Connecting With Patients—The Missing Links

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These are trying times for the patient-physician relationship.[1,2] Patients frequently report that their physician is not listening or, at least, that they do not feel heard.[3] Some research suggests they are right—sometimes their physicians are not listening.[4,5] Appointment times, although short, are longer than in the past and have increased from just over 15 minutes in 1995 to more than 20 minutes in 2015.[6] However, too much of that time is directed not at the patient but at the patient's virtual self, at what Verghese[7] has called the "iPatient" via the now omnipresent electronic medical record (EMR). In their enterprising Special Communication in this issue of *JAMA*, Zulman and colleagues[8] point out that care has become more impersonal, creating an environment in which understanding patients and their symptoms and concerns is made even more difficult.

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The benefits of good communication and a strong patient-physician connection cannot be overstated. Evidence and experience show that this connection improves diagnosis,[9] adherence to prescribed regimens,[10] and even some outcomes.[11] For example, in a study conducted in 2009 that included 583 physician-reported errors, Schiff et al[12] found that the greatest percentage of diagnostic errors occurred in the examination room, and many were related to an inadequate history.

Even when no error occurs, many patients are dissatisfied. Recently, a Twitter hashtag ("#patientsarenotfaking") accumulated over the course of just a few days some 70 000 patient stories of feeling not heard or not believed.[13] This sense of alienation that patients feel contributes to physicians' sense of frustration and alienation. Indeed, many of the same aspects of medicine lead to dissatisfaction for both patients and physicians.[14]

The study by Zulman et al[8] in this issue of *JAMA* offers 5 specific behaviors, or what the authors refer to as "practices," to help physicians communicate their own sense of engagement and promote a more meaningful connection with patients, especially at the start of the visit. The authors used innovative methods to identify and analyze evidence-based practices shown in the literature to enhance communication and connection, then reached beyond the published studies and even beyond medicine. They observed patient encounters with physicians who were perceived to excel at patient-physician communication and sought input from individuals in other industries in which communication and connection were key to identify effective practices in these settings. The authors then culled from these various sources a list of 13 behaviors.

These activities were then presented to a panel of experts who used a modified Delphi process to identify the "top 5" practices. Panel members were given the literature for each of the behaviors and were asked to rate the them based on 3 criteria: effect on the patient experience, effect on the clinician experience, and implementation feasibility. Each behavior was rated using a 9-point Likert scale, and those that were rated in the top quarter in all 3 domains were carried forward. The remaining 8 practices were compressed to the final 5 recommended behaviors to best promote a goal first described 30 years ago as "patient-centered" care.[15] The list contains no surprises. The authors recommend that physicians (1) prepare with intention, (2) listen intently and completely, (3) agree on what matters most, (4) connect with the patient's story, and (5) explore emotional cues.

This study is the newest addition to a long literature on patient-physician communication. The authors' stated goal is to identify a handful of evidence-based behaviors that they hope will be easy to remember and easy to implement. Some of these practices are easy, or at least concrete; physicians are asked to "prechart" for each patient if possible, and if not, at least to review a patient's medical and social history before entering the examination room for the visit.

Once there, the advice is to adopt a posture of listening and attentiveness and avoid interrupting a patient during his or her explanation of the reason for the visit. Negotiating an agenda with the goal of encouraging patients to identify what is most important to them is key. Other medical communication experts might recommend switching items 2 and 3 so that a physician spends precious visit time listening attentively to what is actually most important to a patient.[16,17] Use of these techniques will not only help physicians to appear to be engaged but actually to *be* engaged to create the therapeutic relationship needed to get patients to take their medicine—both literally and metaphorically.

Other recommended practices are more ephemeral: physicians are advised to "connect with the patient's story" by considering the circumstances that influence a patient's health and to "explore emotional cues." These practices go beyond simple, easily described behaviors and edge into areas at the periphery of physician comfort zones—at least for some physicians toward whom these practices are directed. Yet, attending to a patient's story and emotions is likely critical to improving both the patient's and the physician's experience of care. Moreover, this practice can in fact save time. For example, Levinson et al[18] showed that visits were shorter when internists and surgeons responded empathically to their patients' emotional cues.

Traditionally, teaching these parts of patient care depended on physician role-modeling, whereby learners spent time with good clinician-teachers to absorb these skills. In the last quarter of the 20th century, efforts were made to measure the effectiveness of these skills. But because outcomes remained difficult to quantify, much of the evidence is weak. This Special Communication article by Zulman et al is the newest, and perhaps the most evidence-based, addition to a trend to cull clinical wisdom and knowledge, the so-called art of medicine, into specific practices that can be recalled and implemented by physicians in daily encounters. Although no one can be taught to be an artist, it is said that everyone can learn to draw. This article aspires to be the "drawing lessons" designed to help physicians acquire these skills of connection.

Moreover, at a time of increasing intrusion into the patient-physician relationship, the recommended behaviors are reminders of the importance of "humanness" in clinical care.

Zulman and colleagues acknowledge that they do not know how these practices will affect either patients' or physicians' experiences, and recommend that these behaviors should be tested in clinical settings. However, even though the authors specifically looked for practices that could be incorporated into medicine as it is practiced now, how medicine is practiced now is very much a part of the problem. Exhorting physicians to adopt these practices will have limited effect unless some fundamental barriers of the current system are addressed.

First and foremost among these barriers is the EMR as it currently works. Although EMRs were mandated a decade ago to make medicine better, as currently configured, some contend that the EMR actually makes caring for patients much more difficult. A recent study found that EMR design and use were leading factors associated with clinician stress and burnout.[19]

Second, time in the clinical encounter remains a barrier. Although the average visit time has increased by nearly 5 minutes over the past decade,[6] concern about time runs throughout the article by Zulman et al. The authors sought items that would add no time or only a little time to a visit. However, visits are already so crowded with requirements that patients' concerns and their goals, although elicited, can often not be addressed.[20] The authors suggest that "implementation might be a challenge in settings with minimal time between visits." Yet most practices have physicians move from room to room. The medical system needs to change to decompress physician workflow and allow for preparation and thought.

Third, the suggested 5 practices may be easy to implement for patients with straightforward needs, but may be more difficult to adopt for patients with more challenging conditions or concerns. These may include, for example, patients with chronic pain, those with medically unexplained symptoms, those with multiple chronic illnesses, or those who have experienced a medication or surgical error. These patients and their visits will be challenging to navigate no matter what is in a physician's toolbox.

The 5 practices identified in the Special Communication by Zulman et al are already well known and well understood. Repackaging them in this manner is a useful and important service, reminding physicians of what they once learned and of the physician they imagined becoming. While it remains to be seen if implementing these behaviors will do much good, it is difficult to imagine that they would do harm. Yet no matter how well they work, these practices are an inadequate remedy for the ailments of medicine as it is practiced now. Physicians need to move beyond gestures and techniques to recreate a system that values the patient-physician interaction and recognizes that this relationship is one of the most powerful diagnostic and therapeutic tools in medicine. Patients and physicians recognize this, and these practices may help implement it. What remains missing is a system that supports and values this critically important relationship.

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Conflict of Interest Disclosures: None reported.

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