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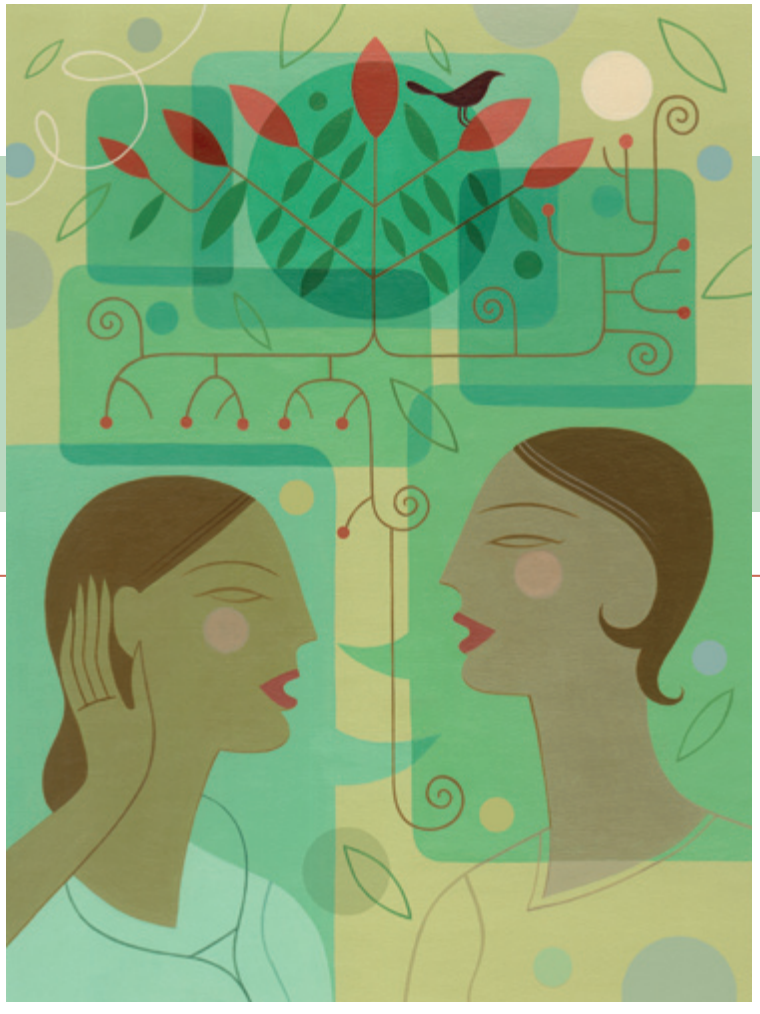
Have You Really Addressed Your Patient's Concerns?



TRACY WALKER

These simple strategies will help you structure the medical encounter to ensure that you and your patient are on the same page.

As family physicians, we often strive to provide patient-centered care and place great value on communicating effectively with patients. We get to know our patients, their families and their concerns over time, and very often patients appreciate the care they receive. Despite our efforts, however, between 30 percent and 80 percent of patients' expectations are not met in routine primary care visits.[1]

Often, important concerns remain unaddressed because the physician is not aware of the patient's worries. Listening to audio recordings of patient-physician visits provides some insight into physician behaviors that keep patients from disclosing their concerns. For example, physicians often redirect patients at the beginning of the visit, giving patients less than 30 seconds to express their concerns.[2] Later in the visit, physicians tend not to involve patients in decision making[3] and, in general, rarely express empathy.[4] Patients

forget more than half of physicians' clinical recommendations,[5] and differences in agendas and expectations often are not reconciled. Not surprisingly, adherence to treatment is poor. These problems are likely to persist even in the face of intensive practice redesign efforts unless communication between patients and physicians is addressed.

This article will describe how to use principles of patient-centered communication to structure the initial moments of a medical encounter so that the physician can more reliably elicit, explore and respond to patients' concerns.

What is patient-centered communication?

Patient-centered communication involves focusing on the patient's needs, values and wishes. It is associated with improved patient trust and satisfaction,[6] more appropriate prescribing[7] and more efficient practice.[8]

The tables below provide examples of patient-centered communication – and its absence. The transcripts in tables 1 and 2 were drawn from actual physician interviews as part of a study in which standardized patients (actors) were sent covertly into physician practices, with prior informed consent,[9] to examine different physician interaction styles.

The differences between the tables are subtle but important. The "non-patient-centered" interview in table 1 might seem reasonable at first, but closer examination reveals that the physician takes control of the conversation, directs the topic away from the patient's concern and does not offer any empathy or validation. In contrast, in table 2, the physician responds to the patient's con-

TABLE 1: A physician-dominated medical encounter, with little opportunity for patient input

TRANSCRIPT	COMMENT
Dr: So, what brings you in today?	
Pt: My back has been bothering me.	Patient expresses a concern.
Dr: What kind of work do you do?	"Cut-off": Physician does not inquire further about concern and changes the topic.
Pt: Um, well, I was an administrative assistant as of the beginning of January, but I got laid off, so –	Patient answers the question and expresses another concern.
Dr: So, recently laid off.	Physician stays on topic but does not give patient the chance to elaborate. Physician offers no empathy in response to distressing event.
Pt: Yes.	Monosyllabic answer suggests that the patient is in a passive mode.
Dr: OK. OK. And when was your last physical exam, like pelvic exam, breast exam and all that?	Physician changes topic.

TABLE 2: A patient-centered medical encounter, without explicit agenda setting

TRANSCRIPT	COMMENT
Dr: So, what brings you in today?	
Pt: My back has been bothering me.	Patient states a concern.
Dr: How so?	Physician explores concern further.
Pt: When I bend over, it hurts, and I'm stiff in the morning.	Patient describes the concern in more detail.
Dr: Do you remember when it started?	Physician initiates further exploration.
Pt: Yes. I was moving boxes in my house.	Patient gives more relevant information.
Dr: What did it feel like when your hurt it?	Physician initiates further exploration.
Pt: It didn't really start hurting until the next day.	Patient gives more relevant information.
Dr: Back pain is pretty annoying, isn't it?	Physician offers validation (empathy).
Pt: It sure is.	Patient confirms that she felt understood.

cerns by exploring them further, asking questions related to the concern and showing empathy; however, it lacks explicit agenda setting, as illustrated in table 3.

Eliciting and prioritizing concerns. Two important elements of patient-centered communication are drawing out a patient's true concerns and then identifying which ones to address first. Physicians often assume that the first concern a patient mentions is the most important one and that patients will spontaneously report all of their fears and concerns. Neither of these assumptions is true. Think of the patients who wait until the end of the visit to report substernal chest pain.

Eliciting all of the patient's concerns early in the visit is as simple as asking "Is there something else you're concerned about?" until the patient answers, "No." Doing this lowers the likelihood that patients will bring up additional concerns late in the visit when there is no time left to address them. While time pressures are real, it is striking how often physicians do not elicit patient concerns even when there is adequate time to do so.[10] Even when concerns are elicited, clinicians rarely prioritize them explicitly with the patient. This can be done by asking the patient, "Which of these issues would you like to start with today?" and then negotiating a reasonable agenda for the visit.

The example in table 2, while more patient-centered than the example in table 1, exhibits the common mistake of diving into the first concern that the patient mentions. In table 3, in contrast, the physician takes time to elicit and list all of the patient's concerns,

TABLE 3: A patient-centered medical encounter, with explicit agenda setting

TRANSCRIPT	COMMENT
Dr: So, what brings you in today?	
Pt: My back has been bothering me.	Patient states a concern.
Dr: Sorry to hear that. Before we go further, though, I'd like to find out if there is something else bothering you.	Physician provides empathy and then defers further discussion pending other issues.
Pt: Well, I was also wondering why I've been feeling so tired lately. I'm a bit down in the dumps.	Patient states another concern.
Dr: So, tiredness and feeling down. Is there something else?	
Pt: No, not really.	Patient is done with her agenda.
Dr: So, which should we start with?	Physician invites patient to prioritize concerns.
Pt: Well, perhaps the back pain, but I did want to make sure we have time for both.	
Dr: OK, fair enough. You said your back has been bothering you. How so?	Physician explores concern further.
Pt: When I bend over it hurts, and I'm stiff in the morning.	Patient describes the concern in more detail.
Dr: Do you remember when it started?	Physician initiates further exploration.
Pt: Yes. I was moving boxes in my house.	Patient gives more relevant information.
Dr: What did it feel like when you hurt it?	Physician initiates further exploration.
Pt: It didn't really start hurting until the next day.	Patient gives more relevant information.
Dr: Back pain is pretty annoying, isn't it?	Physician offers validation (empathy).
Pt: It sure is.	Patient confirms that she felt understood.

Physicians often feel a strong desire to dive into the first problem a patient mentions.

Patient-centered communication requires the primary care team to elicit all of a patient's concerns, respond with empathy and work with the patient to prioritize them.

Patients should be encouraged to ask questions, seek clarification and participate in decision making.

The Establishing Focus Protocol helps the physician quickly set an agenda for the visit, in collaboration with the patient.

respond empathically and prioritize them.

Helping patients prepare for the visit. The physician will have an easier time addressing a patient's concerns during a visit if the patient has first identified his or her own concerns and feels free to ask questions, seek clarification, participate in decisions and be more involved in their care. Practices can use written or online forms to accomplish this. Patients can complete the form at home or in the waiting room prior to the office visit. The form can simply ask patients to list their concerns or agenda items,[11] or it could offer a list of common questions patients should consider asking their physicians (e.g., What is this test for? When will I get the results? Will this medicine interact with medicines I am currently taking?).[12]

This latter approach has been tested most frequently in cancer settings, where use of brief lists of common questions (12 items) leads patients to ask more questions and actually shortens the consultation.[12] In addition, many patients report looking at the lists between visits and in anticipation of an upcoming visit. A similar approach is being implemented in primary care settings. The Agency for Healthcare Research and Quality has developed sets of questions patients can bring to primary care visits to learn more about their prescriptions, diagnoses and tests. The "question builder" tool is available online at http://www.ahrq.gov/questionsaretheanswer/questionbuilder.aspx. To make the tool easy for patients to access, practices can link to it on their own Web sites.

In primary care, agenda forms have resulted in greater number of concerns addressed[13] and, in some studies, greater patient satisfaction with the discussion.[11] However, use of these forms can be ineffective if clinicians do not ask about them or endorse them or if they view them as an annoyance.

There are more intensive ways of increasing patient involvement in care, which physicians should be aware of even if they are not feasible in the physician's current setting. Trained patient coaches can help patients identify specific concerns and practice asking questions and being assertive when they do not get the information that they need. Patients generally interact with the coach for 20 minutes prior to an office visit. Coaching has resulted in improvements in care.[14,15] However, coaching is expensive. The use of interactive coaching software, as an alternative to live coaching, is a promising option being studied in several primary care sites.

One other design combines agenda-setting assistance and coaching by enhancing the role of the medical assistant. Under this model, recently described as the "teamlet model of primary care," medical assistants are trained to help patients identify and prioritize concerns,

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identify important questions and voice these questions to their physicians.[16]

Staying on time

Physicians' fears that eliciting all of a patient's concerns could lengthen the visit have some basis. Without explicit training in setting and focusing patients' agendas, physicians tend to provide longer visits, although the amount of time per problem may not increase.[11,13,17] However, physicians trained using a simple protocol, the Establishing Focus Protocol (see below), were able to address more concerns without affecting visit length.[18] Patients were more satisfied and perceived that more of their concerns were elicited and prioritized. Physicians also learned to negotiate with patients when it seemed necessary to address issues their patients did not rank highly.

Using the protocol, after an inquiry into the patient's concerns, the clinician and patient develop a working agenda, sort through the patient's concerns to see which are most pressing, and structure the office visit accordingly. The protocol may be especially important with patients who have long lists of concerns and seem oblivious to physicians' time limitations.

Enacting the protocol requires discipline. Physicians often feel a strong desire to dive into the first problem a patient mentions and to address all of a patient's stated needs at each visit, along with multiple prevention and chronic illness guidelines. The protocol helps physicians and patients take stock early in the visit and prioritize collaboratively so that

ESTABLISHING FOCUS: COLLABORATIVE AGENDA SETTING

Step 1: Orient the patient.	"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. This way, we can make the best use of our time."
Step 2: Mindfulness cue. Remind yourself that you may not be able to address all problems and issues in one visit.	
Step 3: Make a list.	"What concerns would you like me to know about today?" Then: "Is there something else?" and "Something else?"
Step 4: When necessary, make space for the patient to tell his or her story before the entire list of concerns is elicited.	
Step 5: Avoid premature diving into diagnostic questions.	"Excuse me for a moment. I am getting a little ahead of myself. Before we talk further about your headaches, do you have other problems or concerns you wanted to discuss today?"
Step 6: Mindfulness cue. Ask yourself, "Do I feel able to address all the patient's concerns today? Do I need to put some concerns off for a later visit?"	
Step 7: Confirm what is most important to the patient.	"My impression is that talking about _____ is most important. Is that right?" or "We may not be able to do a good job on all these concerns today. Which concerns are most important today?"
Step 8: If needed, express your concerns about particular issues and negotiate how to best spend your time.	"In addition to talking about your neck pain, I would like to discuss your blood pressure."
Step 9: Seek confirmation and commitment.	"OK, let's start with your neck pain, and we can check in on blood pressure. If we cannot do a good job on the other items, then let's arrange another visit."

Although these principles may seem self-evident, they are strikingly absent from primary care visits.

important issues are addressed first and fully.

Self-awareness is essential. At the most fundamental level, physicians should be aware of their level of attentiveness and distractibility and any biases that favor exploring some illness manifestations more than others. We include two "mindfulness cues" – steps 2 and 6 – to help physicians reflect and determine what is feasible given the time allowed.

Incorporating any new skills into established practices takes time and effort. There are several caveats. Rigid application of the Establishing Focus Protocol solely to save time can compromise physicians' abilities to form secure and trusting relationships. A particular challenge is when a patient launches directly into telling a story before listing all topics of concern (see step 4). In these situations, it is important to take a moment and listen to the patient. Then, respectfully interrupt to confirm whether the topic is the most important one to discuss. Finally, keep in mind that agenda setting should not upstage the interview phases that precede and follow it – establishing rapport and understanding the patient's perspective.

A key step in the protocol is identifying which issues are most important and should be addressed first.

Like any new skill, patient-centered communication takes practice.

While agenda setting is important, it should not get in the way of establishing rapport with patients and understanding their perspectives.

Moving forward

Although the principles 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 redesign 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, prioritize those concerns and ask questions. Ultimately, these interventions can change the overall climate of patient care toward one that is more respectful, comprehensive, effective and efficient.[19] FPM

Send comments to **fpmedit@aafp.org.**

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