three elements in common that I call The Triple E. The first "E" element is *excuse* yourself. This element asks the physician to acknowledge when making an interruption. The second "E" is *empathize* with the topic being interrupted. Letting the patient know that the physician has heard the patient's pain or fears decreases the chance that the patient will feel disrespected or discounted. The final "E" element is *explain* the reason for the interruption. When physicians make their reasoning transparent, patients feel involved and respected.

Interruption is a sharp knife. Respect for the patient and quality of one's relationship should always influence the decision to interrupt. The patient who begins a visit telling an emotionally laden story, often about loss or fear, needs to be listened to. Those who take this essay as a license to discard respect for the patient, are practicing a form of interruption that those 1115 citations of Beckman and Frankel's study are working to avoid.

For the busy physician, when you interrupt your patients, how are you perceived? Do your patients understand your reasoning and continue to feel your care and respect? Do patients appreciate your ability to organize the interview into a productive encounter? Do you ever use interruptions to ensure that patients tell their stories but stay on track? What are the most common ways you interrupt? I hope this essay helps you reflect on your own behavior and become mindful of what you say, when you say it, and why you say it.

To those who teach communication skills, can you help your trainees distinguish between respectful interruption and less helpful forms? I hope this essay helps you identify nuanced skills to help trainees make the best use of time[8] without sacrificing the development of respectful relationships that build patient investment in their health care.

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