

# **James L. Holly, M.D.**

## **Continuity Creativity Consistency Part VII The Patient Centered Conversation By James L. Holly, MD *Your Life Your Health* February 2, 2017**

One of the most elusive aspects of the Patient-Centered Medical Home is, “How do you modify, change, or transform the patient encounter into a patient-centric conversation, which encounter has always been provider-centric, or health-science centric?”

The structure, the spirit and even some of the content of a patient-centric conversation in a patient encounter is suggested by the content of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The HCAHPS survey is required by accreditation bodies for hospitals. While these survey questions were not specifically designed on a patient-centric model, they are helpful in beginning this discussion. Here is what the patient is asked about their interaction with their physician while in the hospital:

1. “Did your physician and his/her team explain your care plan to you? Yes No
2. “Did your physician and his/her team answer all of your questions? Yes No
3. “Did your physician and his/her team listen to your questions or comments without interrupting you? Yes No
4. “Did anyone (doctors, nurses or other hospital staff) ask if you have the help you will need at home once you leave the hospital? Yes No
5. “Did your physician give you in writing the symptoms which would make you need to return to the hospital or get immediate help? Yes No Did they explain this in a way you understood? Yes No
6. “During this hospital stay, how often did SETMA’s doctors treat you with courtesy and respect? Always Sometimes Not at all

Number three is one of the most important issues in regard to the patient-centric conversation. One of the major complaints from patients is how often and how quickly healthcare providers interrupt them while they are relating their illness, or answering a question. The interruption is not out of rudeness, typically, but often the provider gets to the answer before the patient gets to the end of his/her story. Patient-centeredness respects the patient’s need to tell their story themselves.

In a March, 2008 seminal study, Dr. Carlos Jaen, Chairman of Family and Community Medicine and holder of the Dr. and Mrs. James L. Holly Distinguished Chair in Patient-Centered Medical

Home at University of Texas Health Science Center San Antonio School of Medicine, discussed, “What is Patient-Centered Communication?”

This study was introduced with the observation that “despite our efforts between 30 and 80% of patients’ expectations are not met in routine primary care visits,” and “often, important concerns remain unaddressed because the physician is not aware of the patient’s worries.”

Other deficiencies of non-patient-centric communications are:

- “Physicians often redirect patients at the beginning of the visit, giving patients less than 30 seconds to express their concerns.”
- “Later in the visit, physicians tend not to involve patients in decision making and, in general, rarely express empathy.”
- “Patients forget more than half of the physicians’ ...recommendations...not surprisingly, adherence to treatment is poor.”

Dr. Jaen defines “patient-centered communication” as “focusing on the patient’s needs, values, and wishes and is associated with improved patient trust and satisfaction.”

In a physician-dominated medical encounter, there is little opportunity for the patient to have input, such as the following:

Doctor: “So, what brings you in today?”

Patient: “My back has been bothering me.”

Doctor: “What kind of work do you do?”

In this encounter, the patient expresses a concern but the physician cuts the patient off and does not inquire further about that concern or other concerns. When the provider cuts the patient off and/or appears impatient, the patient will resort to monosyllabic answers such as “Yes” and “No.” When that happens, the patient has assumed a passive mode and is no longer actively engaged in the encounter.

In a patient-centered encounter, the patient expresses a concern, the patient has time to give more relevant detail, the physician initiates further exploration, expresses empathy, “I bet that really hurts,” and the patient confirms that he/she felt understood. Dr. Jaen identifies two important elements of a patient-centered communication:

1. Drawing out a patient’s true concerns
2. Identifying which concern to address first

Two invalid assumptions physician-dominated encounters make is that the first concern a patient mentions is the most important one and that patients will spontaneously report all of their fears and concerns.

The ideal nature of a patient-centered medical encounter is when there is “explicit agenda setting” for what will be addressed. The dialogue of such a visit would go like this: “So, what brings you in today?” “My back has been bothering me?” “I am sorry to hear that. Before we go further, though, I’d like to find out if there is something else bothering you.” The patient

expresses a concern and the physician provides empathy, deferring further discussion pending other issues being identified.

**Definition:** A Patient-Centered Communication requires the primary care team to elicit all of a patient's concerns, to respond with empathy and to work with the patient to prioritize the concerns.

In a patient-centric conversation patients should be encouraged to ask questions, seek clarification and participate in decision-making. The use of technology can facilitate this process without sacrificing the patient-centered nature of the encounter. For instance, patients can complete an on-line form, or complete a form in the waiting room with a kiosk or computer access, which allows patients to think about, expand and clarify what their concerns are and to indicate what is most important.

When a patient makes an appointment for a specific issue such as a blood-pressure check, the visit can be turned into a patient-centric visit by simply saying: "I know we planned to talk about your blood pressure, but first I want to check if there are some other concerns you hoped to discuss."

Dr. Jaen concluded: "Although the principle of patient-centered communication may seem self-evident and are widely endorsed by physicians and patients, they are strikingly absent from primary care visits. Current practice design initiatives should include physician training to elicit and prioritize patient agendas as well as patient interventions to help them identify their concerns, fears and expectations. Ultimately, these interventions can change the overall climate of patient care toward one that is more respectful, comprehensive, effective and efficient."

Technology has often been blamed for interfering with the patient/provider relationship but technology properly designed can contribute to and promote better patient/provider communication. For instance, at SETMA we have designed the Automated Team Function. When a patient makes an appointment, the computer searches the patient's medical record and identifies screening, preventive or quality standards which have not been met. Referrals, tests, procedures or other measures are automatically initiated.

When the patient is checked in and their record is opened, three things happen:

1. A document is created for the nurse as to what the patient needs at this visit.
2. A document is created for the provider as to what needs to be done for or to the patient at this visit.
3. A document is created for the patient which we call, "The Patient Activation and Engagement, Shared Decision Making Tool." This gives the patient a list of everything ordered or scheduled with a brief paragraph explaining the value and the meaning of each test, procedure or referral.

The time saved in completing these parts of the visit can be spent expanding the opportunity for a patient-centric, PC-MH conversation with the patient.

Next Week, we will discuss another part of this same issue which is the "power of personal story telling" for the patient and the practice.