

Patient-clinician communication

An overview of relevant research and policy literatures

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Executive Summary

Summary of report

This report summarises the research and policy literatures that address patient-clinician communication.

Why patient-clinician communication?

Concern with patient-clinician communication is growing exponentially. Service users expect clinicians to communicate well in how they enact information provision and in how they conduct their service relationships. The rising complexity of care trajectories, due to the growing numbers of chronically ill patients, further increases the communication demands facing clinicians. Unfortunately, this complexity also raises the likelihood of problems and unexpected errors, and resolving these matters too requires increasingly sophisticated kinds of communication. Finally, research findings demonstrate that effective communication heals, and that sub-standard communication may have nocebic effects. For all these reasons, paying close attention to what defines effective patient-clinician communication is critical to the quality and safety of contemporary health care.

What are researchers' points of departure?

Our report brings together studies that conceive of communication in a variety of theoretical ways; they apply different methodological approaches to studying communication, and they offer a wide range of solutions and interventions for improving patient-clinician communication. For the purpose of classifying the large number of publications found in this domain and categorising their theoretical, methodological and improvement points of departure, it is first necessary to consider the different vantage points from which patient-clinician communication is considered. We propose three overarching vantage points. The *first* is: communication is a structured process engaged in by clinicians with identifiable communication skills and knowledge that can be taught and measured. The *second* is: communication is a form of attentiveness or mindfulness with which the clinician enables the patient to express their concerns, needs and preferences, and this leads to better diagnostic processes and treatment outcomes whose process integrity can be assessed. The *third* is: communication is a non-linear, unpredictable process steeped in uncertainty: the patient has unique needs, views and preferences, and is likely to present with chronic disease potentially complicated by co-morbidities; the clinician is part of a complex team of professionals whose knowledge about the patient is dependent on a variety of sources of

information. In this context, communication is an emergent phenomenon, whose orientation and substance are harder and harder to predict in advance.

What are the main findings arising from this review?

Corresponding to the three vantage points just outlined, this review reveals three overarching kinds of patient-clinician communication research: research that regards the patient as ‘patient object’ comprised of a set of diseases; research that regards the patient as a person, and research that regards the patient as source of uncertainty. The priority for the first kind of research is accurate and comprehensive information, and skills that enable clinicians to elicit and act on that information. The priority for the second kind of research is the clinician-patient relationship, and the relational skills that enable clinicians to ameliorate that relationship. Much if not most current communication research in health turns out to be of this second kind; namely, describing, evaluating and improving the relational and interpersonal dimensions of patient-clinician communication.

The priority for the third kind of research is the question about how clinicians act and maintain continuity of care amidst uncertainty, and the resources they have access to in order to ‘tame’ that uncertainty, prominent among which is *communicating with others*. Here, the principal research question centres on how clinicians and patients contain uncertainty arising from difficult to diagnose ailments, turn-over of clinicians and their challenge to re-establish a relationship with someone seen and advised by colleagues, unclear roles, uncertain effectiveness of medical-clinical treatments, and hard to negotiate services and processes. Often clinicians and patients face ‘wicked problems’ and ‘tragic circumstances’ that are inherent in patients’ increasingly complex (chronic) disease patterns; clinicians’ growing dependence on colleagues and technologies in their service and elsewhere, and the increasingly complicated nature of contemporary care provision generally. While only just emerging, this third kind of research accepts that treatments need to be constantly revisited and reconfigured for patients in need of care, and patients play an increasingly important role in co-producing that care.

What are the critical success factors for improved patient-clinician communication?

The three bodies of research reviewed each propose a different set of success factors. For ‘patient as patient object’ research, success factors lie in clinicians adopting proven routines and strict scripts in order to maximise the accuracy and comprehensiveness of the information needed to make diagnostic and treatment determinations. Here already however, scholars are showing awareness of the centrality of *relational* skills to facilitating

and enhancing the process of obtaining the required information and heightening patient compliance. For 'patient as person' research, the critical success factors are predominantly interpersonal and emotional. They include clinicians' ability to establish and maintain relationships with their patients, supported by emotional intelligence manifesting as 'clinical empathy', 'mindfulness' and 'active listening'. These, in turn, manifest in the use of pauses and silences, the giving of opportunities to speak through appropriate questions, and openings for the patient to articulate matters important to them. For 'patient as uncertainty' research, success factors remain less tied to individuals' skills, conducts and intelligence. Instead, they focus on abilities shown by *teams* of responsible clinicians ensuring the patient is supported through their sometimes extended and highly complex trajectory of care. The provision of such longitudinal support is contingent on the organisation of care, on the ways in which practitioners manage shifts in disease patterns and relevant information, and on *social* intelligence as a means for connecting with the network of people caring for and supporting the patient. Besides 'set skills' and fixed knowledge ('patient as object'), or emotional intelligence, empathy and self-reflection ('patient as person'), critical here are *emergent* behaviours that flow forth from team-based reflexivity, people's *social* intelligence, their forward-looking communication evidencing shared vigilance, and mutual and complementary support through difficult situations manifesting as group resilience.

What interventions are promoted to improve patient-clinician communication?

Communication training started out with inducting students into scripts for negotiating issues with patients, and much training still operates in this way. Typical examples include history taking and breaking bad news. More recently, in acknowledgment of the relational and emotional dimensions that come into play in enacting clinician-patient relationships, and to enhance the experiential dimension of communication education, simulation and role play were introduced. Collectively, simulation and role play can be referred to as 'real play' on ground of their professional and applied orientation and outcomes. Real play involves clinicians acting out scenarios with patient-actors, or using structured simulations that confront clinicians with clinical and organisational problems emerging in practice requiring communicative responses. Communication training trials have pointed to the effectiveness of such training, but its longer-term sustainability is as yet not evident.

Sensitive to the complexities permeating the care of contemporary patients, critiques have targeted the scripted nature of role plays and of simulation scenarios. These critiques suggest that complex situations impose an entirely different set of communication demands on clinicians. Understandably, the 'patient as uncertainty' poses an enormous challenge: it

requires training that familiarises clinicians with communicating amidst complexity. Such training is difficult as it involves trainees in having to communicate in and about never-before-experienced circumstances.

Oriented towards adult educational principles, a more recent consensus is emerging therefore that not script-training but *reflexivity*-based training should be central to educating health care professionals for complex situations and events. Reflexivity training involves professionals in receiving feedback about the *in situ* and real-time practices that they perform as clinician-practitioners. Such training inducts clinicians into 'reflection-in-action' - the habit of reflecting on their own and their colleagues' actions as they unfold, tied to 'reflection-on-action' – the skill of communicating about what just happened as a means to forward planning and improvement. As fast feedback skill, team-based reflection-in/on-action is advocated to enhance clinicians' communication resilience and relieve them of the need to resort to pre-determined (and therefore static and inflexible) scripts and roles, or limiting their communication acumen to creating interpersonal relationships with patients whom they may see for only a limited time before sending them on to colleagues.

What are the main recommendations produced by this review?

The three strands of communication research identified in the review each produce their unique recommendations:

1. the patient as object: pursue and respond to questions about what language and discourse associate with more effective information gathering and analysis, diagnosis, treatment decisions and clinical outcomes;
2. the patient as person: establish which conducts and behaviours associate with better patient understanding of clinical issues and greater patient satisfaction due to better clinical *and* personal-experiential outcomes;
3. the patient as uncertainty: ask how clinicians may be enabled to act and communicate better as *clinician-networks* with patients whose disease and treatment trajectories harbour high levels of uncertainty and complexity.

Introduction: Three strands of patient-communication research

Introduction

Our review of the literature uncovered three strands of patient-clinician communication research. To clarify the foci of these three strands, we begin by considering Beth's story.

Beth is a patient in her sixties and is in need of emergency care¹:

Beth visits her local hospital's emergency department ('ED') because she is having increasing difficulty breathing. She has been referred by her GP and arrives with his referral letter. The triage nurse establishes quickly that Beth needs to be seen by a doctor and arranges an emergency ward bed for her. Before Beth is taken to her bed, a paramedic who is doing extended care paramedic training does a special blood gas test on her. Once Beth is in her bed, a junior nurse arrives. A new graduate, the nurse's nerves show as he asks in rather robotic fashion for Beth's full name and her date of birth. He then leaves to collect an armband for Beth. When he returns, he repeats the questions he just asked of her, and again does so in quite a mechanical way. He is unable to establish interpersonal contact with his patient. He leaves, and a junior doctor arrives.

An hour after Beth's arrival on the ward, a second more experienced nurse arrives to arrange an ECG. He is followed by a junior doctor. The junior doctor introduces himself to Beth, identifies as one of the doctors in the hospital, and then begins the consultation:

D1 What's been going on

P Ooh oh everything

D1 Okay

P Ah

D1 In particular

P Well the oxygen drop is was what Dr D (GP) was worried about and oh coughing and I have been a smoker I'm not denying it but ever since ((chuckles)) I had the Vibramycin

D1 Yeah

P I've it seems to have got rid of everything in the nose and my mouth and my lungs coughing stuff up but I'm not having not coughing enough up I can't seem [

D1 *[OK*

P *[to get it*

up so there's something obviously I need a bomb under me

D1 Sure besides the trouble with the breathing like not being able to get your breath what are the other problems sort of have you got no energy have you had temperatures

P No

D1 Sweats

P Ah well the last couple of nights I've had night sweats

¹ This data was kindly supplied from and collected for Marie Manidis' PhD research that was funded by the ARC-Linkage Grant LP0775435: Emergency Communication: Addressing the challenges in health care discourses and practices. Ethics approval identification number: UTS-HREC 2008-201A.

D1 Okay

P Very sweaty

D1 Yup

P And um I've been too tired to get out of bed and I was nearly gonna get out and have a shower then I thought 'No I'll get a chill'

D1 Okay

In a very matter of fact way, the junior doctor gathers the information he needs to diagnose Beth's problem. Beth explains to him that she has had a couple of night sweats recently, and is finding that she is getting very tired doing basic things like having a shower and walking up the stairs. In the last few days she has also been nauseous, is sore in the nose and has gone off her food and has diarrhoea. She also suffers from irritable bowel syndrome and she has been having oxygen at home to help her breathe. His questions are focused on clinical matters, and he spends little time on 'niceties'. He leaves shortly after.

Over the next nine hours, Beth is visited by three more nurses and one other doctor. This second doctor asks Beth many of the questions that have already been asked of her: what are her medications? and what is her exercise capacity like? As a trained Assistant In Nursing, Beth is able to give good answers to these questions. She is very engaged in the consultation and asks quite a few pertinent questions of the clinicians. At one point she also self-diagnoses: *"So I mean I don't think that's [a pain in her side] anything to do with this [her difficulty in breathing]"*. Although her knowledge is a help in particular to the junior doctor, her signs and symptoms present him with uncertainty. At one point, the junior doctor gets confused about what she has already told him about her history. He says: *"But did you say that [already]? I'm just trying – I'm getting my patients mixed up!"*

We start with this vignette for the following reason. The exchanges between Beth and her clinicians enable us to begin to profile the three over-arching strands of patient-clinician research that we found in the literature. The first of these concerns itself with the clinical-technical dimensions of what clinicians and patients talk about. This strand focuses principally on history taking and information giving, and on the accuracy and comprehensiveness of these kinds of exchanges. When the junior nurse and the junior doctor ask Beth in targeted fashion about her complaints, they are in information seeking and information processing mode.

The first strand of research that we discuss in greater detail in the report that follows concerns itself with precisely this: clinicians asking questions and negotiating answers in such a way as to obtain correct and specific information from patients so that they can make well-informed clinical-technical decisions. We label this strand of research 'patient as object' research, because what matters here are the patient's body ailments, not their person. The person in need of information is the clinician, not the patient. In effect, 'patient

as object' research values the patient only in so far as they are able to elaborate their disease complaints and enable the clinician to produce a relevant and accurate collection of clinical descriptors capturing the complaint(s). Not surprisingly, 'patient as object' research represents the first wave of studies into how clinicians communicated with patients, taking us back to the mid-twentieth century.

In the vignette, we also see the clinicians interacting with Beth at another, more personable level. During the exchange reproduced below, for example, the doctor acknowledges Beth's reluctance:

- D1 *Um and then once all that's back - we'll probably do - I'm sure you've done a spirometry before where we get you to puff into the -*
- P *Oh, please Darl - no I'm not going to go any further than - I'll never do it*
- D1 *Okay - well I'll - I'll ask you to ((Beth coughs)) - I'll ask you to do your best - that's all I can ask for ((Beth coughs)) and once we've got all those things I'll - ((Beth coughs)) um - I'll see where we're at and - um - and basically make a decision then - who do you live with Beth ((Beth coughs))*

By informing Beth of his thinking, and saying "we'll make a decision then", the doctor acknowledges that the patient may want to have a say in what happens next. This suggestion of 'shared decision-making' epitomises our second strand of patient-clinician communication research: research that positions 'the patient as person'. This research is concerned with how clinicians and patients relate to one another, treat one another and respond to one another. This research credits the patient with personhood on the principle that 'good communication heals': that is, the way in which the communication unfolds is as important as what the communication is about. This strand of research looks into the opportunities that patients have for contributing to the decision-making, as well as to a variety of other relationship dimensions that are relevant to how the care as such is *experienced*.



The third strand of research collects the learnings from these first two strands, and goes beyond them without rendering them irrelevant. Essentially, this third strand of research acknowledges that contemporary health care is immeasurably complex. The photo on the left² is of a patient arriving at the

hospital with a bag full of medications, and this image illustrates exquisitely the current complexity of care provision. The third strand of research at issue here focuses on this

² The photo was taken by and is kindly provided by Marie Manidis.

complexity and how it necessitates very specific kinds of communication. Here, the focus is no longer purely on getting accurate information from the patient, or on establishing and maintaining a good relationship with the patient. Rather, in this strand of research the focus shifts out to encompass the ways in which clinical teams (particularly in larger services) are comprised of constantly changing configurations of clinicians, and what this means for how clinicians and patients communicate. This third strand targets the ways in which patients like Beth may need care from a variety of specialties, and clinicians need to navigate Beth through a complex inter-disciplinary trajectory. This strand also looks at the ways in which disease progression – due to multi-morbidity and chronic disease – necessitates constant feedback communication between patients and their clinicians, and, sometimes, involving occasions where the relevant clinicians and the patient co-negotiate what will happen next. In what happens we elaborate these three strands of research and present summaries of papers in accompanying tables.

Background

Methods

The following approaches to identifying the relevant literature were deployed. With regard to finding research articles and other resources, our method was as follows:

- We restricted search dates to between 1970 and the present day.
- We entered the following search items into the Proquest Database, “Clinician-patient AND communication AND safety AND quality”. We also entered the following search items into OVID SP, “Patient-clinician AND communication AND effective”. In the EMERALD database we entered the following key words, “Communication, doctors, patients” and also “Patient-clinician AND communication AND effective”. We entered “Patient-clinician AND communication AND effective” into PsychINFO and “communication AND patient-centred AND clinician” into CINAHL via EBSCO. We searched MEDLINE, and EMBASE entering the terms “effective communication” and included doctor patient relation, nurse patient relationship, patient care as underlying search elements. CENTRAL.
- Utilising qualitative literature search strategies, we progressively identified key authors in the field of patient-clinician communication research. These authors included medical educators, organisational specialists, patient-centred health researchers, psychologists, linguists and medical and nursing communication researchers. Prominent authors included for example Bensing and Verheul, Ong, Roter, Frankel, Street, Mauksch, Stewart, Heritage, Sarangi and Roberts, to name but a few. Their websites and papers yielded access to other frequently cited authors, articles and reports addressing various aspects of patient-clinician communication as we outline elsewhere in this report.
- We searched literature undertaken in relation to key health and government institutional contexts including the National Health Service (UK), NHS Evidence (UK), Canada (for example the Canmeds competency framework), the USA (Planetree), Australia (Medical and nursing Codes of Conduct), Health Foundation Reports, (UK) and others.
- We examined a number of research studies, research in progress, and reviews. We examined grey literature in states and territory health departments in Australia and overseas to source documentation on interventions, resources, websites, guidelines,

etc. We also reviewed published and grey literature identified from sources including electronic databases, the Internet and reference lists of retrieved works.

- We conducted a Google Scholar search and accessed Google images to capture and compare historic and more recent representations of patient-clinician communication.
- We drew on the Centre for Health Communication (UTS)' existing extensive resources and databases, drawing on the wealth of experience of its research staff ranging across palliative and community care nursing, intensive care medicine, paediatric services, emergency medicine, and renal services.
- Finally, we undertook a search of key journals in health and communication. These included, among many others, *Social Science and Medicine*, *Patient Education and Counselling*, *BMJ*, *JAMA*, *Communication & Medicine*, *Sociology of Health & Illness*, *Health Communication*, *Organization Studies*, and the *Journal of Language and Social Psychology*. We conducted an extensive search through their content pages, examined their website front pages, checked their most downloaded articles, most cited articles, and special issues.

Our search was by no means linear. On the contrary, it expanded in scope from day to day.

The dynamics of our search can be described as follows:

- Our search commenced in the area of *patient-clinician communication* as it takes place in the doctor-patient consult. This was due to the predominance of research found there, and to the long-standing tradition of 'doctor-patient' research. The search soon expanded to research that addresses patient-clinician communication in sites other than the primary care setting; research addressing patient-clinician communication involving not just doctors but also other health care professionals; studies targeting the use and impact on communication of information technologies and of organisational structures; research into the effects of patient-clinician communication on continuity of care; studies on the direct and indirect health outcomes of patient-clinician communication, and on the impacts on clinicians' own health of (in)effective patient-clinician communication, and research addressing patient-clinician communication as it bears on patient safety, clinical service design and health care planning more generally.
- Our search for research-based interventions seeking to improve patient-clinician communication yielded different communication training paradigms, interventions to enhance clinicians' relational skills and empathy, and studies to raise levels of patient

satisfaction. This search also yielded interventions ranging from quite concrete aims and outcomes ('prevent the patient feeling lost') to more abstract aims and outcomes ('reflexivity').

Our process of making sense of the vast array of resources available in the area of patient-clinician communication was as follows:

- To render this vast field of research digestible for those not immediately involved in health care communication research, we arranged its multiplicity of orientations, approaches and findings into a tri-partite model. This model is made of three overarching research orientations: 1. *the patient as object*; 2. *the patient as person*, and 3. *the patient as uncertainty*. This model at once clarifies the dominant shifts in health care communication research, and it reflects the most important practical developments in health care communication as it is practised by clinicians today.
- In our review below, we provide introductory summaries of these three kinds of research. These summaries can be read as independent overviews, or they can be read in conjunction with the tables provided in relevant appendices where a larger number of studies are presented and summarised.

This review suffers from a number of limitations.

- The review only covers articles published in English. Some of these papers cover patient-clinician communication practices in countries where English is not the first language, e.g. Sweden, Italy, France, Germany, Belgium, the Netherlands, and Japan. The review team was unable however to make a clear assessment of the extent to which patient-clinician communication was (emerging as) an issue for policy makers and in academic centres in countries outside of the English-speaking world.
- The sheer number of articles published in this domain made it impossible to read everything.
- Our approach was to start with the most frequently-cited overview papers, and this approach may have biased our overview to confirm well-established preoccupations. However, we included trial studies, quantitative studies and qualitative research studies in our review, without privileging the status of large sample studies compared to that of small sample studies.

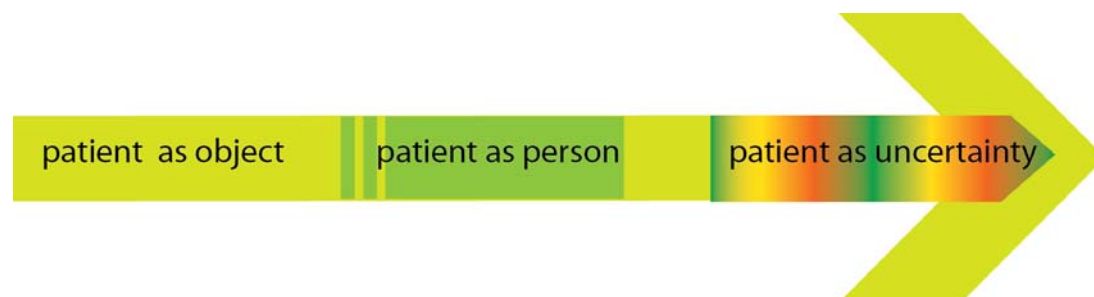
Last, our review is inclusive of most research paradigms and approaches. We acknowledge that the findings produced by these various types of studies all have their own constraints and limitations. Large sample studies may fail to clarify how enrolment processes are

enacted and quality-controlled (Goldacre 2008), and their findings are frequently so bleached of complexity as to reveal little more than what we already knew from commonsense experience and anecdotes (e.g. ‘patient-centred communication associates with higher levels of patient trust’) (Berwick 2007). Small sample studies may have their own limitations, but these are less often technical limitations than theoretical or argument-based ones (Spencer et al. 2003).

We proceed on the basis that the questions asked in large sample quantitative studies are different from, and therefore at times incommensurable to, those asked in small(er) sample qualitative studies. Obviously there is a vast difference between wanting to know if ‘patient-centred communication’ has *causal* implications for ‘patient trust’, and wanting to understand the dynamic complexities of the evolving patient-clinician relationship. In what follows, we have erred on the side of inclusion, and have sought to represent the rich variety of approaches, findings and proposed interventions critically, but also with equanimity.

How is this review organised?

We identified three strands of patient-clinician communication research above. Using these distinctions, we divide clinician-patient research into three over-arching kinds of domains (see diagram below), and we structure the remainder of our report according to these distinctions.



The earliest studies of clinician-patient communication³ emerging in the 1960s and 1970s focus on the technical-medical accuracy, the components of supply-driven health care, and the general structuring and the comprehensiveness of information about the patient’s illness (Byrne and Long 1976; Ong et al. 1995). This domain of research focuses on how health care professionals exercise and provide clinical expertise, and on the resources necessary to the enactment of this expertise. Crudely put, care provision, and therefore

³ Note: In inverting ‘clinician-patient communication’ to become ‘patient-clinician communication’, we demonstrate adherence to the idea that patients and not clinicians should now be at the centre of how we communicate with them. This repositions patient from ‘receivers’ of clinical-medical information to become ‘purveyors’ of what is relevant clinical-medical information for them.

communication about it, are seen to issue from clinicians' paternalistic-maternalistic attitudes towards the patient. This research adheres to the principle of supply-driven disease control. It frames patients as *objects* of medical-clinical attention. The patient-as-object assumption underpinning this research still permeates a good proportion of contemporary patient-clinician communication research, as we shall see below.

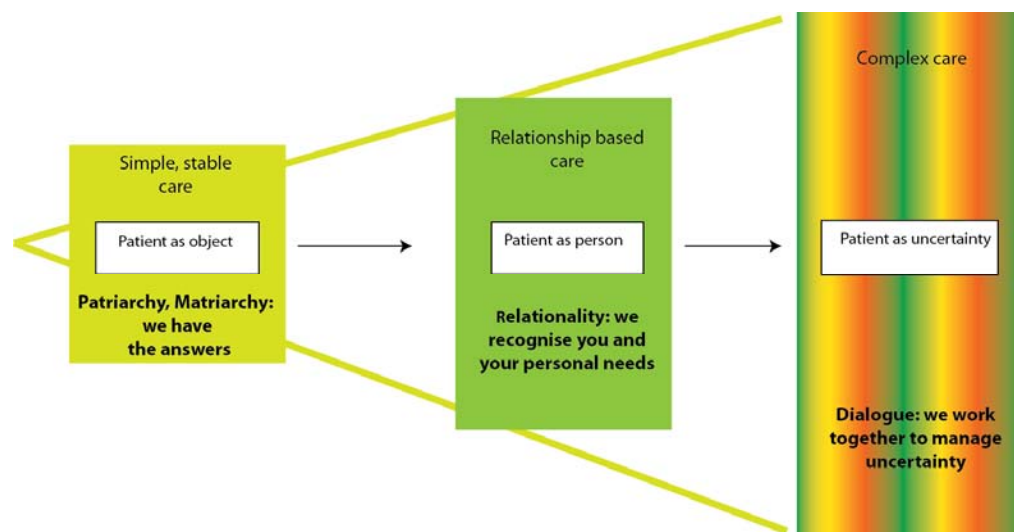
Second, from the 1980s onwards, studies begin to direct their attention to and emphasise the clinician's responsiveness to patient cues. This responsiveness is particularly evident in primary care (Balint 1965) and nursing research (Crawford et al. 1998) and it has thus far not comprehensively filtered through into the medical specialties (Degeling et al. 1998). During this period, however, clinicians' responsiveness to patients becomes an important indicator of their appreciation of the *patient as person* (Lehmann et al. 1988; Zimmermann 2010).

In short, research in this domain begins to focus on how health care professionals enact relational skills, and on how effective is clinicians' attentiveness to and their emotional relationship with their patients. In essence, this research investigates, defines and measures *patient-centredness*, as it is patient-centred in its philosophy. It seeks to study and describe the *relational dynamics* of clinician-patient communication, positing the patient not as someone who answers clinicians' questions, but as someone who comes with a unique set of life circumstances and interpretations that are (or should be) central to the clinical processes of diagnosing and treating the patient. Compared to patient-as-object research, patient-centredness research is currently more prevalent and pervasive.

Third, a research domain is emerging that explores the contours and dynamics of how patients negotiate long-term treatment complexities with multiple clinicians and services (Coulter 2011). Dismissing neither the clinician's authoritative expertise (the first research domain), nor the patient's personal needs, insights and preferences (the second research domain), this domain of research addresses how clinicians and patients negotiate the constantly shifting aspects and possibilities of care *on an ongoing basis* (Mol 2008). Here, at issue are patients' tangled trajectories confronting them with constantly reconfiguring teams of clinicians, multiplying technological options and communication interfaces, as well cross-professional and inter-institutional service arrangements.

These complex trajectories are not just the effect of institutional changes. They also result from the changing needs, preferences and knowledge contributions brought to care by increasingly differentiated patients. That is, patients differentiate according to extremely high or low health literacy, wide-ranging and contrasting socio-cultural preferences, and at

times contradictory care expectations (even with regard to the same disease). These differentiations exacerbate the uncertainty already permeating contemporary health care provision. This uncertainty is acute due to the inconclusive and sometimes conflicting scientific findings and positions regarding clinical-medical treatments and tests (e.g. the use of beta-blockers or the meaning of PSA test results). Taking this uncertainty to heart, research in this field understands care as essentially 'emergent'. Unlike patient-as-object research and patient-centredness research, this patient-as-uncertainty research is as yet much less wide-spread. The schematisation below captures these strands of research and their focus.



Schematising this report's tri-partite organisation

This tri-partite arrangement underpins both the review of patient-clinician literature, and the subsequent sections of this report that address interventions that have been proposed to improve patient-clinician communication. Each section is complemented with a table where relevant individual studies are summarised.

Review of the Patient-Clinician Communication Literature

Introduction to the literature

In this part of the report we provide our analysis of the patient-communication literature. As indicated in the previous section, this part of the review is organised in three sections:

1. patient-clinician communication research that positions the ‘patient as object’
2. patient-clinician communication research that research that positions the ‘patient as person’
3. patient-clinician communication research that research that positions the ‘patient as uncertainty’.

Communicating with the ‘patient as object’

‘Patient as object’ research frames the consult and accompanying care as relatively stable. It subscribes to the view that the point of the consultation, the communication and the care provided is the realisation of clinical-medical expertise to achieve disease control. The enactment of this expertise is information-dependent, and obtaining the right information necessitates the right skills.

Framed thus, this research ‘objectifies’ communication, where ‘to objectify’ means, to portray communication as a defined set of identifiable elements. These elements include skills (interviewing skills, documentation skills) and knowledge (disease-related knowledge, knowledge about the patient). In this research, clinicians’ habits and routines are defined, described and measured according to whether such habits and routines optimise or detract from the ultimate purpose of clinician-patient communication: diagnosis, treatment, and disease control.

Disease control and the communication that supports it operate in a supply-defined fashion: the patient’s disease is elicited and determined, the most effective treatments are determined, explained and applied, and the patient is cured and discharged, or referred on for further care until they are better (or they die). At the centre of this kind of communication are the resources and explanations issuing from modern medicine: diagnostic tests, treatments, treatment measurements, and so forth. Correspondingly, research into communication here is referred to here not as patient-clinician communication, but as ‘doctor-patient communication’ (Byrne and Long 1976) and, somewhat later, also as ‘nurse-patient communication’ (Hewison 1995).

A prime concern to the research reviewed here is that clinicians effectively elicit information from patients in order to determine and apply treatment regimes:

Patients' reports of illness are taken to indicate the existence of disease processes. This indicates a clinical method focused on identifying and treating standard disease entities. To this end, the patient's disease is reduced to a set of signs and symptoms which are investigated and interpreted. (Mead and Bower 2000)

The NHMRC Guidelines on Providing Information to Patients (reproduced below) sets out the minimal information set that needs to be communicated to patients.

General Guidelines on providing information to patients (NHMRC Guidelines) (NHMRC 2004, p. 11).

Information to be given

Doctors should normally discuss the following information with their patients:

- the possible or likely nature of the illness or disease;
- the proposed approach to investigation, diagnosis and treatment:
 - what the proposed approach entails
 - the expected benefits
 - common side effects and material risks of any intervention
 - whether the intervention is conventional or experimental
 - who will undertake the intervention.
- other options for investigation, diagnosis and treatment;
- the degree of uncertainty of any diagnosis arrived at;
- the degree of uncertainty about the therapeutic outcome;
- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all;
- any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention;
- the time involved; and
- the costs involved, including out of pocket costs.

The NHMRC Guidelines reproduced above outline the information to be given to the patient by the doctor. The emphasis is on information provision rather than knowledge negotiation: 'what information needs to be communicated to the patient and what needs to be obtained from the patient'.

Research carried out under this banner is most interested in the recurrent structure, the dominant functions and the requisite skills that associate with what it considers to be an effective clinician-patient information exchange. For example, Byrne and Long's (1976) analysis of around 2000 consultations revealed that the doctor-patient consult tends to consist of a relatively predictable set of moves or 'stages':

1. The doctor establishes a relationship with the patient
2. The doctor discovers or attempts to discover the reason for the attendance
3. The doctor conducts a verbal and/or physical examination
4. The doctor, the doctor and patient, or the patient (in that order of probability) consider the condition
5. The doctor and occasionally the patient detail further treatment or investigation
6. The consultation is terminated, usually by the doctor.

Byrne and Long were also able to conclude from their analysis that doctor-centred behaviours attenuate the therapeutic effectiveness of the consult. Equally, foreshadowing the expansion of research attention to 'patient as person' research, Byrne and Long found that less successful consultations tended to have fewer silent pauses, obviating the patient having input into clinical-medical decision-making. However, the way relational issues are discussed gives "the impression (whether so intended or not) that the relationship is a thing, which works not unlike the way that vitamins do in a case of vitamin deficiency" (Szasz and Hollender 1987 [1956]).

As Byrne and Long's seminal study demonstrates, important concerns in this field of research are the predictable structure and defined functions of the doctor-patient consultation. These concerns are also the focus in earlier studies done by, among others, Bensing and colleagues working in psychology-based communication science, and Heritage and colleagues working in sociology-oriented conversation analysis (Bensing and Verheul 2009; Bensing et al. 2003; Bonvicini et al. 2009; Bourhis et al. 1989; de Haes and Bensing 2008; Fischer and Ereaut 2012; Heritage and Maynard 2006; Mauksch et al. 2008). For their part, psychology-based studies made great strides analysing the communication practices of primary care physicians in particular. In their overview of this work, de Haes and Bensing present a useful schematisation of communication *functions* as provided in the table below (de Haes and Bensing 2008). In essence, de Haes and Bensing's table of functions provides answers to the question: what purposes does the consult communication serve?

As is evident from the table, doctor-patient communication is seen to enact between three and seven essential functions. For Bird-Cohen and Cole, writing in 1990, and for Lazare and colleagues writing in 1995, three functions stand out. Where the earlier Bird and Cohen-Cole

study still emphasised the information-based aspects of this communication and ‘managing emotions’, by the mid-nineties the concern shifted towards relationship building. During the late 1990s and early 2000s, the number of functions expands to six due to the emerging emphasis on (shared) decision-making. Then, in 2007 a new function is added: ‘managing uncertainty’.

This development in function-specification is interesting as it retraces the expansion that underpins the main thesis of the present report: Clinician-patient communication research has expanded from *information* as principal concern toward *relation*, and from *relation* towards *uncertainty*.

	Three function model (Bird & Cohen-Cole 1990)	Three function model (Lazare, Putnam & Lipkin 1995)	Model of medical communication functions (de Haes & Teunissen 2004; Smets, van Zwieten & Michie 2007)	Framework for patient centred communication (Epstein & Street 2007)	Six function model of medical communication (de Haes & Bensing 2008)
1		Develop, maintain & conclude the relationship	Relationship building	Fostering relationships	Fostering the relationship(s)
2	Data gathering	Determine and monitor the nature of the problem	Information exchange: gathering and giving information	Information exchange	Gathering information
3					Providing information
4			Decision making	Making decisions	Decision making
5	Educating patients	Carry out education and implementation of treatment plans	Giving advice/promoting health related behavior	Enabling self management	Enabling disease & treatment related behavior
6	Responding to patient emotions		Managing emotions	Responding to emotions	Responding to emotions
7				Managing uncertainty	

De Haes and Bensing's overview of the functions of medical communication (2008, p. 288)

De Haes and Bensing's 2008 overview further makes clear that clinician-patient communication goes beyond information provision. Anticipating our next section where we discuss ‘patient as person’ research, communication here serves to build the relationship, manage emotions and uncertainty, as well as reach decisions. Speaking generally, the above list of functions is formulated to clarify what the clinician needs to do to realise these functions, and which specialised communication skills and knowledge the clinician needs to possess to do so. This betrays a mechanistic or ‘objective’ view of communication: there are identifiable skills and defined knowledge that are taken to associate with effective communication, and with automatically realising its critical functions.

The functions set out in the above table may capture the main dimensions of the clinician-patient encounter, but by no means capture all. For one thing, the schema does not address the answer to the *inverse* of the question above (why do clinicians communicate with patients?): why do patients communicate with clinicians? In the more recent literature, this question is growing in significance, and will be addressed in the section ‘communicating with the patient as person’.

What the table also does not reveal are significant shifts in communication emphasis from clinical-technical information to relationship building, and from there towards a co-construction of care, or *care co-production* (Wanless 2004). Co-production requires an ongoing relationship, resulting in ongoing and potentially quite complex care negotiation (Mol 2008). These matters are the focus of the section, ‘the patient as uncertainty’.

To return to de Haes and Bensing’s (2008) article, they also include a table 2 (reproduced below) that sets out some important associations. Thus, to achieve a good relationship with the patient and minimise physiological stress, the clinician needs to ensure there is adequate eye contact and opportunities for the patient to participate in the conversation. These conducts are seen to associate, in turn, with the patient’s trust and sense of rapport (short-term) and, longer-term, with satisfaction and improved health outcomes, as well as lower levels of physician stress and burn-out. Information-related conduct calls for adequate diagnosis and interpretation which is produced through explorative behaviour and enabling the patient to express concerns. In turn, these conducts and responses associate with adequate diagnosis and, ultimately, patient health.

	Six function model of medical communication	Goals	Immediate endpoints	Intermediate (and/or surrogate) endpoints	Long term endpoints
1	Fostering the relationship(s)	Good and ethical relationship	e.g. + eye contact + patient participation - physiological stress measure	e.g. + trust + sense of rapport + satisfaction with consultations	+patient satisfaction +patient health - physician stress and burn out
2	Gathering information	Adequate diagnosis and/or interpretation of symptoms	e.g. + explorative behavior + expression of patient concerns	e.g. + adequate diagnosis/ treatment plan - diagnostic test ordering - medical errors	+ patient health + physician satisfaction
3	Providing information	Good information provision	e.g. + check understanding/explore prior knowledge - use of jargon	e.g. - recall - understanding	e.g. - patient uncertainty + patient autonomy
4	Decision making	Decision based on information and preference	e.g. check decision making preference/patient values + provide information	e.g. - decisional conflict + satisfaction with decision	+ satisfaction with decision + health

	Six function model of medical communication	Goals	Immediate endpoints	Intermediate (and/or surrogate) endpoints	Long term endpoints
5	Enabling disease & treatment related behavior	Adequate and feasible disease an treatment related behavior	e.g. address patient motivation and efficacy	e.g. + illness related behavior + treatment adherence + lifestyle ? costs	+ patient health
6	Responding to emotions	Supporting the patient, enhancing the communication and referral where needed	e.g. + clinician explorative skills/silence + patient expression of emotions ? time constraints	e.g. + patient sense of support + treatment of psychopathology	+ patient emotional adjustment -psychological distress ? costs

Functions of medical communication, its goals and outcomes (de Haes & Bensing 2008, p. 290), linking functions to goals and endpoints

Where the psychological research conducted by researchers like Stewart, Bensing and Roter and colleagues is interested in the functional and outcomes dimensions of communication, *sociological* research has made a point of exploring in detail the *interactive* dimensions of communication. For Heritage, a sociologist who practises conversation analysis, communication at the *pico*-level⁴ is of particular interest. His research into the minute dynamics of turn-taking in medical interviews shows how different such interviewing can be from ordinary, everyday talk. For example, Heritage finds that medical interviewing favours ‘any’ questions, such as in “anything else?” ‘Any’, he argues, adds a negative polarity, and this tends to discourage extrapolation on the part of the responder: the patient. In preferring the use of ‘any’ over question-types that have a positive polarity (‘are there further issues?’), the clinician is more likely to attract the socially-expected ‘no’ response. Heritage concludes that medical interviewing may be hostage to “a small-scale, but pernicious, self-fulfilling prophesy”, obviating patient responses and thereby impoverishing clinical decisions and, ultimately, reducing health outcomes (Heritage 2011).

In sum, clinician-patient communication research under this first banner has pursued a range of ‘objective’ concerns by targeting the recurrent or structural aspects of communication. Central for psychologist researchers are the features of conduct that are predictive of positive relational and clinical outcomes. Central for sociologist researchers analysing interaction are the structure and functions of effective interviews, and the turn-taking mechanics of doctor-patient talk. As noted, the term ‘objective’ here refers to those features of communication that researchers deem to be defining and therefore predictive of

⁴ The pico-level of interaction pertains to how clinicians’ and patients’ bodies respond to one another. Here, think of the dynamics of movement and gaze. The micro-level of conduct pertains to turn-taking in talk (see: Thibault, P. (2011) ‘First-Order Linguaging Dynamics and Second-Order Language: The Distributed Language View.’ *Ecological Psychology* 23:210-245.).

the different aspects of clinician-patient communication, including trust, patient adherence, and so forth.

Outside the social sciences, research emanating from within the clinical disciplines also tends to target the more technical, *objective* dimensions of information-based processes. For example, there are studies that ask how much clinicians are telling and should tell their patients (Robins et al. 2011; Smith et al. 1981). Robins and colleagues' team conclude that patients want information about their condition and treatment provided to them in ways they can understand. These researchers also report that the physicians they studied devote relatively little time to proactively helping patients to understand their medical conditions or the pros and cons of treatment options or medications. They found that transparency in consult communication can do a great deal to alleviate patient uncertainty and engender empathy and respect during medical visits.

Robins and colleagues' study further rated clinician communication as transparent if the physician raised one or more of nine types of issues: the process of the clinical encounter, the medical content of the visit, demystified medical terms and jargon, the patient's subsequent course of action, sharing emotions and judgments about the patient's condition, giving reasons for treatment rationale, and orchestrating instructions on taking medications or determining the next appointment. Patients were found to prompt their physicians to be more transparent, but only infrequently. In half of the visits, patients asked their physicians to share their thoughts, but patients only rarely asked for additional information about treatment and diagnosis (Robins et al. 2011).

To ensure adequate information provision and transparency, the practice of **informed consent** was introduced in the industrialised world around the 1980s and 1990s (Nieuwkamp 2007). Informed consent sets a standard that acknowledges patient autonomy as a central bioethical principle (Beauchamp and Childress 1994). Informed consent requires clinicians to appropriately and adequately inform patients about the nature of the intended treatment. It is defined as taking place when the patient has adequate reasoning and is given and able to digest all the relevant facts to consent to a medical-surgical intervention (Medical Board of Australia 2012). For consent to be valid, the clinician must ensure that the information provided is understood by the patient (Lord 1995).

Enrolling patients in clinical trials seeking to test unproven drugs or treatments adds yet another complication to informed consent communication (Barton 2007). Targeting this process of gaining informed consent for patients' participation in clinical trials, Brown and

colleagues have outlined a range of strategies enabling clinicians to conduct more effective informed consent discussions with their patients (Brown et al. 2004).

A closely related concern in this field of research is how much information patients comprehend at the time and remember after the consultation (Ha and Longnecker 2010). On this issue of **information comprehension**, Ong and colleagues' (1995) overview of the literature suggests that "patients often do not recall or understand what the doctor has told them" (Ong et al. 1995). Kinnersley et al. (2007) have also shown that while patients have differing needs for the amount of information they require, "[providing information during the consultation] helps patients recall, understand and follow treatment advice". Information provision may render patients more satisfied (Kinnersley et al. 2007) and troublesome is that "clinicians may underestimate or undervalue the information needs of [their] patients" (Kinnersley et al. 2007).

Effective communication is thus contingent on good knowledge and information exchange, and, to enable that exchange, relational skills. Such exchange takes place not merely during the actual consult but also as part of pre- and post-consultation support. This support plays a critical role in clarifying technical-medical procedures, and serves to reassure patients that they are safe. As Stein-Parbury states, explaining disease and treatment processes to patients is a critical component of nurses' communication with patients. Nurse communication is an important resource for reassuring patients, and for reconciling them as *persons* to the technical dimensions of their care.

Sharing information, especially about what is usual/expected under the circumstances, is reassuring to patients, particularly to those patients whose interpretation is based on faulty or misguided information. For example, a patient who is nil by mouth, and receiving intravenous fluids, may fear that he or she will literally 'starve to death', due to lack of understanding. Explanations provide patients with an opportunity to re-evaluate their situation, in light of new, more valid information. (Stein-Parbury 2006)

Here, of course, patients' **health literacy** plays a critical role (Bostock and Steptoe 2012): do patients have the right language skills for negotiating difficult, technical information that they need to understand their disease and their treatment? There is evidence that this domain of research has begun to address the patient as more than purely a receiver and provider of 'objective' information. Nevertheless, health literacy research tends to place the burden of insufficient knowledge, and therefore the onus of learning, on the patient (Chinn 2011). The task for the clinician is to identify the patient's health literacy status, and tailor their information provision communication to suit that status. The challenge that arises here for clinicians is not just how to determine the patient's health literacy status, but also their

expectations with regard to input into the discussion or the consult. Swenson and colleagues noted in this regard that “although a majority of patients prefer patient-centred communication, a significant proportion of patients prefer a biomedical, or ‘doctor-centred’ style” (Swenson et al. 2006).

An expert in this area, Nutbeam recently made the point that the concept of health literacy has expanded from ‘what does the patient comprehend about their disease and treatment’ to encompass questions like ‘how capable is the patient to make health care and health behaviour-related decisions?’ This expanded concern at the heart of health literacy research, Nutbeam notes, “is focused on the development of skills and capacities intended to enable people to exert greater control over their health and the factors that shape health” (Nutbeam 2008). This expansion indicates that health literacy research is broadening its scope from targeting and improving patients’ comprehension of their clinicians’ communication, to assessing and strengthening patient’s agency in relation to health care decision-making and health behaviour.

This section can now be summed up as follows. The principal contributions of this research are as follows:

1. clinician-patient communication is to provide information that supports and facilitates medical and nursing treatment and disease control;
2. to achieve these aims:
 - a. clinician-patient communication needs to unfold in identifiable ways and requires defined communication skills as outlined above;
 - b. these skills centre on
 - i. verbally eliciting relevant and critical disease-related information from the patient to inform diagnosis and treatment, and to do so in the right order;
 - ii. communicating medical-clinical knowledge, options and decisions in ways that demonstrate awareness of the patient’s needs, preferences, and health literacy.

Anticipating our next domain of research where the patient becomes framed as ‘person’, research in the present domain shows signs of extending its concern with ‘objective’ factors at times also to encompass ‘subjective’ concerns. Thus, it is already evident to researchers operating in this domain that communication is effective and improves patients’ understanding of diagnostic and prognostic information, as well as enhancing their

compliance with the treatment regime, when it *lowers patients' anxiety* (Stewart et al. 2000). The relationship-based, or what Roter terms 'mutualistic', communication at issue here (Roter 2000) also associates with higher levels of clinician satisfaction, and lower numbers of malpractice claims:

We found that partnership building behaviours – checking patients' understanding, eliciting expectations and opinions, encouraging patients to talk, as well as providing orientation statements which help patients anticipate what will happen next in the visit, were associated with a history of fewer malpractice suits. (Roter 2000)

In the research discussed in the next section, the relational dimension of clinician-patient communication is promoted from conduct enabling more effective and accurate information handling to first principle and a central concern and goal in its own right, underpinning patient satisfaction, improved health outcomes, as well as the clinician's own well-being.

The table below provides a collation of the most prominent research literature in this first 'patient as object' strand.

Selected annotated bibliography 1) Communicating with ‘the patient as object’

Study and Authors	Study description and findings/practice implications
(Angus et al. 2011) Visualising Conversation Structure across Time: Insights into Effective Doctor-Patient Consultations	http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0038014 These researchers use an automated computer visualisation measurement technique called <i>Discursis</i> to analyse conversational behaviour in consultations. <i>Discursis</i> automatically builds an internal language model from a transcript, mines the transcript for its conceptual content, and generates an interactive visual account of the discourse. The resultant visual account of the whole consultation can be analysed for patterns of engagement between interactants. The findings from this study show that <i>Discursis</i> is effective at highlighting a range of consultation techniques, including communication accommodation, engagement and repetition.
(Beckman & Frankel 1984) The effect of physician behaviour on the collection of data	This was a seminal study identifying what happens in practice when patients seek to give their opening statements of concern in a medical consultation. The authors identify that determining the patient's major reasons for seeking care is of critical importance in a successful medical encounter. The authors recorded 74 office visits to study the physician's role in soliciting and developing the patient's concerns at the start of a clinical encounter. Findings: The study finds that in only 17 (23%) of the visits the patient is provided the opportunity to complete his or her opening statement of concerns. The study explores different ways that this interruption occurs and reasons for why this might happen so early in the consultation. The authors identify that when the patient's opening statement is terminated, this shifts the focus of information gathering from that of being patient-centred to a physician-centred format. This, in effect, leads the physician to treat the earliest pieces of clinically relevant information as the patient's primary concern or chief complaint. The authors conclude that physicians are active in regulating the quantity of information elicited at the beginning of the clinical encounter, and use closed-ended questioning to control the discourse. ‘The consequence of this controlled style is the premature interruption of patients, resulting in the potential loss of relevant information. In 51 (69%) of the visits the physician < interrupts the patient's statement and directs questions toward a specific concern; in only 1 of these 51 visits is the patient afforded the opportunity to complete the opening statement. In six (8%) return visits, no solicitation whatever is made’ (Beckman & Frankel 1984, p. 692). The authors temper their results by saying that the clinicians in the study are relatively inexperienced and that the population group of patients is homogeneous, which may lead to different findings in other studies. Conclusion(s): The authors conclude that physician participation in the opening moments of the clinical encounter is far from neutral and has a substantial effect on the type and quality of information obtained. Their data, although preliminary, suggest that over-directed interviewing at the beginning of the visit may result in premature termination of opportunities for patients to present the very concerns that the initial segment of the visit is designed to capture.
(Bensing, Roter & Hulsman 2003) Communication Patterns of Primary Care Physicians in the United States and The Netherlands	This study compares the communication of Dutch and U.S. hypertensive patients and their physicians in routine medical visits. Secondary analysis comprises visit audio/video tapes contrasting a Dutch sample of 102 visits with 27 general practitioners and a U.S. sample of 98 visits with 52 primary care physicians. The Roter Interaction Analysis System is applied to the analysis of the audiotapes. The total visit length and duration of the physical exam are measured directly.

Study and Authors	Study description and findings/practice implications
	<p>Findings/conclusion(s): ‘The researchers find that U.S. visits are 6 minutes longer than comparable Dutch visits (15.4 vs. 9.5 min, respectively), but the proportion of visits devoted to the physical examination is the same (24%). The study also finds that American doctors ask more questions and provide more information of both a biomedical and psychosocial nature, but are less patient-centered in their visit communication than are Dutch physicians’ (Bensing, Roter & Hulsman 2003, p. 335). Thus, fifty percent of the Dutch visits are ‘socio-emotional’, while only 10% of the U.S. visits are socio-emotional. Cluster analysis reveals that 48% of the U.S. visits are biomedically intensive, while only 18% of the Dutch visits are of this type (Bensing, Roter & Hulsman 2003).</p> <p>The authors conclude that U.S. and Dutch primary care visits show substantial differences in communication patterns, communication orientation and visit length. They theorise that these differences may reflect country distinctions in medical training and philosophy, health care system characteristics, and cultural values and expectations relevant to the delivery and receipt of medical services.</p>
(Bertakis, Putnam & Roter 1991) The relationship of physician medical interview style to patient satisfaction	<p>In this paper the authors reiterate that effective physician-patient communication is central to the delivery of high-quality health care. Several studies have shown that physician behavior during the medical interview is directly related to such patient outcomes as satisfaction, recall of information received, and compliance. Early research in the field reveals that the outcome of the medical interview is positively influenced by a physician who is friendly, engages in some general or nonmedical conversation, and offers information freely without patients having to request it or feel excessively questioned. The overall findings suggest that most patients are satisfied by interviews that allow them to talk about psychosocial issues without dominance by the doctor.</p>
(Bonvicini et al. 2009) Annotated bibliography for Clinician Patient Communication to Enhance Health Outcomes	<p>This is an annotated bibliography of multiple studies covering a wide range of approaches to understanding links between communication and health outcomes. It is useful as an extensive overall resource useful for locating key papers, articles, reports and books.</p>
(Bourhis, Roth & Macqueen 1989) Communication In The Hospital Setting - A Survey Of Medical And Everyday Language Use Amongst Patients, Nurses And Doctors	<p>In this study, forty physicians, 40 student nurses, and 40 hospital patients are surveyed regarding their usage and evaluations of medical and everyday language use in the hospital setting. The authors operationalise what they mean by medical language (ML) and everyday language (EL). They conceptualise these as distinct speech registers, available to doctors, nurses and patients for use in their encounters with each other. They hypothesise a number of aspects that they think might be influencing switching strategies in the health setting. These include speaker characteristics (bilingualism in ML and EL), motivational factors (accommodation theory) situational language norms in favour of communicative effectiveness, as well as status and power differentials that exist between health professionals and patients.</p> <p>Findings: ‘While doctors report using mostly ML with health professionals, they do report converging to the EL of their patients. However, patients and student nurses do not perceive doctors converging to the EL of their patient. Student nurses report using an equal mixture of medical language and everyday language with each other, while converging to the medical language of the doctor and converging to the everyday language of their patients. The ‘communication broker’ role of the nurse is corroborated by perceptions of nurses’ language use from all groups. Patients report using mostly everyday language with each other while attempting to converge to the medical language of the health professional. Nurses perceive these attempts to converge by the patients, but doctors do not report a change in the</p>

Study and Authors	Study description and findings/practice implications
	<p>patients' register as a function of conversants' (Bourhis, Roth & Macqueen 1989, p. 339).</p> <p>Conclusion(s): Regarding the evaluation of language use strategies, all groups feel that it is more appropriate for health professionals to converge to the everyday language of patients than to maintain medical language. In conversations with health professionals, patient use of everyday language is seen as more appropriate than medical language. Use of medical language by health professionals is felt to be a source of problems for patients while everyday language is seen to promote better understanding for patients.</p> <p>The study concludes that education can assist health professionals to better understand the different registers they and patients use. The authors say it would also be useful for all participants in the healthcare arena to understand the different motivations for using different registers, including how these convey the relative power and status differences between doctors and nurses as professionals and patients as non experts.</p>
(Buckman et al. 1991) Doctor-patient communication: the Toronto consensus statement	<p>This study points out that effective communication between doctor and patient is a central clinical function that cannot be delegated. This is because most of the essential diagnostic information arises from the interview, and the doctor's interpersonal skills also largely determine the patient's satisfaction and compliance and can positively influence health outcomes – they cite [Roter 1997; DiMatteo <i>et al.</i> 1942; Bartlett <i>et al.</i> 1984]. The authors cite research showing that such skills, including active listening to patients' concerns, are among the qualities of a physician most desired by patients [Matthews 1987]. They identify deficiencies in clinical communication as playing a big part in the increasing public dissatisfaction with the medical profession. They also point out that studies in many countries have confirmed that serious communication problems are common in clinical practice.</p> <p>Citing numerous studies, they point out that '[f]or example, 54% of patient complaints and 45% of patient concerns are not elicited by physicians [Stewart 1979]. Psychosocial and psychiatric problems are common in general medical practice, but these diagnoses are missed in up to 50% of cases [Schulberg & Burns 1988; Freeling <i>et al.</i> 1985]. In 50% of visits the patient and the doctor do not agree on the nature of the main presenting problem [Starfield 1979; 1981]. In one study patients are interrupted by physicians so soon after they begin describing their presenting problems (on average within 18 seconds) that they fail to disclose other significant concerns [Beckman & Frankel 1984]. Most complaints by the public about physicians deal not with clinical competency problems [Richards 1990], but with communication problems, and the majority of malpractice allegations arise from communication errors [Shapiro <i>et al.</i> 1989]. Residents or trainees [Platt & McMath 1979] and practising physicians have shown substantial deficiencies when studied [Byrne & Long 1984]. Only a low proportion of visits with doctors include any patient education [Waitzkin 1984], and a surprisingly high proportion of patients do not understand or remember what their physicians tell them about diagnosis and treatment [Ley 1988]. Cultural differences also impede the work with patients' [Kleinman <i>et al.</i> 1978; Waxler-Morrison 1990]' (Buckman et al. 1991, cited in paragraph 'Problems in Practice').</p> <p>This consensus statement addresses three issues: What are the most important facts we already know about doctor-patient communication? What are the most important things that could be done now to improve the situation? and, What are the most important unanswered questions?</p> <p>For question two, the statement proposes that physicians should first encourage patients to discuss their main concerns</p>

Study and Authors	Study description and findings/practice implications
	<p>without interruption or premature closure. This, they contend, enhances satisfaction and efficacy of the consultation--yet, contrary to the expectation of many doctors, this need not take long: a maximum of 2 1/2 minutes, or an average of 90 seconds. Doctors should also strive to elicit patients' perceptions of the illness and associated feelings and expectations. Experience also supports the value of learning methods of active listening and empathy. The appropriate use of open ended questions, frequent summaries, clarification, and negotiation are factors that positively affect the quality and quantity of information gathered; factors with a negative impact include inappropriate use of closed ended questions and premature advice or reassurance. Other important skills include giving clear explanations, checking the patient's understanding, negotiating a treatment plan, and checking patients' attention to compliance.</p> <p>Conclusion(s): The authors conclude that sufficient data are now available to show that problems in doctor-patient communication are extremely common and adversely affect patient management. Even though there are still questions around information exchange and therapy, around the best ways to teach these skills (if they are teachable at all) and around ways to research this problem, they argue that it has been repeatedly shown that the clinical skills needed to improve these problems can be taught and that the subsequent benefits to medical practice are demonstrable, feasible on a routine basis, and enduring. The authors therefore propose that the profession has a clear and urgent need for teaching of these clinical communication skills to be incorporated into medical school curriculums and continued into postgraduate training and courses in continuing medical education. They hope that if current knowledge is implemented in clinical practice, and if the priorities for research are addressed, there may be material improvement in the relationship between patient and doctor.</p>
(Byrne & Long 1976) Doctors talking to patients	<p>This book is a seminal work in doctor-patient consultation research. The authors analysed over 2500 tape-recorded consultations from over 100 doctors in the UK and New Zealand. The study is now considered to be very doctor-centred. The authors discuss how the style of the consultation may reflect the personality of the doctor. They identified a spectrum of approaches to the consultation, ranging from the doctor-dominated consultation (where the patient was severely curtailed in contributing) to those where the patient gave a monologue and the doctor was a passive listener. They described six stages to the consultation. They also identified that doctors tended to use a narrow repertoire of consultation skills and that those doctors who asked more open questions tended to see patients less frequently. They identified six stages of the consultation:</p> <ul style="list-style-type: none"> • The doctor establishes a relationship with the patient • The doctor attempts to discover the reason for the patient's visit – their agenda, their fears and concerns • There is a history taking and possibly an examination • The doctor with the patient considers the condition • They discuss treatment or further investigation • The doctor brings the consultation to a close
(de Haes & Bensing 2008) Endpoints in medical communication research, proposing a	<p>The study begins by pointing out that the evidence base of medical communication has been underdeveloped and the field was felt to be in need of thorough empirical investigation. The authors argue that studying medical communication</p>

Study and Authors	Study description and findings/practice implications
framework of functions and outcomes	<p>could help to clarify what happens during medical encounters and, subsequently, whether the behavior displayed is effective. However, before effectiveness can be established, the functions or goals of the consult need to be established.</p> <p>Results and Conclusions: In the present paper, de Haes & Bensing first outline their six function model of medical communication (referred to in the main report) based on the integration of earlier models. Their model distinguishes (1) fostering the relationship, (2) gathering information, (3) information provision, (4) decision making, (5) enabling disease and treatment-related behavior, and (6) responding to emotions. Secondly, a framework for endpoints in such research is presented. Immediate, intermediate and long-term outcomes are distinguished on the one hand and patient-, provider- and process- or context-related outcomes on the other. Based on this framework they say that priorities can be defined and a tentative hierarchy proposed. Health is suggested to be the primary goal of medical communication as are patient-related outcomes. The authors describe dilemmas in tying the quality of the communication in the consultation to health outcomes.</p> <p>Practice implications: By linking specific communication elements to concrete endpoints in the six function model of medical communication, they argue that communication will become better integrated in the process of medical care. This is helpful to medical teachers and motivational to medical students. They say that this approach can elevate the importance of medical communication.</p>
(Heritage & Maynard 2006a) Introduction: Analyzing interaction between doctors and patients in primary care encounters	<p>This is the introductory chapter of a book titled – Communication in Medical Care: Interaction between Primary Care Physicians and Patients Edited by John Heritage and Douglas W. Maynard published in 2006⁵.</p> <p>In the chapter, the authors outline some of the recent work done on patient clinician communication and propose Conversational Analysis (CA) as a way forward for doing micro-analysis of what is going on in patient-clinician consultations.</p> <p>In the volume Heritage and Maynard revisit Byrne and Long’s project of anatomising the primary care visit, doing so from a primarily sociological and interactional perspective. They begin from the standpoint that physician and patient – with various levels of mutual understanding, conflict, cooperation, authority, and subordination – jointly construct the medical visit as a real-time interactional product. In this orientation, they consider some of the social, moral, and technical dilemmas that physicians and patients face in primary care settings, and the resources that they deploy in solving them. Their objective is to open the study of doctor–patient relations to a wide range of social and interactional considerations. They outline some of the key items of Conversation Analysis (CA) including 1) the importance of sequencing (turns of talk that conversationalists take and what these mean in terms of how people contribute to understanding each other and share actions); 2) how spoken language accomplishes activities; 3) the way that all aspects of the interaction are</p>

⁵ We include this Conversation Analytical study (and others by these authors) in this ‘patient as object’ section to highlight the analysts’ concern with the recurrent structure of consult communication. Their orientation can thus be seen as objectifying communication as is evident from their application of a rigorously defined and carefully circumscribed analytical approach. Further, in contrast to similarly objectifying endeavours such as promoted by the Roter Interaction Analysis System or ‘RIAS’ whose focus is on the *interpersonal* consequences of forms of talk (and which is there listed under the ‘patient as person’ section below), Conversation Analysis does not judge or intervene in how actors communicate beyond seeking to highlight recurrent or structural (‘ethno-methodological’) features of the talk in question.

Study and Authors	Study description and findings/practice implications
	<p>important including (lengths) of pauses, hesitations, overlapping talk, sound stretches, breathing etc.; 4) the importance of repair (how speakers fix what they've said) in turns. From their perspective features of conversation are methodically organised. The chapter makes the point that these basics of conversation still apply in patient-clinician consultations. The authors posit that the consultation can be examined from 1) its overall structure; 2) the sequence of structures and 3) the design of the individual turns of talk. Based on their and others' research they suggest that diagnoses 'tend to be offered and accepted 'on authority'' (Heritage & Maynard 2006b, p. 16). Treatment proposals receive acknowledgement but they can be resisted; and clinicians prepare patients for the delivery of adverse medical diagnoses. When analysing turns they indicate that research shows whether patients are presenting for new, follow-up or chronic concern consultations. They also present research that shows that patients offer explanations for disease in hesitant and disguised ways whereas doctors are more forthright in what they say.</p>
<p>(Heritage & Maynard 2006c) Problems and prospects in the study of physician-patient interaction: 30 years of research (Review of literature)</p>	<p>This paper examines work on the physician-patient interaction examining a range of studies. The authors identify that the complexities of reviewing this work are enhanced by disciplinary, methodological, and ideological divisions that are relatively enduring features of the field, by the changing structure of health care provision in many societies, and by the sheer multiplicity of health contexts and types of health care service in which social interaction plays a pivotal role. They examine the work of Parsons (1951) who conceptualised the physician-patient relationship according to a normative framework defined by the pattern variable scheme. As Parsons clearly recognised, this normative conceptualisation was one that empirical reality at best only approximates.</p> <p>In this review, the authors consider approaches to the medical interview that have a primary focus on observable features of doctor-patient interaction. In this orientation, the authors consider literature dealing with social, moral, and technical dilemmas that physicians and patients face in primary care and the resources that they deploy in solving them. This literature is shown to embody a steady evolution away from a doctor-centered emphasis toward a more balanced focus on the conduct of doctors and patients together.</p> <p>They conclude that the field is still divided into conceptually disconnected quantitative and qualitative research approaches involving what they term as 'disjunctive disciplinary and ideological perspectives with little interchange between them'. They hope that research is at a pivotal moment in the development of studies of physicians and patients with realistic prospects for reconciliation and integration. For them, approaches that deal with practices of talk and social interaction, and which account for the meaningful character of social conduct in the medical encounter could be useful in providing essential building blocks for how other researchers can examine and understand how the consultation communication might link to health outcomes.</p>
<p>(Heritage 2011) The interaction order and clinical practice: Some observations on dysfunctions and action steps</p>	<p>This paper examines three dysfunctional communication processes in the primary care consultation using conversation analysis theory and methods. These dysfunctions become apparent in the way that patients' problems are presented, the way that medical questioning limits patients from expressing additional concerns, and the way that discordance emerges between physicians and patients in the context of treatment recommendations.</p> <p>Heritage proposes that these dysfunctions arise from the transfer of normative (everyday patterns) conventions that function well in the practice of ordinary conversation into medical contexts where they serve to limit the effectiveness of</p>

Study and Authors	Study description and findings/practice implications
	<p>communication. He argues that because these conventions are rooted in, and reinforced by, the activities of daily life, they may be difficult to eradicate from the medical visit. By the same token, these dysfunctions need to be addressed to resolve the limitations of existing consult communication. Heritage argues that these dysfunctions could be reduced when physicians recognise the nature of these dysfunctional practices and learn to appreciate their roots in everyday social life.</p>
<p>(Karnieli-Miller et al. 2012) Are you talking to me?! An exploration of the triadic physician-patient-companion communication within memory clinics encounters</p>	<p>This study sought to explore and gain further insight into the nature of the triadic interaction among patients, companions and physicians in first-time diagnostic encounters of Alzheimer's disease in memory-clinic visits. The researchers analysed 25 real-time observations of actual triadic encounters by six different physicians. The analysis was accomplished through an innovative combination of grounded theory text analysis and graphics to illustrate the communication exchanges. The triadic communication was actually a series of alternating dyadic exchanges where the third person tries, with inconsistent degrees of success, to become actively involved in the consultation. During the initial introduction (phase 1) and summation/disclosure) phase 3), the core dyad shifts from physician-patient to physician-companion.</p> <p>Findings: The focus of communication shifts in these encounters: from talking <i>with</i> the patient to talking <i>about</i> him [sic] or <i>ignoring</i> him [sic]. These shifts may signify an emotionally loaded role transformation from <i>companion</i> to <i>caregiver</i>.</p> <p>Practice implications: The authors conclude that effective and empathic management of a triadic communication that avoids unnecessary interruptions and frustrations requires specific communication skills (e.g. explaining the rules and order of the conversation). Professionals need to facilitate the emotionally difficult shift from companion to caregiver and the adjustment of companion and demented patient to this shift.</p>
<p>(Krupat et al. 2006) The Four Habits Coding Scheme: Validation of an instrument to assess clinicians' communication behavior</p>	<p>The aim of this study was to present preliminary evidence for the reliability and validity of the Four Habits Coding Scheme (4HCS), an instrument based on a teaching model used widely throughout the Kaiser Permanente system to improve clinicians' communication skills.</p> <p>The researchers coded one hundred videotaped primary care visits using the 4HCS, and assessed data assessed against a previously available data set for these visits, including the Roter Interaction Analysis System (RIAS), back channel responses, measures of nonverbal behavior, length of visit, and patients' post-visit assessments.</p> <p>Results: With acceptable levels of inter-rater reliability, the distribution of ratings across items indicated that physicians' modal responses varied widely. Correlations between 4HCS ratings, RIAS, back channel responses, and non-verbal measures provided evidence of the instrument's construct validity.</p> <p>Conclusion(s): The authors conclude that the Four Habits Coding Scheme, an instrument that combines both evaluative and descriptive elements of physician communication behaviour and is derived from a conceptually based teaching model, has the potential to be useful to researchers and evaluators as well as educators and clinicians.</p> <p>Practice Implications: They conclude that the Four Habits Coding Scheme provides a template for both guiding and measuring physician communication behaviours.</p>
<p>(Makoul & Clayman 2006) An integrative model of shared decision making in medical</p>	<p>While this article focuses on shared decision-making and therefore might be better placed in the next section ('patient as person'), we have included it here on account of its formalist concern with the 'what' of SDM rather than the 'how'.</p>

Study and Authors	Study description and findings/practice implications
encounters (Review of literature)	<p>The authors identify that term shared decision making (SDM) is used in teaching, assessment and research in fluid ways. They conduct a focused and systematic review of articles that specifically address SDM to determine the range of conceptual definitions.</p> <p>They ran a Pubmed (Medline) search to identify articles published from April 2005 through to 31 December 2003 with the words shared decision making in the title or abstract. Of the 418 articles examined, 161 (38.5%) had a conceptual definition of SDM. They identified 31 separate concepts used to explicate SDM, but only "patient values/preferences" (67.1%) and "options" (50.9%) appeared in more than half the 161 definitions. Relatively few articles explicitly recognized and integrated previous work.</p> <p>Conclusion(s): Their review reveals that there is no shared definition of SDM. They propose a definition that integrates the extant literature base and outlines essential elements that must be present for patients and providers to engage in the process of SDM. This definition is not easily replicable here as it contains several elements, but is worth following up in the article as it synthesises many of the recurring elements of practising SDM such as defining/explaining problem; presenting options; discussing pros/cons (benefits/risks/costs); considering patient values/preferences; discussing patient ability/self-efficacy; using doctor knowledge/recommendations; checking/clarifying understanding; making or explicitly deferring decision(s); arranging follow-ups. They also list other desirable elements of the interaction.</p> <p>Practice implications: The authors contend that the integrative definition of SDM is intended to provide a useful foundation for describing and operationalising SDM in further research.</p>
(Roter et al. 1998) Effectiveness of Interventions to Improve Patient Compliance: A Meta Analysis	<p>This article summarises the results of 153 studies published between 1977 and 1994 that evaluated the effectiveness of interventions to improve patient compliance with medical regimens.</p> <p>The compliance interventions were classified by theoretical focus into educational, behavioural, and affective categories in which specific intervention strategies were further distinguished. The compliance indicators broadly represent five classes of compliance-related assessments: (1) health outcomes (e.g., blood pressure and hospitalisation), (2) direct indicators (e.g., urine and blood tracers and weight change), (3) indirect indicators (e.g., pill count and refill records), (4) subjective report (e.g., patients' or others' reports), and (5) utilisation (appointment making and keeping and use of preventive services).</p> <p>Results. The interventions produced significant effects for all the compliance indicators with the magnitude of effects ranging from small to large. The largest effects were evident for refill records and pill counts and in blood/urine and weight change studies. Although smaller in magnitude, compliance effects were evident for improved health outcomes and utilisation. Chronic disease patients, including those with diabetes and hypertension, as well as cancer patients and those with mental health problems especially benefited from interventions.</p> <p>Conclusion(s). The study finds that no single strategy or programmatic focus shows any clear advantage compared with another. Roter et al. conclude that comprehensive interventions combining cognitive, behavioural, and affective components are more effective than single-focus interventions.</p>
(Smith, Polis & Hadac 1981) Characteristics of the initial medical interview associated with	This study examines the relationship between selected interview characteristics, particularly physicians' verbal behaviours, and levels of patient satisfaction and understanding. The researchers videotaped twenty-nine initial patient

Study and Authors	Study description and findings/practice implications
patient satisfaction and understanding	<p>interviews by 11 physicians at the University of Washington Hospital Family medical Center. Questionnaires were used to provide measures of patient satisfaction and understanding.</p> <p>Their results (using correlational analysis) indicate that ‘higher patient satisfaction was associated with greater interview length, increases in the proportional time spent by the physician in presenting information and discussing prevention, and shorter chart review times. Increased patient understanding was associated with increases in the proportional time spent presenting both information and opinions, close physical proximity, and reduced chart review time’. The authors indicate that although physicians’ personalities and backgrounds ‘have an effect on patient satisfaction and understanding, the differences found in the dependent variables in this study could not be attributed to physician differences’ (Smith, Polis & Hadac 1981, p. 285). In particular, ‘patient understanding was significantly associated with the amount of time spent providing information and medical opinions by the physician’ (Smith, Polis & Hadac 1981, p. 286).</p>
(Stein, Frankel & Krupat 2005) Enhancing clinical communication skills in a large healthcare organisation: A longitudinal case study	<p>This article describes the approach taken over the past 16 years by one large healthcare organisation, Kaiser Permanente (KP), to enhance the clinical communication and relationship skills of their clinicians. The centerpiece of KP’s approach has been the creation and dissemination of a unifying clinician-patient communication (CPC) framework for teaching and research. This framework is called the Four Habits Model. The Four Habits are: clinicians investing in the beginning of the consultation; eliciting the patient’s perspective; demonstrating empathy; and investing in the end of the consultation. For the researchers these behaviors address the basic tasks or functions of the medical interview, and also conceptualize how the elements of the interview relate to one another in and across medical visits.</p> <p>The Model has served as the foundation for a diverse array of KP programs. They identify that sustained improvement in patient satisfaction scores has been demonstrated using this model. Clinician-patient communication training has become a well-established component of professional development in KP.</p> <p>The authors discuss that enhancing clinicians’ communication with patients is a complex task requiring planning and organisational commitment. They describe factors that contribute to the success of, and lessons learned from, incorporating clinician communication skills across the organisation. The success factors (for introducing the workshops and the model) are that they emphasise that workshops are there to help clinicians with a tough job. They also seek to focus on issues most relevant to the participants (e.g. difficult interactions).</p> <p>Conclusion: the KP experience attests to the feasibility of bringing what the authors regard as the vital skills of effective communication to large numbers of busy clinicians.</p>
(Wolff & Roter 2011) Family presence in routine medical visits: A meta-analytical review	<p>This paper outlines consultations in which older adults are accompanied to routine physician visits primarily by adult children and spouses. The authors identify that this is the first review of studies investigating the dynamics and consequences of patient accompaniment. They examined two types of evidence: (1) observational studies of audio and/or videotaped medical visits, and (2) surveys of patients, families, or health care providers that ascertained experiences, expectations, and preferences for family companion presence and behaviors in routine medical visits. They used meta-analytic techniques to summarise the evidence describing attributes of unaccompanied and accompanied patients and their companions, medical visit processes, and patient outcomes.</p>

Study and Authors	Study description and findings/practice implications
	<p>They found that visits to doctors where patients were accompanied were significantly longer than others, but verbal contribution to medical dialogue was comparable when accompanied patients and their family companion were compared with unaccompanied patients. They also found that when a companion was present, health care providers engaged in more biomedical information giving.</p> <p>The authors propose a conceptual framework that would relate family companion presence and behaviors during physician visits to the quality of interpersonal health care processes, patient self-management and health care.</p>

Communicating with ‘the patient as person’

In this section we review research that expands the focus from *what* clinicians say to *how* they communicate with their patients. Where the principal unit of analysis for the research reviewed above is *information*, the unit of analysis for the research reviewed here is *relation*. Here, then, the concern expands from what can be elicited from patients about their disease to how the relationship with patients is conducted and what the quality is of this relationship. This expansion still acknowledges the patient as a pivotal source of important information, but also regards that information, and the needs and preferences that go with it, to be accessible through and to some extent influenced by a good quality relationship between the clinician and the patient.

The importance of the subjective *relation* was already evident to scholars whose research targeted the more generic *information* dimensions of doctor-patient consult communication. Particularly the ground-breaking studies conducted by Stewart, Roter, Bensing and colleagues, while still focusing on the *structure* of communication, set increasing store by the significance of the *emotional dynamics* of communication (Bensing et al. 2003; Roter and Hall 1992; Stewart 2001). Last but not least, and operating in a very different register, sociological critiques and analyses of medical authority (Freidson 1986; Lupton 1994) contributed significantly to changing the ways in which patients were positioned when communicating with doctors, nurses and other health care workers.

Two important early reviews that summarise clinician-patient research include the Ong et al. 1995 study, and a study published by Stewart in the same year. Both reviews value the responsiveness shown by clinicians to their patients (and how clinician responsiveness relates to health outcomes: Ong et al. 1995; Stewart 1995). Ong et al (1995) deduce that clinician-patient communication answers to three overarching purposes: establishing a relationship, exchanging information, and making treatment decisions, significantly listing the *relational* aspect first. For her part, Stewart (1995) reports a positive correlation between patient health outcomes and **patient-centred** communication. Referring principally to the primary care consult, Stewart defines patient-centred care as incorporating six interacting components: exploring both the disease and the illness experience; understanding the whole person; finding common ground; incorporating prevention and health promotion; enhancing the patient-doctor relationship, and being realistic (see: <http://www.uwo.ca/epidem/people/Faculty/BasicScientists/Stewart.html>). In her overview paper, Stewart also reports on studies that found a significant association between effective communication and clinical outcomes – a line of investigation that is updated and expanded in more recent work by Street and colleagues (Street et al. 2008).

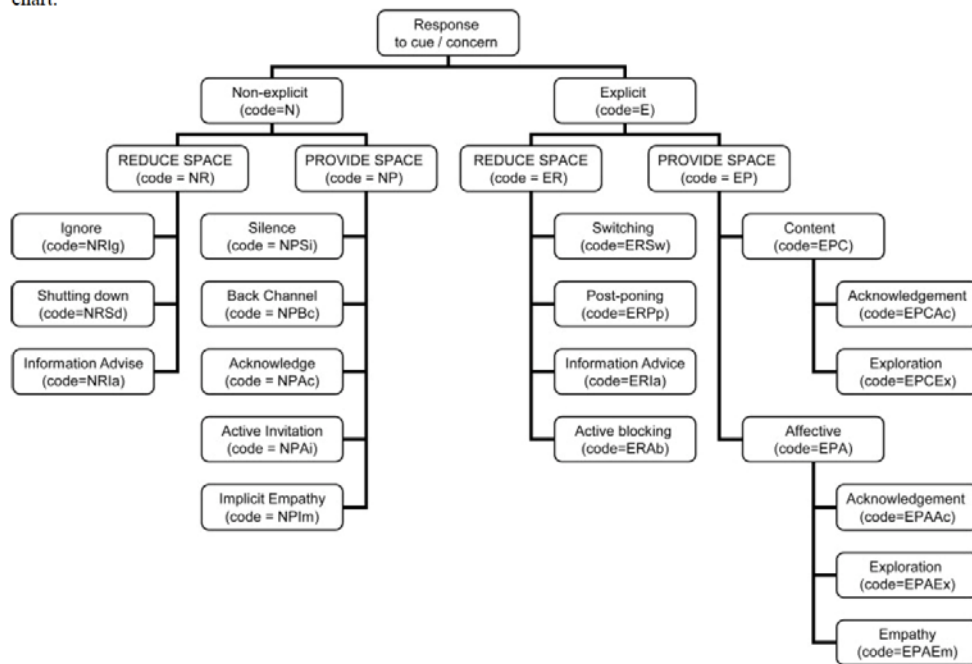
In its concern to describe and promote patient-centredness, the principal question asked by the 'patient as person' research reviewed here is how clinicians develop and maintain rapport with their patients as individuals (Roter 2004). In asking this question, this research seeks to identify the behavioural communication markers that determine relation-centred care, or 'patient-centredness' (Mead and Bower 2000). To investigate this question, this research delves into various pico- and micro-level conducts:

- do clinicians turn their bodies towards their patients (Steffenson et al. 2010)?
- do clinicians allow the patient to ask questions and make observations (Ainsworth-Vaughn 2003)?
- do clinicians build in pauses and silences enabling patients to mention matters they might not otherwise feel free to disclose (Halpern 2003)?
- do they establish and maintain eye contact (Bensing et al. 2011)?(Roter 2004).

The principal difference between the present 'patient as person' research and the 'patient as object' research reviewed in the previous section is that the former goes beyond purely biomedical concerns about the exchange and the accuracy of clinical-medical information. In treating the patient as person, clinicians may communicate about "a far wider range of dysfunctional states" (Silverman 1987). Relatedly, Mead and Bower cite Balint and colleagues who noted in the 1950s that biomedicine then was 'one-person [i.e. the doctor] medicine'. Communicating with the patient as person invokes 'two-person medicine'. This shift towards acknowledging the roles of both the doctor *and* the patient is to draw attention to the placebic or healing effect that may be inherent in effective clinician-patient communication (Del Piccolo L et al. 2010; Mead and Bower 2000). This placebic or healing effect at the heart of effective and patient-centred communication has already been reported on above, and is one that is currently attracting significant research interest (Benedetti 2011).

In their overview of patient-centredness, Mead and Bower list six rating scales, a list that has since been expanded to include still more fine-grained rating devices (Zimmermann 2010). Some of these rating scales delve deeply into the micro-interactions characterising clinicians' and patients' moment-to-moment communication behaviours. Analyses reveal whether clinicians offered patients opportunities to speak, think and articulate their questions and insights. Another rating scale, referred to as the Verona scale, specifically targets the *affective* dimensions of the interaction. This measure takes pauses and numbers of silences, amounts of talk, turn-taking dynamics, and so forth as proxies for affect. Codings of the kind shown in the figure below are applied to sequences of talk, and overall ratings are derived from how much the clinician 'closes off' ['reduce space'] or 'opens up' ['provide space'] the conversation to patient input (Piccolo et al. 2011).

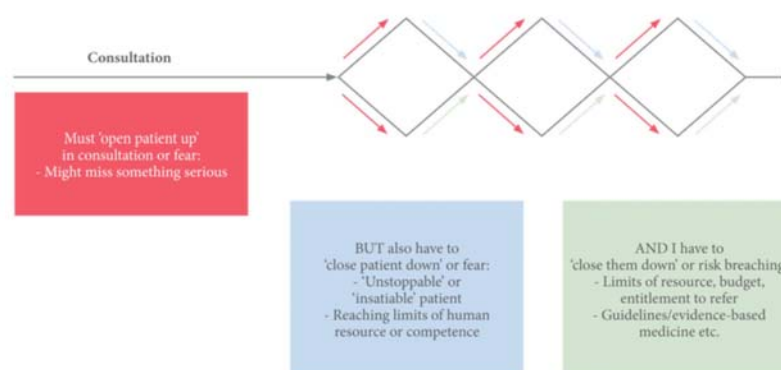
Fig. 1. The Verona coding definitions of emotional sequences for the health Provider (VR-CoDES-P) flow chart.



The main options set out in the network above serve to distinguish ‘reducing the patient’s conversational space’ from ‘optimising the patient’s conversational space’. Here, ‘ignoring the patient’ and ‘shutting the patient down’ are taken to reduce the patient’s conversational space. By contrast, ‘maintaining silence’ and ‘providing back channel confirmations’ (‘ah yes’, etc.) are seen to optimise the patient’s conversational space.

Offering an interesting reading of this dynamic ‘opening up’ and ‘closing down’, Fisher and Ereaut (2012) discuss the fear that can permeate clinical encounters, not just for patients but also for doctors. Their figure 7, reproduced below, is intended to illustrate how a doctor may close down the communication space in an effort to manage their own fear of what might happen were they to open the conversation up too far, allowing the patient ‘to say too much’ (Fisher and Ereaut 2012).

Figure 7: The doctor's solution: ‘opening up and closing down’, driven by competing fears



To tackle the issue of ‘opening the conversation up to allow the patient to speak’, Bensing and colleagues set out to collect a set of ‘tips’ from lay people for both doctors and patients (Bensing et al. 2011). These tips are summarised in the table below.

Tips for doctors	Tips for patients
<p>Before the consultation</p> <ul style="list-style-type: none"> • Give patients the opportunity for meeting the doctor without screening by a receptionist • Prepare the consultation; know who is coming and what the medical background is • Gain knowledge about the patients’ cultural background • Avoid prejudice; keep an open mind • Write on the wall: “what do you expect from the doctor?” in order to stimulate patients to reflect on it before entering 	<ul style="list-style-type: none"> • Go to the doctor if it is needed, but don’t use him/her as a substitute for your social life • Prepare yourself well: <ul style="list-style-type: none"> • -keep a diary of your symptoms • -write down what you want to ask • -reflect on your expectations • -know which medicines you take • Take a companion, if you think that you might need support • Keep your appointment!
<p>During the consultation</p>	
<ul style="list-style-type: none"> • Introduce yourself with unknown patients • Show patients that they are welcome • Keep eye contact • Listen; don’t interrupt the patient • Show compassion; be empathic • Pay attention to psychosocial issues • Take your time; don’t show your hurry • Treat patients as human beings and not as a bundle of symptoms • Take the patient seriously • Be honest without being rude • Avoid jargon, check if the patient 	<ul style="list-style-type: none"> • Take notes • Be honest about your medical problem, don’t exaggerate, don’t underplay your symptoms, and don’t be embarrassed • Tell your doctor what you already did yourself to relieve the symptoms, including self-medication and complementary medicine • Be assertive: tell the doctor what you expect • Ask for clarification if something is not clear • Tell the doctor about relevant psychosocial issues • Ask for benefits, side effects and Alternative options • Ask what you can do yourself • Be realistic; don’t expect miracles;

Tips for doctors	Tips for patients
<p>understands</p> <ul style="list-style-type: none"> • Know your limits; know when you have to refer a patient • Invest in a common agenda • Avoid disturbances by computer or telephone 	<p>the doctor is no God</p> <ul style="list-style-type: none"> • Be aware that there are other patients • Don't leave before you are satisfied with the treatment plan, or ask for a new appointment
After the consultation	
<ul style="list-style-type: none"> • Give the patient always the test-results, even if these are ok • Give the patient clear instructions what to do under certain circumstances • Give explicit opportunity for email contact • Offer sources of (trusted) information (websites; leaflets) 	<ul style="list-style-type: none"> • Adhere to the agreed treatment plan • Inform your doctor on treatment results (could be done per email) • Collect additional information from trusted sources • Respect your doctors privacy • Find another doctor if you are not satisfied, but, first, try to talk about your discontentment

At this point, and precisely because 'patient as person' is so interested in the micro-logical or moment-to-moment dimensions of patient-clinician communication, it may be useful to consider an example of *actual* clinician-patient communication. The extract below illustrates 'reducing the conversational space'. The exchange, reproduced here as a 'transcript of talk', was recorded by Marie Manidis when she was doing observations in an emergency department in 2010 (Manidis 2012; Manidis and Scheeres 2012)⁶. The exchange starts after the doctor was called away while interviewing the patient. The transcript starts with the patient and the doctor reinitiating the consult.

Extract: 'Establishing the reason for the patient's visit'

Turn	Speaker	Talk
1	P	So yes.
2	D1	Have you got any history of asthma?
3	P	No.
4	D1	And any history of any allergies?
5	P	No.
6	D1	Kidney disease?
7	P	No.
8	D1	Heart disease?

⁶ See footnote 1.

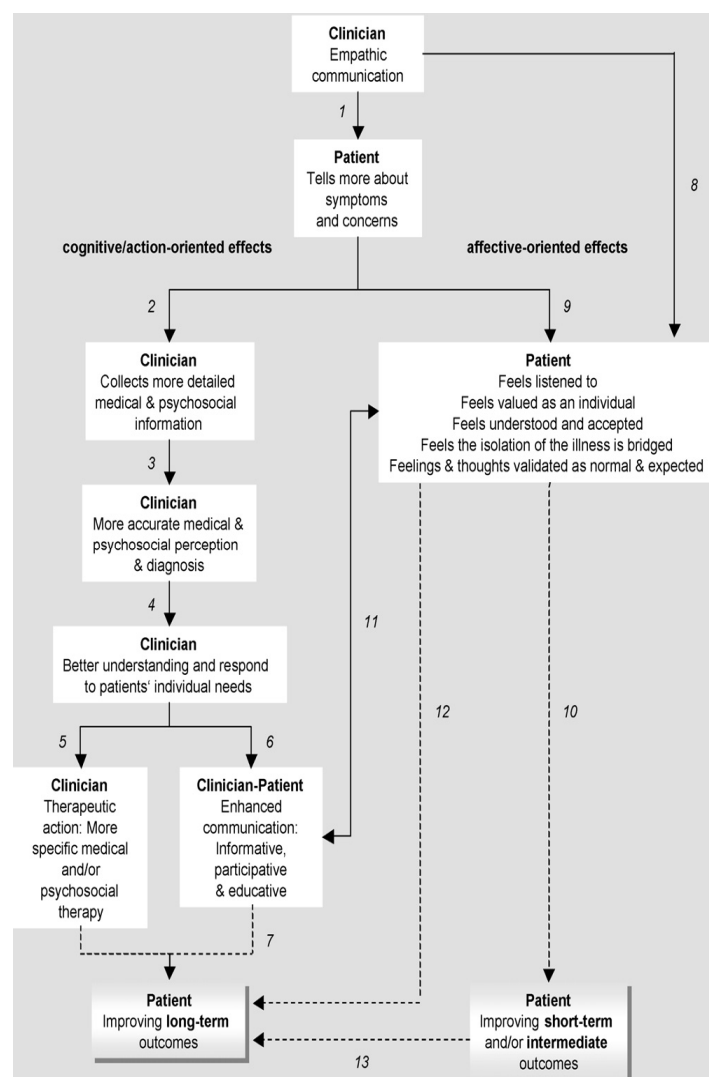
Turn	Speaker	Talk
9	P	No.
10	D1	Diabetes, myeloma?
11	P	No.
12	D1	Sickle cell anaemia?
13	P	No.
14	D1	Have you ever had contrast before?
15	P	What's (that)? Pardon?
16	D1	Intravenous contrast for any investigations or examinations?
17	P	No. I don't think so, no.
18	D1	Do you take any diabetes medications?
19	P	No.
20	D1	No chance you'd be pregnant obviously.
21	P	No.
22	D1	So we just need you to sign this form, consent to contrast. The main reactions people have to contrast are allergic reactions.
23	P	Yes. No, I've gotten pretty okay. I'm very fortunate with my health actually.
24	D1	I mean people can have an allergic reaction to contrast in which case we have to just possibly give a shot of adrenalin, but I've never seen it happen. I'm not saying it doesn't happen, but ...
25	P	Yeah.
26	D1	It's rare.
27	P	Well look I'm pretty fortunate with my - my health so far.
28	D1	Mm Oh, good, ah [date]. Okay, so we'll fax it across. It's going to take a few hours to do because you've got to ...
29	P	How long?
30	D1	A few hours. The contrast takes a couple of hours to go through.
31	P	Yep.
32	D1	That's oral, and then they'll give you the injection and they'll take some pictures.
33	P	Cool. Cool.
34	D1	So () [
35	P	[Um, can I have anything to eat or ...
36	D1	No, not while we're [doing this, no.
37	P	[Not anything? No, okay, well I'll just have some water.
38	D1	Sorry, [but (). ((Doctor leaves))
39	P	[I didn't have breakfast, didn't have dinner last night. But anyway I can – that's cool. Thank you. ((chuckles))

Much can be said about this exchange, but we will restrict ourselves to the most obvious points. No doubt due to the high-pressure environment that is the modern emergency department, the first few questions put by the doctor target clinical-medical information gathering. This conclusion is reinforced by the doctor's curt response (at turn 24) to the patient's mention of how lucky she has been with her health (at turn 23): 'I mean people can have an allergic reaction'. Implicitly signalling that she may have preferred a more personal response from the doctor, the patient repeats the point about how lucky she is with her health (at turn 27). The doctor responds to this (at turn 28), saying 'Mm Oh, good, ah 14/02/08. Okay, so we'll fax it across'. The doctor is clearly preoccupied with the medical-technical aspects of the patient's history and with the tests that need to be done, and does not respond to the patient's (repeated) attempt to broaden the conversation out to her health in general.

Towards the end of the exchange, the doctor decides to leave the consult room (again). In doing so, the doctor does not respond to the patient's query about water, nor wait for the patient to finish their point about already not having had breakfast nor dinner the day before. The haste with which

the doctor leaves raises not just patient safety questions about whether this consult was adequately concluded, but also quality of care questions about whether this exchange was satisfactory for the patient. Admittedly, emergency medicine places many demands on clinicians, particularly when the department faces over-crowding and ‘access block’ (situations where patients are unable to progress to the appropriate specialty for further care) (Horwitz et al. 2008). It remains an open question however whether, even in high stress environments such as these, clinicians can afford to reduce the patient’s conversational space (and thereby potentially also their safety) in their effort to meet formal demands and targets, as happens in the extract reproduced above.

Besides ‘patient as person’ research seeking to develop strategies for illuminating how clinicians can become more patient-centred in their communication, it has also expanded the range of reasons for taking the patient-as-person orientation seriously as clinicians. The diagram below (from Neumann et al. 2009) schematises the benefits were the clinician to be patient-centred in their communication.



Neumann and colleagues' pathway diagram traces the unfolding and effects of 'empathic communication' (Neumann et al. 2009). The pathway is constructed on the assumption that there is sufficient time and the relationship harbours personal and mutual sympathy. The socio-cultural alignment that is presumed here, and the high degree of common ground achieved, may not be realistic given the realities of everyday practice.

Empirical findings appearing in the literature demonstrate that these idealisations come up against resource limits and other practical constraints. For example, in the extract shown below, (see footnote 1), a senior, foreign-trained doctor checks up on a patient's medication. The patient's wife has already handed in a list of the medications, and they have also been written down by one of the nurses. Both these lists are in the notes.

Extract: 'Calculating dosages'

Turn	Speaker	Talk
1	D2	How much dose did you have last - in the last ? ...
2	P	Four three times a day
3	D2	400 milligrams or?
4	P	No um 600
5	D2	Six hundred milligrams
6	P	Yeah four ((patient makes an error)) five 150 tablets
7	D2	Ah okay
8	P	150 gram tablets
9	D2	And 600 milligrams the whole of the day
10	P	Yeah
11	D2	[So one
12	P	[Ah 600 three times a day
13	D2	Three times a day, okay ?
14	F	[Eighteen hundred
15	P	[Yeah so I get a - I get a ()
16	D2	[Eighteen hundred
17	P	Yeah, 10-day cycle is 120 tablets

On this occasion, it took 17 exchanges by the senior doctor to establish an already documented fact. The senior doctor, whose English is not his first language, tends to repeat what he hears each time, either for clarification or confirmation. Here, there is no question of 'opening up' the exchange, mainly due to the need to establish basic information. For overseas doctors, of course, the expectations set out under the aegis of 'patient as person' research can be particularly daunting. In Srivastava's words:

The majority of complaints against doctors, foreign or local, relate to inadequate communication. It is quite possible that foreign doctors fare worse in unfamiliar and challenging situations because they lack not just conversational content but also context. Simply put, many doctors don't know how to address seemingly unique Western problems. (Srivastava 2012)

In this newspaper article, Srivastava continues by stating that the urgency to make up for workforce shortages is made to trump communication training of overseas doctors that inducts them to both linguistic and contextual matters critical to communicating with Australian patients and patients from other cultural and linguistic backgrounds:

There is implicit acknowledgement that we do foreign doctors a disservice by putting our workforce needs before their broader training. Passing an exam doesn't turn anyone into the kind of sensitive, compassionate, engaged doctor that society desires. Investment in communication and cultural competency does. (Srivastava 2012)

For good reasons, the research brought together in this section is particularly interested in communication as it unfolds on a relational, interpersonal level. As researchers delve more deeply into the sequential dynamics of such communication, sophisticated accounts become available of how and why clinicians failed or succeeded in their interactions with patients. On the one hand, these kinds of analyses enable researchers to begin to address the levels of sophistication and success with which medical-clinical information is negotiated between clinicians and patients. This enables researchers to make claims about, among other things, mutual understanding and agreement (Ledford et al. 2010).

On the other hand, these analyses render tangible the relational dimensions of clinician-patient interactions, providing answers to questions surrounding trust, respect, and affect. As Finset concludes (Finset 2012), positive emotions may lead to reduced distress for the patient (Duric et al. 2011), better patient adherence to treatment advice (Soo Kim et al. 2004), and better symptom resolution (Hojat et al. 2011). A review by Makoul & Clayman (2006) confirmed that effective patient-physician communication is related to improved adherence to medical regimens, better decision making, fewer claims of malpractice, and increased satisfaction with the patient physician relationship. In addition, the overall results of Zachariae et al.'s study "showed that higher patient-physician relationship inventory (PPRI) scores of physician attentiveness and empathy were associated with greater patient satisfaction, increased self-efficacy, and reduced emotional distress following the consultation" (Zachariae et al. 2003: 658).

Relatedly, interest in clinicians' **empathy** has led to a host of studies investigating its impact on patients' behaviour and outcomes. Empathy is found to enhance patients' willingness to raise issues and ask questions (Neumann et al. 2009). Here, of course, a connection is forged between the technical task of information gathering and the emotional task of being receptive to patients' concerns, questions and insights (Frankel 2009) in order to ensure that all relevant information is discussed. Soo-Kim et al.'s 2004 study again confirmed that empathy increased patient satisfaction and compliance (Soo-Kim et al. 2004). A recent study established a link between clinical empathy and patients' ability to recuperate from a cold (Rakel et al. 2011).

A persuasive overview of how positive communication ameliorates patients' health outcomes is that by Street and colleagues (Street et al. 2009). They distinguish indirect health outcomes from direct ones, referring to improved comprehension and access (indirect outcomes) and better adherence and clinical results (direct outcomes). In seeking to connect emotional aspects of communication to conversational *and* clinical outcomes, Street and colleagues (2009), conclude the following:

While talk itself can be therapeutic (e.g., lessening the patient's anxiety, providing comfort), more often clinician–patient communication influences health outcomes via a more indirect route. Proximal outcomes of the interaction include patient understanding, trust, and clinician–patient agreement. These affect intermediate outcomes (e.g., increased adherence, better self-care skills) which, in turn, affect health and well-being. We identify seven pathways through which communication can lead to better health including increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment, and better management of emotions. (Street et al. 2009)

These findings point to the placebic effects on patients of effective patient-clinician communication. Bensing and Verheul (2010) set out to demonstrate that placebo effects were relevant and could be used as an effective part of many treatments through using communication as placebic mechanism. Gramling's (2004) study with palliative care nurses demonstrated that "even the briefest touch had the potential to harmonize the social and embodied realities [of patients]". Patients could "vividly remember instances of the nurse's touch, perceived as healing, for many months after the encounter" (Gramling 2004).

Research in this strand also investigates what occurs if clinicians are not responsive and sensitive to patients. For example, the opposite of clinician responsiveness has been identified as a nocebic or detrimental mechanism. Benedetti et al. (2007) identified the powerful force of painful words on the patient's neurological firings in and after consultations, and how this could impact on their health outcomes. Speaking about interaction, but giving it a system's relevance, Frankel & Quill (2005) state that "a growing body of literature on patient safety documents that communication breakdowns between physicians and patients and between physicians and other team members, as well as ineffective systems of care account for a significant percentage of harm done to patients" (2005). They conclude that health licensing agencies, accreditation bodies, teachers, and policymakers are in agreement about care and compassion as essential qualities for graduating physicians.

Now to turn to *analyses of in situ* communication, researchers have made evident that while patient-centredness may in principle have been accepted into health care, its ethics of moral equality and collaborative decision-making is not always, or perhaps even rarely, achieved in practice (King and Moulton 2006). To address this, **shared decision making** was conceived as a means to concentrate clinicians' and researchers' attention on the need for and the means for achieving moral and interactive equality between clinician and patient (Shale 2011). Pushing the empirical reality of how

clinicians position patients in interaction radically to the fore, shared decision-making or ‘SDM’ represents an important extension to the morality of inclusiveness initiated through informed consent, and further expanded through patient-centredness.

Firth however it is important to acknowledge that SDM serves different purposes for different researchers. For example, for Ledford and colleagues, shared decision-making is contingent on the following four conditions:

First, the physician and patient are active in the decision making process. Second, the physician shared information with the patient, and the patient shared information with the physician. Third, the physician and the patient both express treatment preferences. Fourth, the physician and the patient agree on the treatment to implement. (Ledford et al. 2010)

Ledford and colleagues’ definition references predominantly the *informational* dimensions of clinician-patient communication. As for research that treats the patient as object, for the research discussed presently (‘patient as person’) too, the agency of the clinician remains central. The transition from ‘clinician-patient communication’ to ‘patient-clinician communication’ is yet to occur. However, increasing amounts of research have begun to appear during the first decade of the 21st century that position the patient as central, both in principle and in practice. A prime example of this radical shift is the overview article by Mauksch and colleagues’, which lists a set of meta-dimensions that they regard as ‘fundamental to all medical encounters’ (2008).

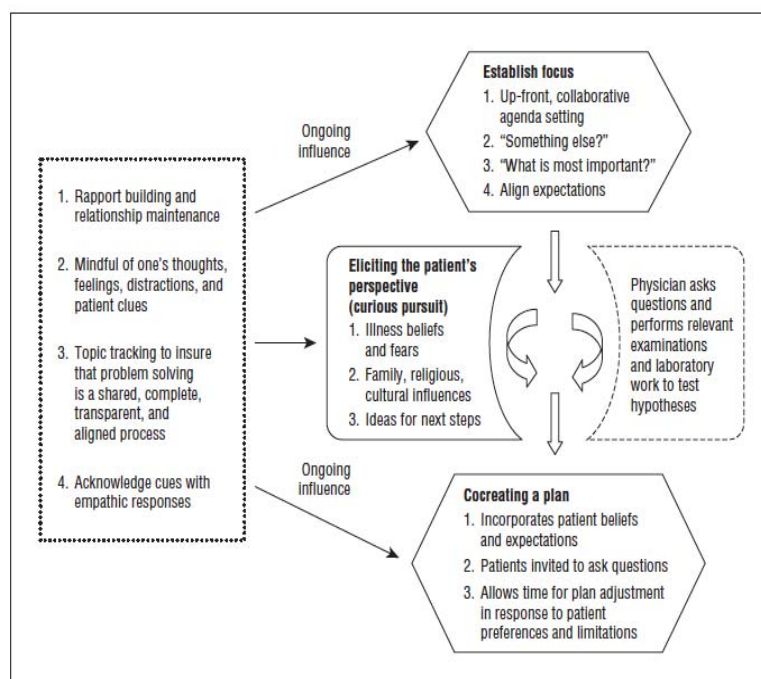


Figure 1. Relationship, communication, and efficiency: skills.

Relationship, communication, and efficiency: skills (Mauksch et al. 2008)

Mauksch et al.'s meta-dimensions are uniquely patient-centred in orientation. The first is '*rapport building*', which they argue may enhance quality of care without taking more time. The second is '*mindfulness*'; the third is '*topic tracking to ensure shared problem solving*', and the fourth is '*acknowledging patient cues*' (Mauksch et al. 2008). In their diagram reproduced above, the authors link these four meta-dimensions of communication to more specific or micro aspects of the communication as it unfolds in real time.

At this micro-level, they list 'establishing a focus', 'eliciting the patient's perspective', and 'co-creating a plan'. These conducts are then further specified. For example, 'eliciting the patient's perspective', defined as 'curious pursuit', breaks down into eliciting 'illness beliefs and fears', family, religious and cultural influences', and 'ideas for next steps'. The way in which these more specific aspects of the conversation are enacted is framed of course by the meta-dimensions referred to earlier, turning this exposition into a very specific behavioural route map.

Mauksch and colleagues' 2008 paper synthesises a host of studies that address the way that clinicians do (and or need to) respond to patient backgrounds, their needs, and their preferences. These include studies that examine the extent to which the clinician establishes a good interpersonal relationship with the patient (Ha and Longnecker 2010); demonstrates empathy (Adams and Frankel 2007; Bensing et al. 2011; Neumann et al. 2009; Roberts et al. 2003; Soo Kim et al. 2004b; Zachariae et al. 2003); engenders trust (Bonvicini et al. 2009; Dyche 2007; Lupton 1997; Ommen et al. 2008; Paget et al. 2011) develops rapport and shows respect (de Haes and Bensing 2009; Hannawa 2011; Knoderer 2009; de Haes & Bensing 2009 in Lupton 1997; Robins et al. 2011; Schirmer et al. 2005); maintains personal (not just biomedical) interest, understands the patient's needs, concerns and fears, exercises power over the patient (Lupton 1997); facilitates the patient's choices, and manages the patient's emotions (Dyche 2007; Finset 2008; Roter 2004).

Critical in most of these studies is the issue of clinician **responsiveness**. Clinicians - doctors, nurses as well as allied health clinicians - must demonstrate listening, hearing, sharing, honesty and empathy and taking patients seriously (Bensing et al. 2011). Many of these studies identify **empathy** as a key component of clinician responsiveness, although empathy is defined in different ways by different researchers. For Dyche (2007), empathy is seen as 'cognitive and bounded', enabling him to frame it as interpersonal skill. This suggests that empathy is a 'conscious' and interactionally achieved capability, rather perhaps than an experienced affect. For their part, Roter and Larson define empathy in linguistic terms as 'statements that paraphrase, interpret, recognize or name the other's emotional state' (Roter and Larson 2002).

For Rao and colleagues (2007), the way the clinician manages the emotional/ knowledge *balance* of the consultation is critical: “In its optimal form, patient-, or relationship-centred communication is characterized by a balanced exchange of information, ideas, and preferences between the physician and patient, with each playing a complementary role during the interaction” (Rao et al. 2007). This question of balance is also central to Roter (2000b):

[I]mprovements in communication require a shift in the balance of power between physician and patient this shift should not be a full pendulum swing to patient autonomy; autonomy is itself appears not to be the answer. When the medical dialogue is a shared process, outcomes are better. Neither physician dominance or total abdication of power was related to positive patient outcomes, rather engagement in a process that leads to agreement on problem and problem solving appears the optimum alternative. (2000b).

The progression of patient-centredness research towards dialogue-centred research is becoming evident here. This development arises from the realisation that patient-centredness, on its own, cannot account for the complexities and vicissitudes inherent in contemporary care. To address these dimensions, a different perspective is needed; one that acknowledges that relationship building is but one among the many communicative skills expected from the contemporary clinician.

‘[T]here are simple actions that clinicians can take [to support patients’ involvement in safety]. These include: actively listening to and taking seriously patients’ concerns; providing a clear explanation when concerns or views differ from those of the patient; appearing to have the time to talk by making eye contact and other non-verbal behaviours such as sitting by the patient’s bed; and if acceptable to the patient, involving relatives in their care. Reassuring patients that it is okay to ask by using posters or information leaflets helps to reinforce this message’ (Doherty and Stavropoulou 2012).

Given the growing complexity, mobility, multi-variacy and fast-paced nature of care, greater emphasis is now placed on how communication is made to continue across gaps between people, spaces, institutions, technologies and channels. It is here that the ‘patient as uncertainty’ perspective arises as distinct strand in patient-clinician communication research. In what follows we list summaries of papers relevant to the present section, before moving on to consider ‘patient as uncertainty’ research.

Selected annotated bibliography 2) Communicating with ‘the patient as person’

Study and Authors	Study description and findings/practice implications
(Beach et al. 2010) Differences in patient-provider communication for Hispanic compared to non-Hispanic white patients in HIV care	<p>For this study, the researchers recruited 19 HIV providers and 113 patients seen by them at two sites in New York City and Portland. The patient group consisted of 58 Hispanics and 55 whites. Patient-provider encounters were recorded in examination rooms and later analysed to determine how well the patient communicated with their provider. This included whether they asked questions, engaged in information exchange, and participated in emotional talk, including positive and negative talk and social chit-chat—areas where the researchers found no significant differences.</p> <p>Hispanics with HIV have different communication styles with their health care providers than whites. One aspect of the medical encounter with health care providers is interpersonal communication during the visit. This is particularly important in HIV care, where discussions about treatment are often complex and personalised. Hispanic patients with limited English proficiency are expected to have communication barriers. However, a new study finds that even Hispanics who speak English well have different communication styles than white patients.</p> <p>Findings: The researchers found significantly less patient-centred communication during encounters between Hispanic patients and their doctors compared with white patients. Specifically, Hispanic patients, regardless of their English proficiency, tended to engage in less psychosocial talk with their providers. However, despite these differences in communication styles, Hispanic patients rated their providers' communication higher than white patients. In light of their findings, the researchers suggest that health care providers should make every effort to ensure that psychosocial issues are addressed during encounters with all patients.</p>
(Benedetti 2011) The Patient's Brain: The neuroscience behind the doctor-patient relationship	<p>This book explains how, from a neuroscientific perspective, doctor-patient communication <i>per se</i> affects the patient's well-being. The book's emphasis on the significance of the therapeutic encounter itself and the communication that takes place during it serves to highlight for clinicians that communicative behaviour has a healing effect in its own right, well before any medical-clinician treatments are initiated.</p>
(Benedetti et al. 2007) When words are painful: unravelling the mechanisms of the placebo effect	<p>This study examines how consult communication may have a placebo (or a nocebo) effect. The authors identify that in recent years, different types of placebo responses have been analysed with sophisticated biological tools that have uncovered specific mechanisms at the anatomical, physiological, biochemical and cellular level.</p> <p>Results: The authors identify that most of our knowledge about the neurobiological mechanisms of the placebo response comes from pain and Parkinson's disease, whereby the neuronal circuits involved in placebo responsiveness have been identified. In the first case, opioidergic, dopaminergic and cholecystokinergic networks have been found to be involved. In the second case, dopaminergic activation in the striatum and neuronal changes in basal ganglia have been described. This recent research reveals that these placebo-induced biochemical and cellular changes in a patient's brain induced as a result of being involved in a consult are very similar to those induced by drugs. The authors suggest that this new way of thinking about communication may have profound implications both for clinical trials and for medical practice.</p>
(Bensing & Verheul 2010) The silent healer: The role of communication in placebo effects	<p>Placebo effects have an ambiguous reputation, as they are associated with sham treatment and deceit on the one hand and as interesting phenomena, which might be clinically relevant on the other. The goal of this paper is to demonstrate</p>

Study and Authors	Study description and findings/practice implications
	<p>that placebo effects are relevant and can be used as an effective part of many treatments by using communication targeting placebo effect mechanisms. The researchers examine the history of placebos and the placebo effect, addressing common misconceptions and disentangling ambiguities. They then review whether the placebo effect can be robustly shown in the current literature, and zoom in on the plausible mechanisms (conditioning, expectancies and affect manipulation) through which the placebo effect might be produced.</p> <p>Observing the link with the doctor-patient communication literature, and pleading for a better integration of the two research traditions, the authors conclude by setting out a research agenda for testing the placebo effect(s) of consult communication.</p>
(Bensing et al. 2011) How to make the medical consultation more successful from a patient's perspective? Tips for doctors and patients from lay people in the United Kingdom, Italy, Belgium and the Netherlands	<p>The aim of this study was to generate empirically based 'tips' from lay people on how medical consultations could become more successful from a patient perspective. The researchers invited 258 lay people in the United Kingdom, Italy, Belgium and the Netherlands, distributed over 32 focus groups, to formulate 'tips' for doctors as well as patients after rating the quality of communication from videotaped consultations and discussing their arguments in focus groups.</p> <p>Results: The authors found that tips were remarkably similar across the four countries. Moreover, most tips reflect what is known in the professional literature, such as the importance of nonverbal communication, personal attention and empathy, but also addressed issues as how to deal with new technologies and new accessibility arrangements (triage). The tips were targeted to the consultation itself, its preparation and the aftercare.</p> <p>Conclusion(s): The researchers concluded that lay people appear to be competent in participating in quality-of-care debates. They are well aware of patients' own responsibilities. Besides, they have clear opinions about novel technology and healthcare arrangements (triage).</p> <p>Practice implications: Listening to patients, showing empathy and personal attention seem to have a universal value. Doctors should be trained to practise these behaviors, and healthcare managers should be assisted to involve patients in practice re-organisation.</p>
(Bonvicini et al. 2009) Annotated bibliography for Clinician Patient Communication to Enhance Health Outcomes	<p>This is an annotated bibliography of multiple studies covering a wide range of approaches to understanding links between communication and health outcomes.</p>
(Charlton et al. 2008) Nurse practitioners' communication styles and their impact on patient outcomes: an integrated literature review (Literature review)	<p>This review seeks to examine published research stretching from 1999 to 2005 and seeks to draw a link between patient outcomes and best practice communicative styles. The authors describe two communication styles, in particular biomedical and biopsychosocial. They identify the latter as patient-centered. They find that biopsychosocial (patient-centered) communication influences patient outcomes positively, including improved patient satisfaction, better adherence to treatment plans, and improvements in patient health. The article makes the following clinical suggestions: more work should go into defining patient-centred communication and then measuring it. Measurements should specifically focus on patient satisfaction/dissatisfaction; adherence to treatment plans and improved/decreased patient health and finally what impact communication styles have on lawsuits relating to malpractice.</p>
(Del Piccolo et al. 2004) The biopsychosocial domains and the functions of the medical	<p>This is a psychometrically-based study examining the construct validity of the Verona Medical Interview Classification System in GP consultations. Factor analysis (FA), the authors argue, is a powerful method of testing the construct validity</p>

Study and Authors	Study description and findings/practice implications
<p>interview in primary care: construct validity of the Verona Medical Interview Classification System (Conceptual paper)</p>	<p>of coding systems of the medical interview. The study used FA to test the underlying assumptions of the Verona Medical Interview Classification System (VR-MICS). The authors examine the relationship between factor scores and patient characteristics. The VR-MICS coding categories consider the three domains of the biopsychosocial model and the main functions of the medical interview—data gathering, relationship building and patient education.</p> <p>FA is performed on the frequencies of the VR-MICS categories based on 238 medical interviews. Seven factors (62.5% of variance explained) distinguish different strategies patients and physicians use to exchange information, build a relationship and negotiate treatment in the domains of the biopsychosocial model.</p> <p>Results: The study's results show that distinguishing the content of speech acts provides a richer description of the exchanges between patients and physicians than would occur by considering only speech acts. For example, they find that the Psychological Inquiry factor shows that physicians investigate psychological topics with psychological and bio-psychological questions. The GPs also give information—at this stage certainly premature—rather than helping the patient explore psychological issues. As expected the Psychological Inquiry factor correlates with the GP's knowledge of a patient's past psychiatric history and his [sic] attribution of a psychological disorder.</p> <p>Conclusion(s): The authors concluded that three factors, Psychological, Social Inquiry and Management of Patient Agenda are related to patient data: sociodemographic (female gender, age and employment), social (stressful events), clinical (GHQ-12 score), personality (chance external health locus of control) and clinical characteristics (psychiatric history, chronic illness, attributed presence of emotional distress).</p> <p>The results demonstrate which skills the GPs of this study actually use in conducting the biopsychosocial inquiry and in carrying out the three functions of the medical interview, and which key skills are missing. The authors identify that these findings have important implications for training, suggesting that physicians have to learn to widen their repertoire of patient-centred skills in relation to the domain they are exploring and the function they wish to accomplish. For example, the use of facilitation skills for information gathering should be encouraged in each domain—psychological, social and biomedical.</p>
<p>(Dyche 2007) Interpersonal Skill in Medicine: The Essential Partner of Verbal Communication</p>	<p>In this paper, Dyche identifies interpersonal skills as a distinguishable component of communication skills. The paper offers a framework for describing interpersonal skills and understanding their relationship to verbal communication. The interpersonal skill-set comprises Understanding, Empathy and Relational Versatility. The author begins by pointing out that medical educators have promoted skilful communication as a means for doctors to develop positive relationships with their patients. He says that in practice, communication tends to be defined primarily as what doctors say, with less attention to how, when, and to whom they say it. These latter elements of communication, which often carry the emotional content of the discourse, are usually referred to as interpersonal skills. Dyche says that although recognised as important by some educators, interpersonal skills have received much less attention than task-oriented, verbal aspects. Dyche further identifies that the field lacks a common language and conceptualisation for discussing them.</p> <p>Conclusion(s): Dyche says by way of conclusion, that if medical educators are to heed Roter's 2003 challenge to move everyone's understanding of the healing relationship beyond a linear, reductionist model, then they must incorporate methods that explore the characteristics and experiences of all participants and the interaction among them. He argues</p>

Study and Authors	Study description and findings/practice implications
	for greater clarification of language, better integration of frameworks, and the need to produce and research new hypotheses about the relationship between communication and interpersonal skills. He says students deserve the best possible training in these skills, and that patients deserve no less.
(Epstein 2000) The science of patient-centered care	Epstein challenges some of the ideas about the meaning of the term 'patient-centred'. He draws on the paper by Stewart <i>et al.</i> (2000) and other research to comment on the impact of patient-centred care on (health) outcomes. He outlines that patient-centred care expands on the disease-oriented model by incorporating the patient's experience of illness, the psychosocial context, and shared decision making. This type of care, Epstein points out, has been adopted as a model of medical practice by many primary care physicians, medical educators, and specialists. He suggests that elements of patient-centred care have been described since antiquity, and although different authors have used different nomenclature, the fundamental idea is that the process of healing depends on knowing the patient as a person, in addition to accurately diagnosing their disease. He confirms that evidence that elements of a patient-centred approach improve important outcomes of care is abundant, but many myths about this type of care persist. For example, some clinicians conflate the concepts of 'patient-centred' and 'psychosocial', and thereby place a limit on the interpersonal potential of the consult.
(Finset 2012b) "I am worried, Doctor!" Emotions in the doctor-patient relationship (Review of literature)	<p>This study seeks to review research on emotional communication in medical interviews regarding predictors, physiological correlates and effects of clinicians' responses to patients' cues and concerns and individual differences among patients. In the study, Finset explores four questions regarding emotional communication: What factors predict how clinicians respond to emotional cues and concerns? What happens in the brain and the body of both patients and clinicians during emotional talk? Are there individual differences in patients' responses to emotional talk in medical interviews? Do clinicians' responses to emotion affect health outcome?</p> <p>Conclusion(s): Finset concludes that building on evidence reviewed, research on predictors of clinician responses, physiological correlates of behaviour, individual differences and effects on outcome should be further pursued.</p> <p>Practice implications: In communication skills training programs, better understanding of the phenomena described could have implications for training clinicians to handle emotions in clinical interviews.</p>
(Finset 2012a) Communication about pain in medical consultations (Editorial)	<p>Taken together, findings (of the studies addressed in this editorial) indicate that physicians and patients are both concerned with the importance of good information about diagnosis and treatment, but that the underlying understanding of the mechanisms are not always sufficiently explored. Finset addresses a number of studies in the editorial. He mentions a study of 509 videotaped consultations in a university medical centre, finding that a larger proportion of time is allocated to history taking and physical examination and proportionally less to talk about health knowledge and beliefs in high pain patients, compared to those with low pain [Bertakis <i>et al.</i> 2003]. He suggests that there appears to be a potential for improvement in consultations about pain, by spending more time in the consultation to promote common ground and agreement between physician and patient and to promote coping with stress. Agreement between physician and patient has actually been identified as a significant predictor of higher patient satisfaction and better health status outcomes in patients with back pain [Staiger <i>et al.</i> 2005].</p> <p>Finset identifies a number of different psychological approaches that have been applied recently in primary care to</p>

Study and Authors	Study description and findings/practice implications
(Fischer & Ereaut 2012) When doctors and patients talk: making sense of the consultation	<p>promote better cognitive and emotional handling of pain, also in the framework of medical consultations [Turk <i>et al.</i> 2008; Sanders <i>et al.</i> 2007].</p> <p>This research – bringing together insights from two quite distinct disciplines, complex adaptive social systems and discourse analysis – makes the very simple point that it is the relationship between doctors and patients that is at the heart of a health system. The authors suggest that if a different health system is required, it will be necessary to have a different type of relationship.</p> <p>The authors describe their work as research-based consulting. They undertook data collection and analysis in the NHS (National Health Service of the UK) but also drew on the collective experience and interpretative ability of their own work, as consultants and The Health Foundation as experts in this field.</p> <p>They describe their approach as qualitative, eclectic and pragmatic; thus the work is systematic and based in data but is also interpretative, drawing on two distinct theoretical frameworks and on the experience of the authors.</p> <p>The authors describe a dynamic that, whether or not it is fit for a bygone age, does not meet the needs of a health system in an economically developed, politically democratic, technologically sophisticated country. They contend that partly due to the success of medical intervention, the hospital has become a place for the very ill and the community has become a place in which people live with long-term conditions. Recognising that everyone is stuck in a relationship that does not meet current needs and which disadvantage patient and doctor alike is not easy. As the authors say:</p> <p style="padding-left: 40px;">In the early stages of transformation the dominant powers and logic of any system may not even see the problems or recognise them as significant. Often even those who are disadvantaged by the clinician-patient dynamic do not recognise it. (Fischer & Ereaut 2012, p. 4)</p> <p>The report offers a powerful analysis of the current patient-clinician relationship – from recognition of the mutual fears and anxieties that drive doctors and patients, to the invisible structures that are natural to the doctor but hidden from the patient, notably the fact that patients do not understand the process of how the consultation works. The authors recommend that quality improvement interventions should be part of a strategy that aims to: surface and make unsustainable some of the systemic forces and practices that maintain the status quo; co-create a desired model of the patient–doctor dynamic (not just in the moment of consultation, but of their relationship to the whole system); develop processes and support systems that increase likelihood of the patient and clinician being at their best in the moment of interaction; support organisations to be ‘joined up’ around the consultation (both before and after); institutionalise learning about what supports and grows the above (items), and identify constraints that could be overcome with supported innovation.</p> <p>Furthermore the authors add that any strategy should aim to promote interventions that address: the identity (meaning) of the consultation: the necessary relationships in it (and between it and the rest of the system); the information (in the widest sense, not just conventional data) around which the consultation should be structured.</p>
(Frankel 2009) Empathy research: A complex challenge (Editorial)	<p>Frankel states that for as long as he can remember ‘the standard critique of the biomedical model was that it completely bypassed the social and the psychological’ (Frankel 2009, p. 1). Now he says its time to ask what the role is of biology and physiology in physician-patient communication. He thinks that asking that question may lead to a kinder, gentler and more</p>

Study and Authors	Study description and findings/practice implications
(Gramling 2004) A Narrative Study of Nursing Art in Critical Care	<p>caring approach to the study of clinical empathy.</p> <p>This study is based on research in an ICU using patient narratives of their time in ICUs. The study identifies a number of elements in this highly mechanised setting, particularly around the benefits of nurses' touch as a healing practice. The study identifies that (a) the subjectivity of the patient in the critical care setting is protected when the patient's knowledge practices are honoured; (b) the patient's ability to know the nurse is as crucial to the interaction as the nurse's ability to know the patient; (c) in the respondents' narrative accounts, technological apparatus is rarely identified as a cause for dehumanisation or impugning a patient's dignity. Despite the overwhelming presence of medical machinery, the nurse remains the primary agent of humanisation or dehumanisation of the patient's body; and (d) the nurse is the patient's intersubjective partner in the procedure of "gaining footing" in a social frame (the ICU) that he or she has not entered voluntarily; the presence and proximity of the nurse enables the patient to recover self as an everyday social being. The present study offers further evidence that even the briefest touch from the nurse has the potential to harmonise the social and embodied realities of respondents. Likewise, patients can vividly remember instances of the nurse's touch, perceived as healing, for many months after the encounter.</p>
(Ha & Longnecker 2010) Doctor-Patient Communication: A Review (Review)	<p>This is an Australian paper that takes a somewhat unorthodox approach to the write up. Although the authors reference 47 studies/papers, they indicate neither study inclusion criteria, nor the time frame of the review. Studies reviewed appear to have been conducted over the past decade. The authors however title the paper as a review of the literature on doctor-patient communication. In this study, the authors identify from the studies reviewed that effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship, which they say is the heart and art of medicine. They identify good communication as important in the delivery of high-quality health care. They also point out that much patient dissatisfaction and many complaints are due to breakdown in the doctor-patient relationship. They contend that many doctors tend to overestimate their ability in communication. They acknowledge that doctors are in a unique position of respect and power, and they outline the importance of this in relation to patients' health.</p> <p>According to their review of the literature, effective doctor-patient communication can be a source of motivation, incentive, reassurance, and support. A good doctor-patient relationship can increase job satisfaction and reinforce patients' self-confidence, motivation, and positive view of their health status, which may influence their health outcomes. Most complaints about doctors are related to issues of communication, not clinical competency. Patients want doctors who can skilfully diagnose and treat their sicknesses as well as communicate with them effectively. The paper concludes that doctors with better communication and interpersonal skills are able to detect problems earlier, can prevent medical crises and expensive intervention, and provide better support to their patients. This may lead to higher-quality outcomes and better satisfaction, lower costs of care, greater patient understanding of health issues, and better adherence to the treatment process. There is currently a greater expectation of collaborative decision making, with physicians and patients participating as partners to achieve the agreed upon goals and the attainment of quality of life.</p>
(Hulsman, Visser & Makoul 2005) Addressing some of the key questions about	<p>The editorial is useful in that it identifies some of the key issues that have continually been addressed in medical communication research. The authors give an overview of this issue of <i>Patient Education and Counseling</i>, which offers a</p>

Study and Authors	Study description and findings/practice implications
communication in healthcare (Editorial)	<p>range of articles related to the AAPP 2005 Forum/International Conference on Communication in Healthcare, held at Northwestern University Feinberg School of Medicine in Chicago in October 2005. The conference itself focused on communication skills in medical education and medical practice, as well as research on communication in a variety of healthcare contexts.</p> <p>The authors point out that the scientific language of communication training and research, with its emphasis on relationship and patient involvement, overlaps substantially with the moral language of humanity and autonomy. Across nearly four decades of communication research, the need of methods to observe and analyse clinical communication in a valid and reliable way has resulted in the development of a large variety of instruments. Still, they say, the context in which students acquire their skills is more complex than that. They identify that an important stress factor for practicing physicians is low treatment adherence of their patients, often resulting in behaviours by the clinicians such as confronting (their patients), advising and stressing the importance of the patient's behaviour change.</p> <p>The editorial also mentions two studies in the issue that focus on the communication needs of particular patient groups. They identify children and parents as another category of patients that need special attention in medical communication. They hope that like this special issue, the conference will highlight innovative and relevant approaches for addressing some of the key questions regarding communication in healthcare.</p>
(Lawton & Carroll 2005) Communication skills and district nurses: examples in palliative care	<p>This is a short professional development resource that reviews some verbal communication skills that are applicable to district nursing.</p> <p>The discussion focuses particularly on palliative care situations because, in the experience of primary care, people face numerous challenges in relation to communication with patients who are dying. They point out that nurses in the community may face particular challenges because the location of care delivery – in people's own homes – and this creates a different dynamic to care in a hospital environment (they cite McGarry 2004). For example some specific situations that the district nurse may encounter include being called upon to answer direct patient questions, being asked to collude with family members, and having to face denial and anger. The paper identifies that communication skills are a fundamental component of successful nursing, and as such they cannot be taken for granted. The writers highlight a couple of key items in this nurse patient relationship including that assessing what the patient knows about their illness is a key factor to effective communication. The short paper pays particular attention to the first visit made by the district nurse to the patient's home. A framework of communication styles is used to understand the responses that may be given in such challenging situations. The authors propose that as much thought and care are required to develop good communication skills as are needed for any other element of nursing.</p>
(Lehmann et al. 1988) Measurement of Patient Satisfaction: The Smith-Falvo Patient-Doctor Interaction Scale (Review of methods)	<p>Patient satisfaction has been considered important for many years. This article provides a review of various methods that have been developed to measure patient satisfaction and describes the use of the Smith-Falvo scale in determining patient satisfaction with the medical services provided by residents in the Verdun Family Practice Program.</p> <p>In view of the limited range of scores provided by the use of this scale, the authors recommend that further research be done to develop a method of assessment of patient satisfaction that will take into account the duration of patient physician interviews.</p>

Study and Authors	Study description and findings/practice implications
(Levinson, Lesser & Epstein 2010) Developing Physician Communication Skills for Patient-Centred Care	<p>Growing enthusiasm about patient-centred medical homes, fuelled by the Canadian Patient Protection and Affordable Care Act's emphasis on improved primary care, has intensified interest in how to deliver patient-centred care. Essential to the delivery of such care are patient-centred communication skills. The authors propose that these skills have a positive impact on patient satisfaction, treatment adherence and self-management. The authors propose a progressive scale on the links between teaching patient-centred communication skills and outcomes. These move from immediate outcomes such as clinicians demonstrating these skills in the interview, to intermediate outcomes such as increased patient knowledge, increased patient self-efficacy, better informed decision making and increased adherence and finally improved patient self care. Finally the scale addresses improved health outcomes which include improved biologic outcomes, improved quality of life and well-being, improved survival, reduced care disparities and reduced care costs.</p> <p>The authors argue that patient-centred skills can be effectively taught at all levels of medical education as well as to practicing physicians. Yet most physicians receive limited training in communication skills. They identify a number of ways to fund this training including policy makers and stakeholders leveraging training grants. They also propose payment incentives, certification requirements, and other mechanisms to develop and reward effective patient-centred communication.</p>
(Lewin et al. 2001) Interventions for providers to promote a patient-centred approach in clinical consultations	<p>This is a review of 17 studies (RCTs, CCTs, CBA's) examining the effects of interventions directed at health care providers that are intended to promote patient-centred care in clinical consultations, and the extent to which these interventions succeed in making consultations patient centred. The review also examines the effects of the interventions on health care behaviours, health status and well-being and patient satisfaction with care.</p> <p>A broad definition of Patient-Centred care is adopted for the purposes of the review as follows: 1) health care providers share control of consultations, decisions about interventions or the management of the health problems with patients, and/or 2) health care providers focus on the patient as a person, rather than solely on the disease, in consultations. A number of processes and outcomes might be affected by interventions that aim to promote patient-centred care in the clinical consultation. These outcomes are grouped in the following categories: 1) consultation processes, including the extent to which patient-centred care is judged to be achieved in practice; 2) other health care behaviours, including types of care plans agreed; providers' provision of interventions; patients' adoption of lifestyle behaviours; and patients' use of interventions and services; 3) health status and well-being, including physiological measures (i.e., blood pressure); clinical assessments (i.e., wound healing); patient self-reports of symptom resolution or quality of life; and patient self-esteem; 4) patient and/or families' satisfaction with care.</p> <p>Conclusion(s)/recommendations: There is fairly strong evidence to suggest that some interventions to promote patient-centred care in clinical consultations may lead to significant increases in the patient centeredness of consultation processes. 12 of the 14 studies that assessed consultation processes show improvements in some of these outcomes. There is also some evidence that training health care providers in patient-centred approaches may impact positively on patient satisfaction with care. Of the eleven studies that assessed patient satisfaction, six demonstrated significant differences in favour of the intervention group on one or more measures. It is important to note that none of the included studies used measures explicitly designed to assess the patient-centeredness of the consultation. There is currently no</p>

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<p>(Mauksch et al. 2008) Relationship, Communication, and Efficiency in the Medical Encounter Creating a Clinical Model From a Literature Review (Review of literature)</p>	<p>gold standard for measure of patient centeredness, and this area needs further work if the effects on consultation processes or interventions to promote patient-centred care are to be appropriately assessed.</p> <p>Mauksch <i>et al.</i> present what they see as the current scenario in patient-clinician consultations, indicating that while there is consensus about the value of communication skills, many physicians complain that there is not enough time to use these skills. They say that little is known about how to combine effective relationship development and communication skills with time management to maximise efficiency. Their objective in this review is to examine what physician-patient relationship and communication skills can enhance efficiency.</p> <p>They conduct searches of PubMed, EMBASE, and PsychINFO for the date range January 1973 to October 2006. They review the reference lists of identified publications and the bibliographies of experts in physician-patient communication for additional publications.</p> <p>From their initial group of citations (n=1146), they include only studies written in English that report original data on the use of communication or relationship skills and their effect on time use or visit length. Study inclusion is determined by independent review by 2 authors (L.B.M. and D.C.D.). This yields 9 publications for their analysis.</p> <p>They have 2 reviewers independently read and classify the 9 publications and catalogue them by type of study, results, and limitations. Their differences are resolved by consensus.</p> <p>Findings: They identify that three domains that may enhance communication efficiency have emerged: rapport building, up-front agenda setting, and acknowledging social or emotional clues.</p> <p>Conclusion(s): Building on these findings, Mauksch et al. offer a model blending the quality- enhancing and time management features of selected communication and relationship skills such as those identified above and others like mindfulness, topic tracking and up front collaborative agenda setting. They argue that there is a need for additional research about communication skills that could be linked to enhancing quality and efficiency.</p> <p>Their diagram on efficient versus less efficient consultations has been included in the first section of this report (Mauksch et al. 2008, p. 1392).</p>
<p>(Neumann et al. 2009) Analyzing the "nature" and "specific effectiveness" of clinical empathy: a theoretical overview and contribution towards a theory-based research agenda (Review and conceptual paper)</p>	<p>The authors point out that to establish sound empirical evidence that clinical empathy (abbreviated as CE) is a core element in the clinician–patient relationship with profound therapeutic potential, a substantial theoretical-based understanding of CE in medical care and medical education is still required.</p> <p>The two aims of the paper are, therefore, (1) to give a multidisciplinary overview of the “nature” and “specific effectiveness” of CE, and (2) to use this base as a means of deriving relevant questions for a theory-based research agenda.</p> <p>The authors make an effort to identify current and past literature about conceptual and empirical work focusing on empathy and CE, which derives from a multiplicity of disciplines. They argue that they review the material in a structured fashion.</p> <p>The authors describe the “nature” of empathy by briefly summarising concepts and models from sociology, psychology, social psychology, education, (social-)epidemiology, and neurosciences. To explain the “specific effectiveness” of CE for patients, they develop the “Effect model of empathic communication in the clinical encounter”, which demonstrates how</p>

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	<p>an empathically communicating clinician can achieve improved patient outcomes. Both parts of their theoretical findings are synthesised in a theory-based research agenda with the following key hypotheses: (1) CE is a determinant of quality in medical care, (2) clinicians biographical experiences influence their empathic behaviour, and (3) CE is affected by situational factors.</p> <p>Conclusion(s): The main conclusions of their review are twofold. First of all, CE seems to be a fundamental determinant of quality in medical care, because it enables the clinician to fulfil key medical tasks more accurately, thereby achieving enhanced patient health outcomes. Second, the integration of biographical experiences and situational factors as determinants of CE in medical care and medical education appears to be crucial to develop and promote CE and ultimately ensuring high-quality patient care.</p> <p>Practice implications: Due to the complexity and multidimensionality of CE, evidence-based investigations of the derived hypotheses require both well-designed qualitative and quantitative studies as well as an interdisciplinary research approach.</p> <p>See their diagram that traces a critical pathway in an empathic consultation (Neumann et al. 2009, p. 342).</p>
(O'Grady & Candlin In press) Engendering trust in a multiparty consultation involving an adolescent patient	<p>This chapter traces the skilful way that a doctor uses empathy in a consultation that is attended by an adolescent man (as the patient) and his mother. The doctor manages to give autonomy to the patient, through her actions which are strategic, and include her gaze, the way she positions her body in relation to the patient, how she addresses the young man and how she manages to incorporate his input and his mother's into the consultation. The doctor builds the patient's independence and allows him to speak for himself, and finally positions him as responsible for his own health. The chapter uses discourse analysis to show how this is done by the doctor as she reflexively, and empathetically manages the young patient's privacy and develops his trust in her. The authors of this chapter draw on work they have conducted in other contexts on the benefits of using discourse analysis as a pedagogical intervention. They cite the value of discourse analysis which they posit can be used in training for medical practitioners to manage consultations more effectively. This procedure follows a 'pedagogically phased cycle of Awareness, Knowledge, Critique and Action' (see Candlin et al. 1994 in O'Grady & Candlin In press, p. xx) in which transcribed interactions can be used to jointly reflect on what has been said by the doctor and the patient, and thereby result in behaviour change of clinicians.</p>
(Ommen et al. 2008) Trust, social support and patient type - Associations between patients perceived trust, supportive communication and patients preferences in regards to paternalism, clarification and participation of severely injured patients	<p>The authors identify that trust is an important aspect of physician–patient-interaction, both in terms of compliance and patient- and physician-reported outcomes. Trust-building communication is especially important in terms of severely injured patients because of severity of their injuries and frequently associated physical and psychological consequences. Patients preferences concerning medical treatment, (what the authors conceptualised as patienttype) is also regarded to be important in terms of trust. The authors also conceptualise a number of components of what they label 'perceivedtrust'.</p> <p>The objective of this study is to investigate the relationships between patients' perceivedtrust, supportive communication of physicians and patienttype of severely injured patients.</p> <p>Seventy-one severely injured patients, who were predominantly injured in the workplace or in traffic accidents and who were treated in one of four hospitals in Northrhine-Westfalia between 2001 and 2005, completed a self-administered</p>

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	<p>questionnaire. "Trust in physicians_short form" (TRIP_sf) describes different aspects, such as general trust, competence of doctors and the feeling to be in good hands. "Informational support" and "emotional support" comprise verbal and non-verbal aspects, such as clear and understandable information or devotion and empathic manner. "Patienttype" measures patients' preferences in regard to the paternalism of physician, clarification of medical facts and participation in treatment' (cited in the section 'Methods' 2008).</p> <p>Results: The researchers conclude that 'trust is strongly correlated with informational (.628**) and emotional support (.542**) and is less correlated with patients preferences of "paternalism" (.250*), "clarification" (.438**) and participation" (.378**). They also find that informational and emotional support are in general not significantly correlated with type of patient. (All correlations have been adjusted for age, gender, marital and socioeconomic status, length of hospital stay, and severity of injury)' (cited in the section 'Results' 2008).</p> <p>Conclusion(s): They conclude that trust is significantly related to patienttype but more related to doctor support: the results confirm the importance of supportive communication in terms of emotional and informational support.</p> <p>Practice implications: Medical education should integrate sound knowledge about the psychosocial aspects of physician patient interaction to enable doctors to provide effective social support and to identify and consider patients preferences.</p>
(Ong et al. 1995) Doctor-patient communication: a review of the literature (Review of literature)	<p>The authors' background to this review suggests that communication can be seen as the main ingredient in medical care. In reviewing doctor-patient communication, they address the following topics: (1) different purposes of medical communication; (2) analysis of doctor-patient communication; (3) specific communicative behaviours; (4) the influence of communicative behaviours on patient outcomes; and (5) they provide concluding remarks.</p> <p>They identify three different purposes of communication in the consultation, namely: (a) creating a good inter-personal relationship; (b) exchanging information; and (c) making treatment-related decisions.</p> <p>They also identify that communication during medical encounters can be analysed by using different interaction analysis systems (IAS). These systems differ with regard to their clinical relevance, observational strategy, reliability/validity and channels of communicative behaviour. They discuss several communicative behaviours that occur in consultations: they categorise these as instrumental (cure oriented) vs. affective (care oriented) behaviour, verbal vs. non-verbal behaviour, privacy behaviour, high vs. low controlling behaviour, and medical vs. everyday language vocabularies.</p> <p>Conclusion(s): The review describes consequences of specific physician behaviours on certain patient outcomes, namely: satisfaction, compliance/ adherence to treatment, recall and understanding of information, and health status/psychiatric morbidity. Finally, the review presents a framework relating background (culture, doctor patient relationship, types of patients and doctors, disease characteristics), process (instrumental versus affective behaviours) and outcome (short term and long term including satisfaction, recall, compliance, health status and psychological morbidity) variables. They posit that clear connections between these are still uncertain.</p>
(Phillips-Salimi, Haase & Carter-Kookken 2011) Connectedness in the context of patient-provider relationships: a concept analysis (Review)	<p>This paper is a report of an analysis of the concept of connectedness, written in the context of nursing practice although the paper does have broader applicability.</p> <p>The authors point out that previous attempts to conceptualise patient-provider relationships have been limited in explaining how such relationships are fostered and maintained, and how they influence patient outcomes. In this paper,</p>

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	<p>they put forward the concept of Connectedness as one that might provide insights into the advantages of the patient–provider relationship. However, they propose that the usefulness of this concept in health care is limited by its conceptual ambiguity. Although Connectedness is widely used to describe other social relationships, little consistency exists among its definitions and measures.</p> <p>The researchers identify sources through CINAHL, OVID, PubMed and Psych- INFO databases and references lists of selected articles between 1983 and 2010. They undertake a hybrid concept analysis approach, involving a combination of traditional concept analysis strategies that included: describing historical conceptualisations, identifying attributes, critiquing existing definitions, examining boundaries and identifying antecedents and consequences.</p> <p>Results. Using five distinct historical perspectives, they identify seven attributes of Connectedness applicable to patient–provider relationships: intimacy, sense of belonging, caring, empathy, respect, trust and reciprocity. They develop a broad definition of Connectedness, which can be used in the context of patient–provider relationships. They also derive a preliminary theoretical framework of Connectedness from the identified antecedents, attributes and consequences.</p> <p>Conclusion(s): They conclude that research efforts to advance the concept of Connectedness in patient-provider relationships have been hampered by a lack of conceptual clarity. Their proposed concept analysis offers a clearer understanding of Connectedness, provides recommendations for future research and suggests practice implications.</p> <p>Practice implications include (1) raising an awareness of the importance of patient–provider Connectedness and its relationship to positive patient outcomes; and (2) developing staff education programs to help healthcare providers understand the behaviours and attitudes that foster Connectedness.</p>
(Rakel et al. 2011) Perception of empathy in the therapeutic encounter: Effects on the common cold	<p>This study seeks to evaluate the effects of patient–practitioner interaction on the severity and duration of the common cold. The researchers conduct a randomised controlled trial of 719 patients who had just started a cold. Participants were randomised to three groups: those where there was no patient–practitioner interaction, those who received a “standard” interaction and those who received an “enhanced” interaction. They assessed the severity of patients’ colds twice daily. They utilised the Consultation and Relational Empathy (CARE) measure to rate clinician empathy. ‘Interleukin-8 (IL-8) and neutrophil counts were obtained from nasal wash at baseline and 48 h later’ (Rakel et al. 2011, p. 390).</p> <p>Results: The researchers find that patients’ perceptions of the clinical encounter are associated with reduced cold severity and duration.</p> <p>Conclusion(s): The authors conclude that when patients perceive clinicians as empathetic, rating them perfect on the CARE tool, the severity, duration and objective measures (IL-8 and neutrophils) of the common cold significantly change.</p> <p>Practice implications: This study helps us to understand the importance of the perception of empathy in a therapeutic encounter as it appears to impact on health outcomes.</p>
(Shattell 2004) Nurse-patient interaction: a review of the literature	<p>This review examines a theoretical model of nurse-patient interaction. It also reviews the literature on nurse-patient interactions. The authors conclude that communication is a central element of clinical nursing practice. The paper also concludes that Goffman’s model can be used to better understand nurse-patient communication. This is because Goffman’s framework an understanding of the reciprocal nature of nurse-patient interaction as it helps us to understand communication behaviour. The authors review studies in which patients in the review identify how they sometimes feel</p>

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	<p>excluded and had their energy taken away if nurses were hurried, emotionally cold or avoided eye contact. On the contrary, when they were energetic and enthusiastic, patients felt confirmed and supported in the hospital setting. The study identifies that there is evidence that patients understand that they need to demonstrate certain practices, particularly those of being good patients. The paper identifies studies that find positive nursing interventions as treating the patient with respect, displaying empathy, having normal conversations with them, facilitating the patients' control over their care, listening to the patient and believing in them. The paper also identifies studies that have investigated patient involvement in their care. The paper suggests that 'nurses were found to exert power over patients. Nursing students' communication skills did not improve with communication skills training and nursing related work experience. Nurses distanced themselves from patients who were labelled 'bad' or 'difficult' thereby decreasing the quality of care' (Shattell 2004, p. 720). Patients report that they want nurses to be genuine, unhurried, willing and able to talk to them. They also want to be recognised, valued and respected as individuals and patients also understand the value of social interaction. Patients object to being treated as objects, and can avoid communicating with nurses if they are fearful of the response. Shattell calls for further research in these areas.</p>
<p>(Nadia & Trisha 2006) "You have to cover up the words of the doctor": The mediation of trust in interpreted consultations in primary care</p>	<p>This article explores issues of trust in narratives of consultations involving interpreters in primary health care. The paper is based on empirical data from a qualitative study of accounts of interpreted consultations in UK primary care, undertaken in three north London boroughs.</p> <p>In a total of 69 individual interviews and two focus groups, Robb & Greenhalgh sought narratives of interpreted consultations from 18 service users, 17 professional interpreters, nine family member interpreters, 13 general practitioners, 15 nurses, eight receptionists, and three practice managers.</p> <p>Findings: They find that trust is a prominent theme in almost all the narratives. The triadic nature of interpreted consultations creates six linked trust relationships (patient-interpreter, patient-clinician, interpreter-patient, interpreter-clinician, clinician-patient and clinician-interpreter). Different types of trust have important implications for the nature of communication in the consultation and on patients' subsequent action.</p> <p>Research limitations/implications: The authors suggest that the methodological and analytic approach, potentially, has wider applications in the study of other trust relationships in health and social care.</p> <p>Practical implications: The authors suggest that quality in the interpreted consultation cannot be judged purely in terms of the accuracy of translation. The critical importance of voluntary trust for open and effective communication, and the dependence of the latter on a positive interpersonal relationship and continuity of care, should be acknowledged in the design and funding of interpreting services and in the training of both clinicians, interpreters and administrative staff.</p>
<p>(Paget et al. 2011) USA - IOM- Patient-Clinician Communication: Basic Principles and Expectations (Discussion paper)</p>	<p>This is a discussion paper that draws on marketing experts, decision scientists, patient advocates, and clinicians. These people developed a set of guiding principles and basic expectations underpinning patient-clinician communication. The work in this discussion paper was stewarded under the auspices of the Best Practices and Evidence Communication Innovation Collaboratives of the Institute of Medicine (IOM) Roundtable on Value & Science-Driven Health Care. Collaborative participants intend these principles and expectations to serve as common touchstone reference points for both patients and clinicians, as they and their related organisations seek to foster the partnership and patient engagement</p>

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	<p>necessary to improve health outcomes and value from care.</p> <p>The discussion paper identifies mutual respect, harmonised goals, a supportive environment, appropriate decision partners, the right information, transparency and full disclosure and continuous learning as basic principles and expectations for optimal patient-clinician communication.</p>
(Rao et al. 2007) Communication interventions make a difference in conversations between physicians and patients: A systematic review of the evidence (Review)	<p>In this review, Rao <i>et al.</i> seek to synthesise the findings of studies examining interventions to enhance the communication behaviors of physicians and patients during outpatient encounters.</p> <p>The authors conduct searches of 6 databases between 1966 and 2005 to identify studies for a systematic review and synthesis of the literature. Eligible studies they review are those that tested a communication intervention; are randomised controlled trials (RCTs); objectively assessed verbal communication behaviors as the primary outcome; and are published in English. They characterise Interventions by type (e.g., information, modeling, feedback, practice), delivery strategy, and overall intensity. They abstract information on the effects of the interventions on communication outcomes (e.g., interpersonal and information exchanging behaviors). They examine the effectiveness of the interventions in improving the communication behaviors of physicians and patients.</p> <p>In total, they review thirty-six studies: 18 of those involve physicians; 15 involve patients; and 3 involve both. Of the physician interventions, 76% include 3 or 4 types of interventions, often in the form of practice and feedback sessions. Among the patient interventions, 33% involve 1 type, and nearly all interventions are delivered in the waiting room.</p> <p>Results: The authors find that intervention physicians are more likely than controls to receive higher ratings of their overall communication style and to exhibit specific patient-centered communication behaviors. Intervention patients obtain more information from physicians and exhibit greater involvement during the visit than controls.</p> <p>Conclusion(s): The authors conclude that the interventions are associated with improved physician and patient communication behaviors. They identify a challenge for future research which is to design effective patient and physician interventions that can be integrated into practice. (This study should be considered in conjunction with Bombeke <i>et al.</i>'s study (2011), which identifies that students trained in patient-centred communication seem to lose their patient-centred attitudes while untrained students remain stable).</p>
(Robins, Witteborn & Miner 2011) Identifying transparency in physician communication	<p>This study aims to categorise physician communication, demonstrating understanding of what patients want to know, and skill in conveying that information. Physicians underestimate how much information patients want and patients rarely seek information during clinic visits. The study advocates transparent communication to facilitate patient understanding and support autonomy, informed decision-making and relationship development.</p> <p>This team analyses audiotapes of 263 patient visits to 33 physicians providing care to adult patients in eight community-based, university-affiliated primary care practices. Communication is defined as transparent if the physician uses nine types of conversational phrases. Some phrases communicate the process of the clinical encounter, such as what will be included in the visit or stages of the physical exam. Some phrases clarify the medical content of the visit and demystify medical terms and jargon. Other phrases centre around the patient's subsequent course of action, e.g., what the patient needs to do next or instructions in how to take their medication. Physicians spend the greatest amount of time during the encounter demystifying medical terms into lay language and concepts. Other types of transparent communication often</p>

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	<p>include sharing emotions and judgments about the patient's condition, giving reasons for treatment rationale, and orchestrating instructions on taking medications or determining the next appointment. Patients prompt their physicians to be more transparent, but relatively infrequently. They average around one prompt per visit to ask for clarification about medical jargon. In half of the visits, patients ask their physicians to share their thoughts. Patients only infrequently ask for additional information about treatment and diagnosis.</p> <p>Physicians proactively use five types of process transparency to preview speech and actions. Four types of content transparency are used to explicate diagnosis and treatment, demystify medical language and concepts, and interpret biomedical information. Physicians spend the greatest proportion of clinic time explicating medical content.</p> <p>Good physician-patient communication is the cornerstone of patient-centered care. Patients want information about their condition and treatment in ways they can understand. Yet, patients are reluctant to engage in information-seeking behaviours during visits. What's more, physicians devote relatively little time to proactively helping patients to understand their medical conditions or the pros and cons of treatment options or medications. This new study reveals that transparency in communication by physicians can do a great deal to alleviate patient uncertainty and engender empathy and respect during medical visits.</p> <p>The primacy of information exchange over process-oriented, relational communication is demonstrated. Proactive transparency appears promising to increase understanding and collaboration.</p> <p>Practice implications: In patient-centered care where collaboration is the ideal, transparency in its various forms is a critical ingredient. Without much communicative effort, physicians who proactively communicate that an examination is over, that they are leaving the exam room briefly so patients can dress, provide information that appears to address patient uncertainty and also demonstrates empathy and respect.</p>
(Rogers et al. 2005) Uncovering the Limits of Patient-Centeredness: Implementing a Self-Management Trial for Chronic Illness	<p>The researchers in this study begin by saying that research evaluating self-management of chronic conditions points to the effectiveness of interventions' changing the health behavior of individuals. However, they point out that little is known about how self-management is negotiated in health services. To undertake the study therefore, the authors design a qualitative investigation to illuminate the quantitative findings of a randomised controlled trial (RCT) of a self-management program for people with inflammatory bowel disease. They conduct in-depth interviews with physicians and patients, and through qualitative analysis, seek to illuminate the nature of doctor-patient encounters and to identify possible reasons for lack of change in patient satisfaction with the consultation.</p> <p>Their findings suggest that factors inhibiting effective patient-centered consultations include the failure of physicians to incorporate expressed need relevant to people's self-management activities fully. The authors also identify the interpretation of self management by clinicians is seen as nothing other than compliance with medication in relation to a medically defined notion of a flare-up, involving little negotiation or reevaluation with the patient. Finally, the existing organisational arrangements of the outpatients' clinics also presented difficulties in terms of ensuring the imperative of continuity of care, which is implicit in the philosophy underpinning the patient-centered approach to self-management. The authors conclude that giving attention to these barriers might maximise the opportunities for patient self management of chronic illness based on a therapeutic alliance with health care professionals.</p>

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(Roter & Larson 2002) The Roter interaction analysis system: utility and flexibility for analysis of medical interactions	<p>In this paper, Roter and Larson argue that The Roter Interaction Analysis System (RIAS) when used as a teaching tool has improved interview communication skills. This paper is a response to a critique of the RIAS by Sandvik <i>et al.</i> (2002). In it, Roter and Larson argue that when residents were given structured feedback on their skills they found ‘significant differences in three of the four core competencies that were targeted: increase in data gathering techniques using open-ended questions; increase in problem solving and negotiating skills; and decrease in verbal dominance’ (Roter & Larson 2002, p. 246). The authors propose that the RIAS is highly adaptable and can be tailored to capture dimensions of the patient clinician consultation in different settings and circumstances.</p> <p>In the paper Roter <i>et al.</i> usefully define empathy (in the RIAS) as ‘statements that paraphrase, interpret recognise or name the other’s emotional state’ (Roter & Larson 2002, p. 249).</p>
(Roter 2000) The enduring and evolving nature of the patient-physician relationship	<p>In identifying the shift from the biomedical to the interpersonal, Roter begins by situating the patient’s perspective as central to modern day healthcare. She says that just as the molecular and chemistry oriented sciences were adopted as the 20th century medical paradigm, incorporation of the patient’s perspective into a relationship-centered medical paradigm has been suggested as appropriate for the 21st century. It is the medical dialogue that provides the fundamental vehicle through which the paradigmatic battle of perspectives is waged and the therapeutic relationship is defined. She says that in many regards, the primary challenge to the field is the development of operationally defined and measurable indicators of medical communication that will provide a valid representation of the conceptual models of the therapeutic relationship.</p> <p>The purpose of this essay, she says, is to explore the implications of a relationship-centered medical paradigm on the nature of the patient–physician relationship and its expression in the communication of routine medical practice. She suggests an organising framework for distinguishing commonly measured communication elements into conceptually distinct components. She illustrates the application of this framework through an empirical study of communication in primary care practice.</p> <p>Results: The results of the study demonstrate the usefulness of this approach in linking communication to models of therapeutic relationships. Roter further explores the importance of medical communication in a summary of studies that establish its association to outcomes and in an overview of future challenges to the field. These include:</p> <ul style="list-style-type: none"> • We (researchers) assess communication in very different ways • Those undertaking quantitative and qualitative measures are still divided • Researchers ought to focus on the longer term issues of the patient-clinician relationship and in obtaining longitudinal data sets • The field needs more data on analysing relationships under stress • Researchers need to integrate psychotherapeutic and communication theory approaches to the consultation • We need better insight into the social context of the therapeutic relationship with attention to issues of gender, SES, and ethnicity, particularly as these characteristics relate to physicians • We have tended to neglect relationships outside of primary care

Study and Authors	Study description and findings/practice implications
(Roter et al. 2008) Interactive and evaluative correlates of dialogue sequence: a simulation study applying the RIAS to turn taking structures	<ul style="list-style-type: none"> • While we understand the social psychology of the patient-clinician relationship there are still gaps • We need to embrace the new computer technologies available for analysis <p>See Roter's Table 3 on page 11 of the article on relationship centred care and supportive communication elements.</p> <p>This study explores novel characterisations of turn taking structure and its interaction and evaluative correlates. The Interaction Analysis System (RIAS) was applied to videotapes of 51 physicians with a simulated patient (SP) to create a variety of novel turn taking measures including turn frequency, rate of interactivity, density, duration, and statement pacing.</p> <p>Visits averaged 52 speaker turns with an interactivity rate of 3.9 turns per visit minute. For physicians, turn duration averaged 13.7 seconds with a turn density of 4.2 statements paced at one statement every 3 seconds. For the SP, turn duration was 3 seconds with a turn density of 1.4 statements paced at one statement every 2 seconds. More turns, briefer turn duration and faster physician pacing were significantly related to positive ratings of affective demeanour, interpersonal satisfaction and collaborative decision-making. These measures, and interactivity, were also associated with a RIAS-based patient centeredness score and more overall patient talk.</p> <p>Turn taking structures can be characterised in novel ways lending depth and richness to our understanding of dialogue, relationships to the patient centeredness of a visit, and evaluative judgments of physician performance.</p> <p>Practice Implications: The study findings suggest specificity to the interviewing admonishment "talk less and listen more" by enhancing the interactivity of the dialogue and guarding against the doctors tendency toward long monologues.</p>
(Safran, Miller & Beckman 2006) Organizational Dimensions of Relationship-centered Care: Theory, Evidence, and Practice	<p>The authors begin by identifying that according to Beach & Inui 2006, four domains of relationship have been highlighted as the cornerstones of relationship-centered health care. These are: clinician-patient relationships: clinician-colleague relationships: clinician-community relationships: and clinicians' relationships to self. Of these, clinician-patient relationships have been most thoroughly studied. The authors say there is a rich empirical literature illuminating significant linkages between clinician-patient relationship quality and a wide range of outcomes. This paper explores the realm of clinician-colleague relationships, which they define to include the full array of relationships among clinicians, staff, and administrators in health care organisations. Building on a stream of relevant theories and empirical literature that have emerged over the past decade, the authors synthesise available evidence on the role of organisational culture and relationships in shaping outcomes, and posit a model of relationship centered organisations.</p> <p>The paper concludes that turning attention to relationship-centered theory and practice in health care holds promise for advancing care to a new level, with breakthroughs in quality of care, quality of life for those who provide it, and organisational performance.</p>
(Shaw, Dunn & Heinrich 2012) Managing the delivery of bad news: An in-depth analysis of doctors' delivery style	<p>The purpose of this study is to identify and describe the delivery styles doctors typically use when breaking bad news (BBN).</p> <p>The researchers recruit thirty-one doctors to participate in two standardised BBN consultations involving a sudden death. The authors determine delivery styles using time to deliver the bad news as a standardised differentiation as well as qualitative analysis of interaction content and language style. They also assess communication performance.</p> <p>Findings: Analysis of BBN interactions reveals three typical delivery styles. A blunt style characterised by doctors delivering</p>

Study and Authors	Study description and findings/practice implications
	<p>news within the first 30s of the interaction; forecasting, a staged delivery of the news within the first 2min and a stalling approach, delaying news delivery for more than 2min. This latter avoidant style relies on the news recipient reaching a conclusion about event outcome without the doctor explicitly conveying the news.</p> <p>Conclusion(s): The authors confirm three typical bad news delivery styles used by doctors when BBN both semantically and operationally in the study.</p> <p>Practice implications: This research provides a new template for approaching BBN training and provides evidence for a need for greater flexibility when communicating bad news.</p>
(Soo Kim, Kaplowitz & Johnston 2004) The Effects of Physician Empathy on Patient Satisfaction and Compliance	<p>This study seeks to develop new scales of patient-perceived, empathy-related constructs and test a model of the relationships of physician empathy and related constructs to patient satisfaction and compliance. Five hundred and fifty outpatients at a large university hospital in Korea were interviewed using a questionnaire. The data were analysed using structural equation modelling.</p> <p>Findings/conclusion(s): The main findings are that patient-perceived physician empathy significantly influences patient satisfaction and compliance via the mediating factors of information exchange, perceived expertise, interpersonal trust, and partnership.</p> <p>The authors conclude that improving physician empathic communication skills should increase patient satisfaction and compliance. They propose that health providers who wish to improve patient satisfaction and compliance should first identify components of empathic communication needing improvement and then try to refine those skills to better serve patients.</p>
(Stein-Parbury 2006) Patient & Person: Interpersonal skills in nursing	<p>This is a Google eBook written by an Australian academic. Stein-Parbury has worked in the Australian context for decades specialising in mental health and communication pedagogy. Patient & Person provides a practical guide to establishing and building relationships in nursing practice. It systematically addresses the theoretical, practical and personal dimensions of relating to patients and provides guidelines for determining when and how to act. It encourages meaningful nursing practice by focusing on patients as individuals.</p>
(Stewart 1995) Effective physician-patient communication and health care outcome: A review (Review)	<p>This is a seminal study in patient-clinician communication research. In this paper Stewart seeks to ascertain whether the quality of physician-patient communication makes a significant difference to patient health outcomes.</p> <p>Stewart searched the MEDLINE database for articles published from 1983 to 1993 using "physician-patient relations" as the primary medical subject heading. Several bibliographies and conference proceedings were also reviewed.</p> <p>She examined randomised controlled trials (RCTs) and analytic studies of physician-patient communication in which patient health was an outcome variable.</p> <p>She records the following information about each study: sample size, patient characteristics, clinical setting, elements of communication assessed, patient outcomes measured, and direction and significance of any association found between aspects of communication and patient outcomes. Of the 21 studies that met the final criteria for review, 16 reported positive results, 4 reported negative (i.e., nonsignificant) results, and 1 was inconclusive.</p> <p>She finds that the quality of communication both in the history-taking segment of the visit and during discussion of the management plan is found to influence patient health outcomes. The outcomes affected are, in descending order of</p>

Study and Authors	Study description and findings/practice implications
	<p>frequency, emotional health, symptom resolution, function, physiologic measures (i.e., blood pressure and blood sugar level) and pain control.</p> <p>Conclusion(s): Most of the studies Stewart reviews demonstrate a correlation between effective physician-patient communication and improved patient health outcomes. She proposes that the components of effective communication identified by these studies can be used as the basis both for curriculum development in medical education and for patient education programs. She suggests that future research should focus on evaluating such educational programs.</p>
(Stewart et al. 2000) The impact of patient-centred care on outcomes	<p>This is a seminal study on the impact of patient-centred care on outcomes. Patient-centred communication influences patients' health through perceptions that their visit was patient centred and especially through perceptions that common ground was achieved with the physician. Patient-centred practice improved health status and increased the efficiency of care by reducing diagnostic tests and referrals.</p> <p>The researchers design this observational cohort study to assess the association between patient-centered communication in primary care visits and subsequent health and medical care utilisation.</p> <p>They select 39 family physicians at random, and 315 of their patients participate. Office visits are audiotaped and scored for patient-centered communication. In addition, patients are asked for their perceptions of the patient-centeredness of the visit. The outcomes are: (1) patients' health, assessed by a visual analogue scale on symptom discomfort and concern; (2) self-report of health, using the Medical Outcomes Study Short Form-36; and (3) medical care utilisation variables of diagnostic tests, referrals, and visits to the family physician, assessed by chart review. The two measures of patient-centeredness are correlated with the outcomes of visits, adjusting for the clustering of patients by physician and controlling for confounding variables.</p> <p>Results: Patient-centered communication is correlated with the patients' perceptions of finding common ground. In addition, positive perceptions (both the total score and the subscore on finding common ground) are associated with better recovery from their discomfort and concern, better emotional health two months later, and fewer diagnostic tests and referrals.</p> <p>Conclusion(s): Patient-centered communication influences patients' health through perceptions that their visit is patient centered, and especially through perceptions that common ground is achieved with the physician. Patient-centered practice improves health status and increases the efficiency of care by reducing diagnostic tests and referrals.</p>
(Street & Haidet 2011) How Well Do Doctors Know their Patients? Factors Affecting Physician Understanding of Patients' Health Beliefs	<p>This study takes a convenience sample of 207 patients and 29 primary care physicians from ten outpatient clinics, to examine what the authors see as an important feature of patient-centered care: physician understanding of their patients' health beliefs and values.</p> <p>After consultations, patients and physicians independently complete the CONNECT instrument, a measure that assesses beliefs about the degree to which the patient's condition has a biological cause, is the patient's fault, is one the patient can control, has meaning for the patient, can be treated with natural remedies, and patient preferences for a partnership with the physician.</p> <p>Physicians complete the measure again on how they think the patient has responded. Active patient participation (frequency of questions, concerns, acts of assertiveness) is coded from audio-recordings of the consultations. Physicians'</p>

Study and Authors	Study description and findings/practice implications
	<p>answers for how they think the patient responds to the health belief measure are compared to their patients' actual responses. Degree of physician understanding of patients' health beliefs is computed as the absolute difference between patients' health beliefs and physicians' perception of patients' health beliefs.</p> <p>Findings/conclusion(s): Physicians' perceptions of their patients' health beliefs differ significantly ($P < 0.001$) from patients' actual beliefs. Physicians also think patients' beliefs are more aligned with their own. Physicians have a better understanding of the degree to which patients believe their health conditions have personal meaning ($p = 0.001$), will benefit from natural remedies ($p = 0.049$), are conditions the patient can control ($p = 0.001$), and want a partnership with the doctor ($p = 0.014$) when patients more often ask questions, express concerns, and state their opinions. Physicians are poorer judges of patients' beliefs when patients are African-American (desire for partnership) ($p = 0.013$), Hispanic (meaning) ($p = 0.075$), or of a different race (sense of control) ($p = 0.024$).</p> <p>Overall, the study concludes that physicians are not good judges of patient's health beliefs, but have a substantially better understanding when patients more actively participate in the consultation. This involves patients asking questions more frequently, expressing concerns, and stating preferences and opinions. The study identifies strategies for increasing physicians' awareness of patients' health beliefs. These include preconsultation assessment of patients' beliefs, implementing culturally appropriate patient activation programs, and greater use of partnership-building to encourage active patient participation.</p>
(Street et al. 2009) How does communication heal? Pathways linking clinician-patient communication to health outcomes	<p>The researchers begin this paper by pointing out that although prior research indicates that features of clinician–patient communication can predict health outcomes weeks and months after the consultation, the mechanisms accounting for these findings are poorly understood. They identify that while talk itself can be therapeutic (e.g. lessening the patient's anxiety, providing comfort), more often clinician–patient communication influences health outcomes via a more indirect route. Proximal outcomes of the interaction include patient understanding, trust, and clinician-patient agreement. These affect intermediate outcomes (e.g., increased adherence, better self-care skills), which, in turn, affect health and wellbeing. The authors propose seven pathways through which communication can lead to better health. These include increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment, and better management of emotions.</p> <p>Conclusion(s): The authors propose that future research should hypothesise pathways connecting communication to health outcomes and select measures specific to that pathway.</p> <p>Practice implications: The authors suggest that clinicians and patients should maximise the therapeutic effects of communication by explicitly orienting communication to achieve intermediate outcomes (e.g., trust, mutual understanding, adherence, social support, self-efficacy) associated with improved health.</p>
(Wynn & Wynn 2006) Empathy as an interactionally achieved phenomenon in psychotherapy: Characteristics of some conversational resources (Linguistic and psychosocial focus)	<p>This is a linguistically-oriented paper. The authors identify that empathy is a central notion in psychotherapy and has been the attention of much research, focusing on its importance for the provider-patient alliance and for the success of psychotherapy. They point out that despite its importance, little effort has previously been made in order to study the details of actual sequences through which empathy is achieved. They also point out that empathy is a complex concept. In this study drawing on the method of conversation analysis, actual interactions between therapists and their patients</p>

Study and Authors	Study description and findings/practice implications
	<p>were video taped and analysed in detail.</p> <p>The present study describes and analyses three types of empathy that can be identified in actual sequences of talk; cognitive empathy, affective empathy, and sharing empathy. These types of empathy are identified as higher-level conversational resources that build on the more basic resources, such as questions, assertions, and other types of utterances and non-verbal behaviour.</p> <p>The study finds that empathy is interactionally achieved, but in order for this to occur, certain aspects of interaction must be present. The present study demonstrates that the three types of empathy identified, in fact, can be found in actual sequences of talk. The sequences by which empathy is expressed consist of, at a minimum, a therapist utterance with an expression of empathy, followed by a patient's receipt of the therapist's expression of empathy. When empathy is expressed, the patient must receive the empathic overture by responding appropriately to the therapist's prior utterance. This receipt may involve answering questions, agreeing with assertions, demonstrating understanding, and an appropriate showing of feelings. A lack of proper receipt by the patient is oriented to by those in the conversation and may result in signs of conversational failure, such as reformulations, pausing, and an abrupt change of topic.</p>
(Zachariae et al. 2003) Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease	<p>The aim of the study is to investigate the association of physician communication behaviours as perceived by the patient with patient reported satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease in cancer patients. Questionnaires measuring distress, self-efficacy, and perceived control are completed prior to and after the consultation by 454 patients attending an oncology outpatient clinic. After the consultation, the patients also rate the physicians' communicative behaviours by completing a patient-physician relationship inventory (PPRI), and the physicians are asked to estimate patient satisfaction.</p> <p>The overall results show that higher PPRI scores of physician attentiveness and empathy are associated with greater patient satisfaction, increased self-efficacy, and reduced emotional distress following the consultation. In contrast, lower PPRI scores are associated with reduced ability of the physician to estimate patient satisfaction. The results confirm and expand previous findings, suggesting that communication is a core clinical skill in oncology.</p>
(Zimmermann et al. 2010) Coding patient emotional cues and concerns in medical consultations: The verona coding definitions of emotional sequences (VR-CoDES)	<p>The aim of this study is to examine the efficacy (usefulness?) of the Verona Coding Definitions of Emotional Sequences (VR-CoDES CC). The VR-CoDES CC is a consensus based system for coding patient expressions of emotional distress in medical consultations, defined as Cues or Concerns. The authors define a Cue as a verbal or non-verbal hint, which suggests an underlying unpleasant emotion that lacks clarity. They define a Concern as a clear and unambiguous expression of an unpleasant current or recent emotion that is explicitly verbalised with or without a stated issue of importance. The conceptual framework sets precise criteria for cues and concerns and the raters can identify whether it is the health provider or the patient that elicits the cue/concern.</p> <p>The aim of the paper is to explain the results of the conceptual and procedural process achieved by the group of international communication researchers, which took a number of years. The researchers reached consensus on the codes via different steps. Second, they conduct a reliability study on 20 psychiatric consultations. In the study, the inter-rater reliability proves satisfactory.</p> <p>The authors conclude that the VR-CoDES CC will facilitate comparative research on provider-patient communication</p>

Study and Authors	Study description and findings/practice implications
	<p>sequences in which patients express emotional distress. They conclude that cues and concerns require different skills from the healthcare provider. They also conclude that the differentiation between concerns and cues will help providers to recognize emotional distress in patients.</p> <p>Practice implications: The authors conclude that the VR-CoDES CC may be used to help clinicians in recognising or facilitating cues and concerns, thereby improving the recognition of patients' emotional distress, the therapeutic alliance and quality of care for these patients.</p>

Communicating with ‘the patient as uncertainty’

Mankind [sic] is at a turning point, the beginning of a new rationality in which science is no longer identified with certitude and probability with ignorance. [This science] is no longer limited to idealised and simplified situations but reflects the complexity of the real world. (Prigogine 1996: 7)

In this section, we introduce research that positions the patient as a source of uncertainty, and that regards care as steeped in complexity. Labelling this research ‘patient as uncertainty’ research is done to distinguish it from the previous two kinds of research on the following grounds:

1. In contrast to ‘patient as object’ research, studies described in this section do not regard communication as an exchange of verbal or written ‘goods’. Instead, ‘patient as uncertainty’ studies approach communication as a more complex phenomenon. This is not to deny that communication harbours recognisable patterns or that we could not fruitfully describe those patterns. Studies emphasise communication as being complex, because, aside from its patterned and iterative dimensions, it operates increasingly in circumstances where fewer and fewer things can be ‘taken as given’. The unpredictability of these circumstances reshape communication to such an extent that its previously stable formats and scripts now have to give way to more and more invention and experimentation, or *bricolage*. Above we explained why this is so: patient mobility, citizen migration, staff churn, patient’s socio-cultural specificity, care speed, ongoing technologisation, growing regulation - all factors that contribute to shrinking the social distance between communicators (Buetow et al. 2009b) while exacerbating the urgency to navigate successfully across the differences that separate them (Iedema et al. 2009).

2. In contrast to ‘patient as person’ research, studies in this ‘patient as uncertainty’ strand acknowledge that ‘the’ clinician-patient relationship is a privileged and increasingly rare one. This is because patients come into contact with growing numbers of clinicians in their episodes of care (Degeling et al. 2000). This means, in turn, that they have to constantly re-establish relationships with incoming clinicians (Manidis 2012). In addition, around three-quarters of patients using health services suffer from chronic disease (National Health Priority Action Council 2006), and this means they have to re-negotiate their care with these constantly reconfiguring clinician teams on an ongoing basis. Here, communication does much more work than ‘merely’ covering patients’ clinical, psycho-social and personal information, needs and preferences. The effort to technologise health records and other aspects of the clinician-patient relationship notwithstanding⁷, real-time

⁷ The hope that standardised ICTs will compensate for (rather than exacerbate) these destabilising developments may well reflect the idea(lism) that Esperanto should replace all European languages. Technologies emerge from and act as prosthetics for different life-worlds (which embody divergent interests, concerns and ideologies). Since there is and will remain a multiplicity of life-worlds, it may not be realistic to expect ICTs to be the answer to the increasing urgency to bridge across those life-worlds, and to assume the costs of introducing new technologies are *automatically* outweighed by their advantages. Ultimately, face-to-face, embodied and co-present communication affords extreme richness, versatility

communication is burdened with re-inventing 'common ground' and shared understanding between people, spanning increasingly short-term relationships, and precarious care continuity (Ling et al. 2012). While acute care might seem to be unique in this regard, primary care and chronic care are not immune to these pressures.

We should also acknowledge that 'patient as uncertainty' research shares much with its forebears. Indeed, the former is in essence the latter two paradigms' logical extension. Thus, it shares the concern of communication research that approaches the patient as object; namely, accuracy of information. In fact, 'patient as uncertainty' research is so concerned about accurate and up-to-date information that it seeks ways of giving patients *more* opportunities for sharing information, enhancing the feedback between patients and clinicians, and ensuring the uptake by clinicians of this information in their treatment design. Equally, it shares with 'patient as person' research the concern that patients be respected for who they are, given the opportunity to outline their socio-cultural views on medical-clinical issues, and supported in articulating those issues.

Seen thus, the present section marks a shift in emphasis and an accentuation of matters already considered in the other research domains, rather than constituting an new area of investigation in its own right.

We should also acknowledge that nursing research tends to have faced up to complexity and uncertainty with a greater degree of determination and insight than has medical communication research. Prominent in particular is the work done by Patricia Benner and colleagues in the US (Benner 1994; Benner et al. 1999), and Julianne Cheek in Australia (Cheek 2000; Cheek and Gibson 1996). For Benner and colleagues, nurses work at the complex interface between medical practice and patient experience. This intermediate role means they need "the skill of presenting ambiguous patient changes [and] patient concerns" to doctors. Here, nurses are encouraged to initiate discussion of "practical and ethical issues [that] can improve communication and the reliability of clinical decisions" (Benner et al. 1999: 406).

For Cheek too, nurses' position is a 'liminal' one, requiring sophisticated communication strategies in order to mediate and 'manage' the disjunctions between medical and patient/public expectations (Cheek and Gibson 1996). Also exemplified in the work by Manias and colleagues, this research accepts complexity and uncertainty to be endemic to patient-clinician communication, and it does

and speed, as well as a common anchor to our shared humanity. It is and remains central to how we negotiate and 'tame' difference, discontinuity and diversity. Face-to-face communication also remains critical to how we do care, and this is now particularly evident from neuroscientific findings that show that merely *encountering* a clinician can have a healing effect on patients (Benedetti 2011).

not shy away from investigating the implications of this for nurses' agency and power (Manias and Street 2001; Riley and Manias 2007; Riley et al. 2007).

Uncertainty manifests in physician-oriented research generally not as an inevitable *given* but as a *problem* to be negotiated between the patient (who has now become central to research *and* to the communication) and their clinician(s). With this, research and communication priorities have begun to shift as is evident from the inversion of 'clinician-patient' to become 'patient-clinician' in descriptors to do with care provision. As early as 2004, Moira Stewart initiated a special issue for the *Annals of Family Medicine*, with articles focusing not on the single visit or consult, but on the longer-term aspects of the care relationship (Stewart 2004). While the phrase patient-doctor communication had already gained currency at the time, this 2004 special issue of the *Annals*, as far as we are able to discern, is among the first to use the label 'patient-clinician'. In doing so, it distinguishes itself from studies preceding it and their focus on the clinician as information gatherer and as relational expert.

The prominence of the patient in the phrase patient-clinician communication now gives way to concern about whether and how the patient feels able to partake in the exchange. The brief survey below is an expression of this concern:

No.	Item
1	I can <i>easily</i> list problems or barriers that get in the way of good patient-doctor communication.
2	I can <i>easily</i> list the reasons why I need to communicate effectively with my doctor.
3	I can <i>easily</i> give examples of what my role, as a patient, should be when I talk to my doctor.
4	I can <i>easily</i> list goals I want to achieve when talking to my doctor.
5	I can <i>easily</i> give examples of what a good doctor's role should be when he/she interacts with me.
6	I know ways to improve my communication with my doctor.
7	I use good communication skills when talking to my doctor.

Table: Patient Confidence in Communication Scale (PCCS) (Tran et al. 2004).

The deep interest shown in earlier studies in pico- and micro-level analyses of clinician-patient communication notwithstanding, their target remains the identification of skills needed by the clinician to achieve their informational or relational goals. Even the goal of shared decision-making and its emphasis on collaborative dialogue cannot dissimulate the ultimate centrality of the clinician, their behaviour and their skills in managing these investigations.

Two critical considerations can be raised with regard to these assumptions and orientations. First, patient-centred care risks neglecting the broader contextual, technological and institutional

dimensions that define such care (Safran et al. 2006b). Second, the former two research paradigms risk positioning the patient as the person to and for whom things are done, rather than as the person who has a central role in shaping and managing the care themselves, as well as initiating opportunities for communicating with their clinician(s).

For these reasons, the present more recent ‘patient as uncertainty’ research strand moves on from the ‘objectification’ of the patient typical of the first kind of information-oriented research, and from the ‘subjectification’ imperative that is at the heart of research concerned with the relational dimensions of communication. Defining of the present strand is a third concern: developing and maintaining patient-clinician *common ground* amidst the complexity of patients’ everyday social and personal circumstances, clinicians’ professional and work circumstances, and constantly changing institutional and technological circumstances (Mol 2008). This concern does not invalidate clinicians’ need for accurate information, and neither does it supersede the importance of clinicians establishing strong and empathetic relationships with their patients. On the contrary in fact, information and relation are becoming increasingly critical amidst the hurly-burly of contemporary care.

However, the circumstances and ways in which these processes are enacted are very different from the ones that contextualise the other two kinds of research. For instance, research in this strand pays increasing attention to different kinds of **patient engagement** (Coulter 2011). Coulter’s recent book provides a rich overview of the ways in which policy makers and patients-for-patient-safety organisations are beginning to reframe not just patient-clinician communication, but also its entire context. For Coulter, patient engagement is principally about challenging the supply-driven disease control orientation of health, including professional dominance and structural inertia. Having spent many years investigating patient satisfaction levels in the UK and elsewhere, Coulter’s work expands the agenda of patient-centredness into one centring on enhanced involvement of patients in all aspects of care provision (Coulter 2007).

Besides patients having greater input into health care decision-making, another intended outcome of patient engagement is the patient’s strengthened capacity for **self-management**. Self-management was originally put on the agenda by the UK policy analyst Derek Wanless (2002). For him, bolstering the patient’s own role in their care should produce a ‘co-production of care’. Co-production offered a critical solution to a range of emerging problems, among which were inadequate financial resources, and a lack of public support for government services. But co-production is by no means easily achievable. In their study of patients’ views on self-management, Doherty and Stavropoulou report that “[o]lder people were less likely to ask questions about hand washing or the purpose of the medication” and that “women were found to be more willing to ask

challenging questions of clinicians” (Doherty and Stavropoulou 2012: 259). Conversely, “men appeared more willing to self-manage” (Doherty & Stavropoulou 2012: 259). As the leaflet shown below demonstrates, health services are increasingly concerned to inform patients about the importance of appropriate self-medication.



Self-management obviously requires complex and ongoing negotiations between the patient and their clinician(s) (Rogers et al. 2005). This may include patients being expected to ask questions about their medications, learn about their medications and what they do, and handle their medications in expert ways (see the NZ Health Quality & Safety Commission leaflet above). Rogers and colleagues’ study reports on patients’ view that physicians may not offer them sufficient opportunities for discussing self-management issues, including continuity of care, organisational arrangements dominating outpatients clinics, and related care trajectories issues (Rogers et al. 2005).

Addressing these matters by technologising how patients and clinicians communicate is the introduction of **computer-mediated communication**. Katz and Moyer point to the rise of email communication between patients and providers (Katz and Moyer 2004), and more recent studies point to high rates of patients’ approval of email contact (Burke-Beckjord et al. 2007). The impact of email communication on the patient-provider relationship can be considerable. In some instances,

the intensity of patient-clinician communication rises significantly, where in others, both satisfaction and the quality and outcomes of care are improved (Zhou et al. 2010).

Another way in which these more recent concerns about complexity and uncertainty have begun to inform how we think about and investigate patient-clinician communication is by looking at how teams of clinicians communicate with a patient under their responsibility. Such **team-based care communication** is already apparent in Rogers and colleagues' work, thanks to its emphasis on care trajectory and continuity – uniquely the domain of the clinical team rather than merely the individual clinician. Team communication informs the context of care – an angle on patient-centredness brought out especially in the work by Safran and colleagues (Safran et al. 2006). Their model of 'relationship centred organisations' is reproduced below.

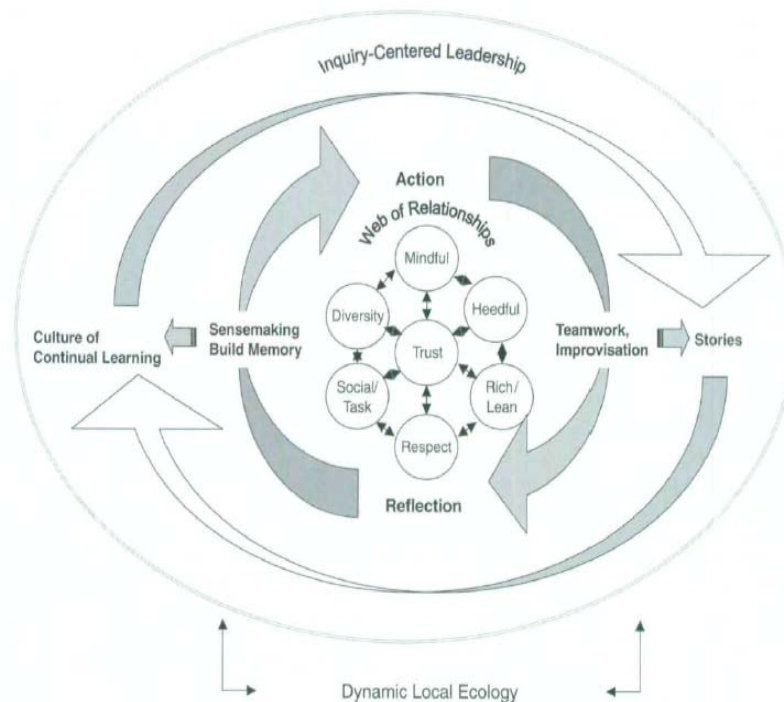


FIGURE 1. A model of relationship-centered organizations.

Figure: A model of relationship-centred organizations (Safran et al. 2006)

The recent interest in teams as *micro-systems* (Bate 2009; Mohr et al. 2004) offers further indication that research is now targeting how multiple clinicians interact with and around the individual patient. Moreover, they do so not merely during a single encounter, but right across the unfolding of their long-term care. The emphasis on effective team communication to enabling excellent clinician-patient communication is extended to the system as a whole in Safran and colleagues' work (Safran et al. 2006). They posit a direct link between good systems (read: group member communication

processes) supporting doctors and nurses in their work, and this support translating into better individual interactions. The relevant connections are schematised in Safran and colleagues' diagram, reproduced above.

Interestingly, Safran et al. (2006) identify 'mindfulness' as a key aspect of institutional work *per se*. For them, "[m]indfulness refers to organizational and employee awareness of self and others, of relationships, and of what is happening elsewhere in the organization, along with openness to new ideas and different perspectives (emotional intelligence)" (Safran et al. 2006). Mindfulness extends the individual's awareness of the other person, to include awareness of the broader context within which action and communication take place (Weick 2004). In Weick's work, mindfulness becomes a mode of mutual awareness and social interdependence, pointing towards what Iedema has referred to as professionals' and patients' 'weave of shared commitment' (Iedema 2011). This 'weave' transcends the personal-emotional intelligence advocated in 'patient as person' research, and gives it a social dimension. Here, we are therefore concerned not with information or one-on-one relations, but with what Goleman terms 'social intelligence' (Goleman 2006).

The centrality of such social (and in effect *organisational*) intelligence for how clinicians and patients communicate was of course already touched on in earlier work. Noteworthy here are studies by Bensing and colleagues (2003) and Rogers and colleagues (2005). Rogers and colleagues' study already laments that "[i]t is worth noting that although the individual consultations might have been patient-centred, nothing else about the organization of NHS outpatient clinics was, and patients generally had to wait for long periods in a crowded and busy place that was not conducive to the introduction of the intervention. The atmosphere was viewed as constraining to both patients and health professionals" (2005). The authors go on to make a critical point:

The perceived effectiveness of the patient-centred approach in our study was dependent in large measure on the constraints of the outpatient clinic infrastructure, the clinical load, and time available per patient. It was apparent that for some patients and consultants, one consultation was not enough to introduce the approach and that the general environment acted against the ethos of patient-centredness. (Rogers et al. 2005)

In similar vein, Fischer & Ereaut explore this more complex and contextualising view of the patient-clinician consultation. They question the generally-advocated reliance on technical and personal skills of the clinician as the only factors ensuring a successful consultation (2012). Firstly, they do this by positing that clinicians themselves as practitioners are vulnerable, as are patients, and both need to manage their own fears, anxieties and efficiencies. Then they point out that the content of what is negotiated between patients and their doctors/nurses is similarly fragile and impacted on by outside or intra- and inter-institutional factors. They examine the 'surrounds' of the consultations and highlight what they identify as the fragmented nature of the one-on-one conversations within the bigger picture of institutional care. Their diagram (reproduced below) illustrates how fragmented

patient-clinician consultations can be as people engage in multiple one-on-one consultations in an institutional setting, and how this obviates connectedness among people and processes.

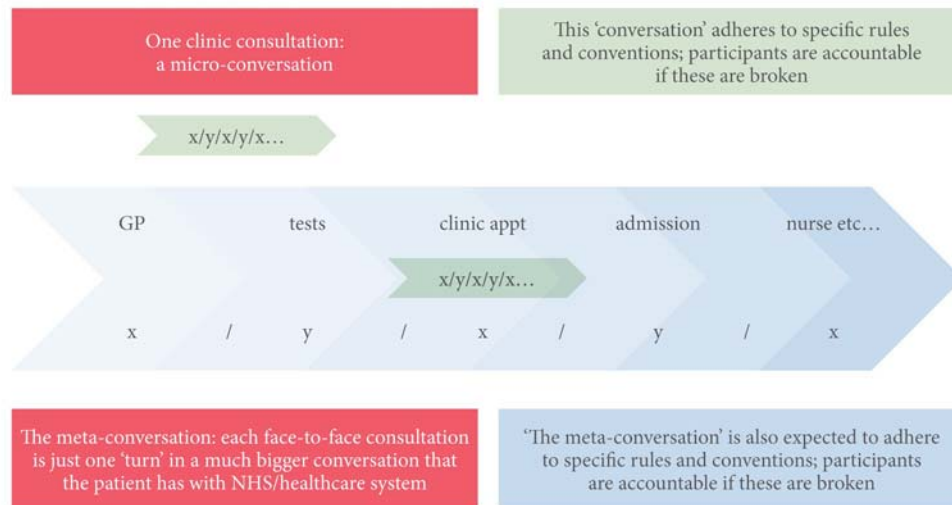


Figure: The 'consultation' within a bigger 'conversation' (Fischer and Ereaud 2012)

Others are also exploring institutional and contextual impacts on one-on-one patient-clinician communication, using predominantly ethnographic and story-telling methodologies. Jones and Watson provide a recent overview of this research (Jones and Watson 2012). They cite Berridge et al. (2010) who argue that "simple standardized communication interventions to improve quality of care may be ineffective if no account is taken of the particular communication context or organizational culture" (cited in Jones and Watson 2012). Communication pathologies can result from how institutions prefigure and skew communication in ways that are detrimental to effectiveness, respect and continuity. "[T]his kind of communication problem is being so entrenched in a culture that it is invisible; socio-structural power inequalities lie at the heart of such miscommunication. In other words, the hospital system, as an unseen force, drives communication" (Hewett & Gallois 2012, cited in Jones and Watson 2012).

A running theme in the contemporary studies reviewed thus far is their acceptance of and interest in uncertainty, complexity and context. This interest is evident from their focus on the lived dilemmas of clinicians and patients. By specifying how particular episodes of care unfolded for specific patients, clinicians and services, they draw attention to the inordinate complexity of these processes, and to the importance of finding answers for frontline clinicians to negotiate that complexity, rather than impose simplistic procedures and routines that ignore real-life problems (Greenhalgh et al. 2005; Greenhalgh et al 2011).

One perhaps *less expected* dilemma is how formal resources may at times obviate access and good communication, rather than facilitate it. Jerak-Zuiderent's recent study explains such a dilemma

faced by clinicians when they deny a father of a suicidal woman access to medication on the ground that he is not a registered carer (as specified in the relevant guideline), resulting in the father becoming increasingly anxious and aggressive (Jerak-Zuiderdent 2012). Formulating a parallel argument, Hor and colleagues describe how clinicians negotiate unexpected outcomes in paediatric care and agree to down-grade their administrative status, effectively denying patients and their families their disclosure (Hor et al. 2010). In both cases, formal rules are mobilised in a way that produces unsafe practice. Both studies call for a reassessment of whether formal rules are indeed *the* precondition for safe and high quality care. Both studies ask whether there is an ethics of care that answers to a very different modality of accountability than the one that is prevalent in today's health care. Instead of mechanical conformity, this research proposes a *practical ethics of care* (Mol 2008).

A note on research methodology

The 'patient as uncertainty' research reviewed here heralds an important methodological development in the investigation of clinician-patient communication. It targets how care unfolds in real-time and how it gains structure from how people enact it and communicate about it. In focusing on this progressive structuring of care from the perspective of the care and the patient, this research is no longer beholden to the dichotomy that has emasculated health services research for decades: the dichotomy that divorces individuals' activities from systems' effects. By adopting a lens that privileges the *in situ* unfolding of patient care, the present research leaves behind this dichotomy, and the attendant sociological question about how and where micro (the individual and their agency) and macro (social-organisational structure) meet (Giddens 1979). For the present body of research, neither individual nor over-arching structure are defining of what happens in the here-and-now. Instead, what is defining of the here-and-now is the rhythms and routines of *situated practice* (Nicolini 2011).

'Situated practice' is a term that refers to what people do, the resources they invoke or mobilise to do it, and the purposes and motivations that drive what they do (Schatzki 1996). To obtain a sense of what a practice is, we can observe it from a distance (deduction achieved through 'objective' research), place ourselves within it and experience it (induction derived from specificity), or experiment with it ('abduction')⁸. Some of the most persuasive accounts of practice therefore are those produced by actors working in the field – those who are best placed to guess or 'abduce' what will happen next in real-time practice. Their accounts are often detailed and therefore sensitive to the contradictions and dilemmas facing professional practitioners and patients (Hillman 2010; Jorm 2012; Kadra 2010). They too are acutely aware of the burden of enacting and maintaining respectful, continuous and safe communication in an increasingly complex, fragmented, resource-constrained and dangerous health care system (Mauksch et al. 2008).

⁸ Deduction involves testing what we (think we) know to reach a logically certain conclusion. Induction produces general conclusions from specific experiences. *Abduction* is tantamount to educated guessing (Peirce, C.S. (1955) *The Philosophical Writings of Peirce*. New York: Dover Publications), acknowledging that our conclusions may get contradicted by future experiences.

All told, studying communication and taking account of everyday pressures and complexities requires a different research paradigm from the ones adopted for 'patient as object' and 'patient as person' research. Here, we enter a world of instability: "the new laws of nature [read: communication] deal with the possibility of events, but do not reduce these events to deductable, predictable consequences. ... As we follow the narrow path that avoids blind laws and arbitrary events, we discover that a large part of the concrete world around us has until now 'slipped through the meshes of the scientific net'" (Prigogine 1996, p. 189).

The present section of this report deals with studies that have begun to address those aspects of the concrete world that have thus far 'slipped through the net' because they were either too complex or too ephemeral for the methods deployed (Iedema et al. 2013). Thus, there are studies that delve into the uncertain consequences of expecting patients to speak about their care, its processes and arrangements. In seeking to expand the ways in which and the issues about which clinicians communicate with patients, these researchers have begun to advocate that patients should intervene in care more generally, particularly when it appears unsafe. This research is at times referred to as '**patients for patient safety**' research (Ward et al. 2011).

No doubt challenging for most if not all patients, as well as for clinicians not used to patients engaging in safety talk, this expectation means that patients are to raise issues that matter to them or come to their notice during care (Davis et al. 2007). This research makes evident that patient-clinician communication need not be limited to treatment-based issues and medical choices. On the contrary, a host of 'process of care' issues may arise, to do with, for example, inadequate hand hygiene (Koutantji et al. 2005), incorrect treatment information or unexpected outcomes (Iedema et al. 2011), whether and how clinicians disclose incidents (Iedema et al. 2011), and so forth.

Communicating these matters to clinicians is difficult, because it elevates the patient from their 'sick-role', converting their 'patience' into potentially unwelcome displays of agency (Stockwell 1972).

The drive towards patient engagement has also re-oriented the agenda from organisations using patients' ('satisfaction') feedback to reassess their own priorities, towards organisations involving patients at a variety of levels of care and care facility design. This enables patients to realise their priorities, well over and above care and treatment processes provided to them as individuals. This radical expansion of the role of patients in health care generally has led to **co-design** initiatives in the UK (Bate and Robert 2007) and in Australia (Iedema et al. 2008; Piper et al. 2010). Co-design centres on bringing together cohorts of patients who have moved through a particular specialty with that specialty's clinicians to discuss 'how things are done around here', and whether things can be done (or designed) differently (Iedema et al. 2010). Both Bate and Robert, and Piper and colleagues set out advice for organisations intending to engage patients in co-design (Bate and Robert 2007; Piper

et al. under review). The essence of their advice is that building relationships with patients and among project staff is a critical pre-condition for ensuring the success of co-design initiatives.

In engendering communication among patients and clinicians through co-design, health care policy-makers and organisations are not just acknowledging patients' ability and their right to have a say in health care decision-making, or to address matters previously considered to be the unique preserve of health service managers and clinicians. Indeed, the new National Quality and Safety Health Service Standards (Australian Commission on Quality and Safety in Health Care 2012) have begun to institutionalise new forms of communication in an as yet un-trampled space: patient and clinicians sharing insights about clinical governance matters, including complaints, and incident investigations. Seen in the light of the new Standards, co-design acts as an important *democratising* forum and impetus for how clinicians perceive themselves and their roles. As novel kind of conversation, co-design results not merely in practical solutions but also in important reflexive and behavioural effects for stakeholders (Iedema 2011).

As noted above, the recent 'patient as uncertainty' studies discussed here have begun to shift from analysing specific communication events to examining how patient-clinician communication unfolds right across the whole episode of care, and even inter-institutionally. This broader view is endorsed by Wynia and colleagues, who locate at least some of the responsibility for improving communication at the systems level: "there is already considerable interest looking at how organizations and systems can support more effective communication, especially as regards health literacy and language services" (Wynia 2012). Wynia and colleagues touch on a range of complexities that may perturb such communication, such as communication needing to be conducted with patients from **culturally and linguistically diverse ('CALD') backgrounds**, involving interpreters, translators, or perhaps family members with expertise in different languages.

Investigating communication in this challenging CALD domain, Butow and colleagues are able to highlight the challenges to comprehension that arise in communication about metastatic cancer with patients from Lebanese, Greek and Chinese patients (Butow et al. 2011a; Butow et al. 2011b; Duric et al. 2011). They found that interpreters' translations from English into Greek, Chinese and Arabic were correct between 50% of the time (family members) and 65% of the time (professional interpreters). Butow and colleagues recommend communication training to include doctors training alongside interpreters to give them a chance "to negotiate their roles, language and cultural approaches before the consultation". Investigating a similarly fraught area, Shahid and colleagues (Shahid et al. 2009) found hospital communication between clinicians and Aboriginal patients to lack in culturally sensitive and empathetic contact, and have inadequate acknowledgement of Aboriginal family structures. Key for these commentators is growing the number of Aboriginal health workers

to obviate the kinds of alienation that are experienced now (Shahid et al. 2009). This shift towards patient-clinician partnerships was formalised by the US Institute of Medicine, as shown below:

USA Institute of Medicine - Patient-Clinician Communication
Basic Principles and Expectations (Paget et al. 2011):
1. Mutual respect
2. Harmonized goals
3. A supportive environment
4. Appropriate decision partners
5. The right information
6. Transparency and full disclosure
7. Continuous learning

No doubt, this emphasis on partnerships is to countervail the growing amount of evidence that is appearing pointing to uncertainty permeating most kinds of clinical work. Jorm notes in her recent book that “an estimated 50-80% of all medical treatments have never been validated by trials” (Jorm 2012, p. 103). This does not invalidate time-honoured treatments, but it does direct attention to the high levels of uncertainty permeating what many clinicians do. For them, negotiating uncertainty with patients is critical, and it requires special skills:

Diagnosing physicians manage the uncertainty associated with these illnesses by using strategies that enhance bounded rationality and aid in thinking beyond current disease models. Strategies include consulting ancillary information sources, conducting analytically informed testing, and considering physiological explanations of causation. (Swoboda 2008)

For Mol, negotiating such uncertainties necessitates a rather different approach. She charts ongoing discussions with the patient to see how decisions are impacting on the patient’s well-being, re-evaluation of those decisions over time, and tailoring decisions to accommodate the constraints, changes and uncertainties inherent in everyday life itself (Mol 2008). Mol’s *logic of care* model posits ongoing communication as the basis for addressing and ‘taming’ complexities that arise during the unfolding of health care treatment, particularly in the case of care provided to chronically-ill patients.

What is effective patient-clinician communication?

We define effective patient-clinician communication as the use, by the clinician and their team, of both spoken and non-verbal behaviours that convey accurate information, respect and individual attention, as well as a

style of interaction that enables dialogue and is responsive to particular needs and questions of the patient and the situation as it evolves over time. Effective patient-clinician communication includes positive outcomes for the patient and the clinician (team) in both the short and the long term. This includes the feeling of being respected (short-term effect) and being reassured that the health service, the clinical team and the treating clinician are constantly seeking to establish and plan ways for 'going on', and sharing these possibilities and plans, including their evidentiary basis, openly and transparently with patients and their families.

The Australian Code of Conduct for Doctors shown below makes clear that it is a critical component of patient-clinician communication not just to listen to patients' concerns and address these as and when they arise, but also to negotiate a *care management plan* and ensure appropriate arrangements are made given the patients unique background and circumstances:

A Code of Conduct for Doctors in Australia (2010)

Excerpt from Good Medical Practice – A Code of Conduct for Doctors in Australia (2010)
<http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx> (Medical Board of Australia)

Effective communication

An important part of the doctor–patient relationship is effective communication. This involves:

- 3.3.1 Listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences.
- 3.3.2 Encouraging patients to tell you about their condition and how they are currently managing it, including any alternative or complementary therapies they are using.
- 3.3.3 Informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment.
- 3.3.4 Discussing with patients their condition and the available management options, including their potential benefit and harm.
- 3.3.5 Endeavouring to confirm that your patient understands what you have said.
- 3.3.6 Ensuring that patients are informed of the material risks associated with any part of the proposed management plan.
- 3.3.7 Responding to patients' questions and keeping them informed about their clinical progress.
- 3.3.8 Making sure, wherever practical, that arrangements are made to meet patients' specific language, cultural and communication needs, and being aware of how these needs affect understanding.
- 3.3.9 Familiarising yourself with, and using whenever necessary, qualified language interpreters or cultural interpreters to help you to meet patients' communication needs. Information about government funded interpreter services is available on the Australian Government Department of Immigration and Citizenship website.

We conclude this section by providing detailed summaries of articles that populate this strand of 'patient as uncertainty' research. The multi-coloured bars at the top of the tables are to indicate that the three strands of research often converge in the concerns pursued here.

Selected annotated bibliography 3) Communicating with ‘the patient as uncertainty’

Study and Authors	Study description/findings/practice implications	
(Adams et al. 2012) The doctor and the patient - How is a clinician encounter perceived?	<p>This study seeks to examine the population distribution of different types of relationships between people with chronic conditions and their doctors that influence decisions being made from a shared-decision making perspective. A survey questionnaire, based on recurring themes about the doctor/patient relationship identified from qualitative in-depth interviews with people with chronic conditions and doctors, was administered to a national population sample (n = 999) of people with chronic conditions.</p> <p>Results: ‘Three factors explained the doctor/patient relationship. Factor 1 identifies a positive partnership characteristic of involvement and shared decision-making; Factor 2 doctor-controlled relationship; Factor 3 relationship with negative dimensions. Cluster analysis identifies four population groups. Cluster 1 doctor is in control (9.7% of the population); Cluster 2 ambivalent (27.6%); Cluster 3 positive long-term relationship (58.6%); Cluster 4 unhappy relationship (4.4%). The proportion of 18–34 year olds is significantly higher than expected in Cluster 4. The proportion of 65+ year olds is significantly higher than expected in Cluster 1, and significantly lower than expected in Cluster 4’ (2012, p 127).</p> <p>Conclusion(s): This study adds to shared decision-making literature in that it shows in a representative sample of people with chronic illnesses how their perceptions of their experiences of the doctor–patient relationship are distributed across the population. Practice implications: Consideration needs to be given as to whether it is better to help doctors to alter their styles of interactions to suit the preferences of different patients or if it is feasible to match patients with doctors by style of decision-making and patient preference.</p>	
(Ashton 2003) Racial and Ethnic Disparities in the Use of Health Services: Bias, Preferences, or Poor Communication?	<p>The study found that racial bias and patient preferences contribute to disparities in the use of health services, but their effects appear small. Communication during the medical interaction plays a central role in decision making about subsequent interventions and health behaviours.</p> <p>The authors evaluate the evidence that poor communication is a cause of disparities and propose some remedies drawn from the communication sciences.</p>	
(Buetow, Jutel & Hoare 2009) Shrinking social space in the doctor-modern patient relationship: a review of forces for, and implications of, homologisation (Conceptual Review)	<p>This is a review and a conceptual sociological paper on the changing nature of the relationship between patients and doctors. The authors discuss how forces for modernisation appear to have led to role convergence and reduced social distances between doctors and modern patients. The review sets out to document and understand this process in theory and practice, and to consider the implications for modern patients in particular but also what this means for non modern patients and doctors.</p> <p>The researchers undertook a narrative review of published and grey literature identified from sources including electronic databases, the Internet and reference lists of retrieved works.</p> <p>Results: The authors identified that forces for role convergence between doctors and modern patients include consumerism and increased patient literacy; socio-technological changes; values convergence; increased licence for doctors to use their emotions in patient care; and structural changes in the social organisation of health care. As a result, they say, <i>modern</i> patients appear to have gained more in health care than they have lost and more than have</p>	

Study and Authors	Study description/findings/practice implications	
	<p>the <i>non-modern (or less modern)</i> patients. At the same time doctors have lost authority and autonomy in patient care.</p> <p>Conclusion(s): The authors conclude by saying that the net impulse toward role convergence (of doctors and patients) is, on balance, a positive development. However, the differential uptake of modernisation by patients has increased health inequalities between modern and non-modern patients. The need of doctors to accommodate these changes has contributed to a form of reprofessionalisation.</p> <p>Practice implications: A key challenge is to make available the benefits of organisation, for example through patient education, to as many patients as possible while minimising the risk of harm. They say that it is important therefore to elucidate and be responsive to patient preferences for modernisation, for example by enlisting the support of <i>modern</i> patients in overcoming barriers to the modernisation of nonmodern patients. They also identify a need to support doctors as they redefine their own professional role identity.</p>	
(Cook, Render & Woods 2000) Gaps in the continuity of care and progress on patient safety	<p>This article is principally about patient safety, but connects to our theme of the complexity and uncertainty of modern healthcare. The patient safety movement includes a wide variety of approaches and views about how to characterise patient safety, study failure and success, and improve safety. Ultimately all these approaches make reference to the nature of technical work of practitioners at the “sharp end” in the complex, rapidly changing, intrinsically hazardous world of health care. It is clear that a major activity of technical workers (physicians, nurses, technicians, pharmacists, and others) is coping with complexity and, in particular, coping with the gaps that complexity spawns. Exploration of gaps and the way practitioners anticipate, detect, and bridge them is a fruitful means of pursuing robust improvements in patient safety.</p>	
(Da Silva 2012) Helping people share decision making: A review of evidence considering whether shared decision making is worthwhile	<p>In drawing together the evidence on shared decision making, ‘Helping people share decisions’ highlights gaps in current knowledge, such as the long term cost-effectiveness of shared decision making if, for example, treatment decisions are deferred. There is also little evidence on how it can impact on domains of quality such as equity and patient safety. This lack of evidence does not mean that there is no relationship or benefit, but that there is currently insufficient research to draw conclusions. One of the striking findings in this review is that there is no common definition of shared decision making in the studies, creating significant challenges in understanding and replicating benefits and drawing conclusions across multiple studies.</p> <p>Findings: This evidence review also clearly demonstrates that putting shared decision making into practice will not be achieved through policy statements: active steps to change the behaviour of both healthcare professionals and patients are central to its successful delivery. In concert with Helping people help themselves, the Health Foundation’s May 2011 review of the evidence on supporting self-management, highlights the need for approaches that support patients to have the confidence, information and support to participate in decisions about their health and healthcare.</p>	
(Davis et al. 2012) An examination of opportunities for the active patient in improving patient safety	<p>Patients can make valuable contributions to their health care safety. Little is known, however, about the factors that could affect patient participation in safety-related aspects of their health care management. Examining and understanding how patient involvement in safety-related behaviours can be conceptualised will allow greater insight into why patients may be more willing to participate in some behaviours more than others.</p> <p>This study aims to develop a new approach for understanding and conceptualizing patient involvement in safety with</p>	

Study and Authors	Study description/findings/practice implications	
	<p>specific reference to a surgical patient cohort.</p> <p>The authors conduct a review of the key opportunities for patient involvement along the surgical care trajectory and examination and identification of the properties and characteristics of different safety-related behaviours and the barriers to patient involvement they entail.</p> <p>According to the study, safety-related behaviours 'comprise 3 main properties including the type of error the behaviour is trying to prevent (e.g., medication error), the action required by the patient (e.g., asking questions), and the characteristics of the action (e.g., whether the behavior involves interacting with a health care professional)' (2012, p. 36). The study concludes that barriers to patient involvement that relate to patients and health care professionals can be broadly categorised as interpersonal, intrapersonal, and cultural. The authors believe that thinking of patient involvement in safety relating to properties and characteristics of the behavior together with the barriers to involvement could aid the design, implementation, and evaluation of interventions aimed at encouraging patient participation. They suggest this approach will also enable a greater understanding and assessment of not only what interventions may be effective (at encouraging patient involvement) but when they might be effective (i.e., what stage of the care pathway) and why.</p>	
(Deledda et al. 2012) How patients want their doctor to communicate. A literature review on primary care patients' perspective (Review of literature)	<p>This study reviews the literature on the communicative behaviours primary care patients want from a 'good' physician. The authors conduct an electronic search used the key words doctor-patient relation AND patient desires OR patient expectations OR patient preferences (from now referred to as expectations). The qualitative and quantitative articles meeting the selection criteria are analysed separately, comparing methods, definitions, measures and outcomes. The physician behaviours desirable from a patient perspective are grouped by linking them to the communicative functions of an effective medical encounter as defined from a professional perspective.</p> <p>Results: The authors include twenty-seven studies Critical issues are the heterogeneity of definitions and measures and the lack of integration between quantitative and qualitative findings. Most of the expectations in qualitative studies are related to the function "Fostering the relationship". Similar expectations arise less often in quantitative studies.</p> <p>Conclusion(s): The authors find that patients do have concrete expectations regarding each of the functions to be met in the medical encounter. They suggest that the research approach tends to bias the results. Practice implications: The collected expectations suggest how physicians may perform each of their tasks according to the patient perspective. Future research on patients' communicative expectations needs to overcome the gap between qualitative and quantitative findings.</p>	
(Doherty & Stavropoulou 2012) Patients' willingness and ability to participate actively in the reduction of clinical errors: a systematic literature review (Review of literature)	<p>This systematic review identifies the factors that both support and deter patients from being willing and able to participate actively in reducing clinical errors. Specifically, the authors add to our understanding of the safety culture in healthcare by engaging with the call for a greater focus on the relational and subjective factors which enable patients' participation (they reference Iedema, Jorm, & Lum 2009; Ovreteit 2009). Based on the current emphasis in patient safety on open communication and the promotion of the JCAHO standard, the authors sought to assess the strength of the evidence for disclosing errors to patients and to present practical suggestions for disclosing medical errors based on a review of the literature. The authors undertook a systematic search of six databases, ten journals and seven</p>	

Study and Authors	Study description/findings/practice implications	
	<p>healthcare organisations' web sites, which resulted in the identification of 2714 studies of which 68 were included in the review. These studies investigated initiatives involving patients in safety or studies of patients' perspectives of being actively involved in the safety of their care. The factors explored varied considerably depending on the scope, setting and context of the study. Using thematic analysis the authors synthesised the data to build an explanation of why, when and how patients are likely to engage actively in helping to reduce clinical errors. The studies they reviewed reveal gaps between patients' preferences and current practice, as well as physician support for the principle of disclosure and hesitation to share information because of a fear of liability. They identified that some institutions adopted policies without adverse malpractice consequences.</p> <p>The findings show that the main factors for engaging patients in their own safety can be summarised in four categories: illness; individual cognitive characteristics; the clinician-patient relationship; and organisational factors. The paper also finds that illness and patients' perceptions of their role and status as subordinate to that of clinicians are the most important barriers to their involvement in error reduction. In sum, patients' fear of being labelled "difficult" and a consequent desire for clinicians' approval may cause them to assume a passive role as a means of actively protecting their personal safety.</p> <p>The study gives practical suggestions for talking with patients about errors. These include: actively listening to and taking seriously patients' concerns; providing a clear explanation when concerns or views differ from those of the patient; appearing to have the time to talk by making eye contact and other non-verbal behaviours such as sitting by the patient's bed; and, if acceptable to the patient, involving relatives in their care. Reassuring patients that it is okay to ask by using posters or information leaflets helps to reinforce this message.</p> <p>A good interpersonal relationship with patients, in particular, has an important influence on patients' willingness and ability to participate in error reduction. Their review found that when clinicians encourage patients' involvement in safety then patients are generally willing to participate.</p> <p>The authors note that the literature contains important but unanswered questions such as cultural variations and whether disclosure does improve patient trust and decrease lawsuits. They say that research in this area is in its infancy. They suggest that future research should consider the broad range of outcomes before concluding whether disclosure has an overall positive or negative effect.</p>	
(Engestrom 2008) From Teams to Knots: Activity - Theoretical Studies of Collaboration and Learning at Work	<p>This book traces the complexities of connection and continuity in healthcare. Engestrom outlines the challenges faced by modern healthcare practitioners 'where the centre does not hold'. In other words, he examines how practitioners learn to manage fragmented knowledge networks and how they work in isolated groups and accomplish 'knot working', i.e. flexible ways of working and connecting in groups that form and reform.</p> <p>Lessons for managing complexity and uncertainty in healthcare that arise from the book are that practitioners will need to adopt (and adapt to) new ways of working. The focus of this book is on the way that work is organised.</p> <p>Engestrom also attends to the way that people learn in organisational settings but warns that that our interprofessional relationships are not yet ready for this new world of healthcare. In his words, 'the shape and implications of spatio-temporally distributed work and expertise are still fragile and open, literally under construction. When professionals</p>	

Study and Authors	Study description/findings/practice implications	
(Epstein, Alper & Quill 2004) Communicating Evidence for Participatory Decision Making (Review)	<p>perform such work and discourse, they also give shape to it' (Engestrom 2008, p. 217).</p> <p>The authors' background to this study identifies that informed patients are more likely to actively participate in their care, make wiser decisions, come to a common understanding with their physicians, and adhere more fully to treatment. However they contend, that at the time of writing there were no evidence-based guidelines for discussing clinical evidence with patients who were in the process of making medical decisions. The study sought to identify ways to communicate evidence that would improve patient understanding and involvement in decisions, and outcomes. The authors undertook a systematic review of MEDLINE for the period 1966-2003 and a review of reference lists of retrieved articles to identify original research dealing with communication between clinicians and patients and directly addressing methods of presenting clinical evidence to patients.</p> <p>Two investigators and a research assistant screened 367 abstracts and 2 investigators reviewed 51 full-text articles, yielding 8 potentially relevant articles.</p> <p>The authors identified that methods for communicating clinical evidence to patients include 1) nonquantitative general terms, 2) numerical translation of clinical evidence, 3) graphical representations, and 4) decision aids.</p> <p>These suggest (based on focus-group data) presenting options and/or equipoise before asking patients about preferred decision-making roles or formats for presenting details. They discuss that relative risk reductions may be misleading; absolute risk is preferred. Their review also found that the order of information presented and time-frame of outcomes can bias patient understanding. Limited evidence supports the use of human stick figure graphics or faces for single probabilities and vertical bar graphs for comparative information. Less-educated and older patients preferred proportions to percentages and did not appreciate confidence intervals. Studies of decision aids rarely addressed patient-physician communication directly. No studies addressed clinical outcomes of discussions of clinical evidence.</p> <p>The study concluded that there is a paucity of evidence to guide how physicians can most effectively share clinical evidence with patients facing decisions; however, basing their recommendations largely on related studies and expert opinion, they describe means of accomplishing five communication tasks to address in framing and communicating clinical evidence. These include: understanding the patient's (and family members') experience and expectations; building the partnership; providing the evidence, including a balanced discussion of uncertainties; presenting recommendations informed by clinical judgment and patient preferences; and checking for understanding and agreement.</p>	
(Fallowfield & Jenkins 2004) Communicating sad, bad, and difficult news in medicine' (A review)	<p>The authors begin this Review published in the Lancet in 2004 by reminding us that in every medical specialty bad, sad, and difficult information must be given to patients and their families. They point out that an insensitive approach increases the distress of recipients of bad news; it may also exert a lasting impact on the patients' ability to adapt and adjust, and they say an insensitive approach can lead to anger and an increased risk of litigation.</p> <p>They point out that many doctors also find these interactions stressful, and in the absence of much effective training, they may adopt inappropriate ways of delivering bad news and coping with the emotional fall-out.</p> <p>They identify that these difficulties have been recognised and this has led to many initiatives, ranging from increased communication skills training to the development of guidelines and protocols.</p>	

Study and Authors	Study description/findings/practice implications	
	<p>In this paper, they review some of the research on the impact that giving sad, bad, and difficult news has on doctors and patients, and assess whether interventions are helping. They focus mainly on difficulties encountered involving parents in an obstetric or paediatric setting, people in acute trauma situations such as accident and emergency departments, and patients with cancer.</p> <p>The authors conclude that over the past ten years people have recognised the need to integrate appropriate communication skills teaching into undergraduate and postgraduate education. They argue that research has shown that if bad news is communicated badly it can cause confusion, long lasting distress, and resentment; if done well, it can assist understanding, acceptance, and adjustment. They therefore suggest that training health-care professionals how to do the task more effectively will produce benefits for them as well as their patients. However they do caution this training needs to be based on sound educational principles, informed by evidence, and assessed and monitored adequately.</p>	
(Fischer & Ereaut 2012) When doctors and patients talk: making sense of the consultation	<p>This research – bringing together insights from two quite distinct disciplines, complex adaptive social systems and discourse analysis – makes the very simple point that it is the relationship between doctors and patients that is at the heart of a health system. The authors suggest that if a different health system is required, it will be necessary to have a different type of relationship.</p> <p>The authors describe their work as research-based consulting. They undertook data collection and analysis in the NHS (National Health Service of the UK) but also drew on the collective experience and interpretative ability of their own work, as consultants and The Health Foundation as experts in this field.</p> <p>They describe their approach as qualitative, eclectic and pragmatic; thus the work is systematic and based in data but is also interpretative, drawing on two distinct theoretical frameworks and on the experience of the authors.</p> <p>The authors describe a dynamic that, whether or not it is fit for a bygone age, does not meet the needs of a health system in an economically developed, politically democratic, technologically sophisticated country. They contend that partly due to the success of medical intervention, the hospital has become a place for the very ill and the community has become a place in which people live with long-term conditions. Recognising that everyone is stuck in a relationship that does not meet current needs and which disadvantage patient and doctor alike is not easy. As the authors say:</p> <p style="padding-left: 40px;">In the early stages of transformation the dominant powers and logic of any system may not even see the problems or recognise them as significant. Often even those who are disadvantaged by the clinician-patient dynamic do not recognise it.</p> <p>(Fischer & Ereaut 2012, p. 4)</p> <p>The report offers a powerful analysis of the current patient-clinician relationship – from recognition of the mutual fears and anxieties that drive doctors and patients, to the invisible structures that are natural to the doctor but hidden from the patient, notably the fact that patients do not understand the process of how the consultation works. The authors recommend that quality improvement interventions should be part of a strategy that aims to: surface and make unsustainable some of the systemic forces and practices that maintain the status quo; co-create a desired model of the patient–doctor dynamic (not just in the moment of consultation, but of their relationship to the whole system); develop processes and support systems that increase likelihood of the patient and clinician being at their best in the moment of</p>	

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	<p>interaction; support organisations to be 'joined up' around the consultation (both before and after); institutionalise learning about what supports and grows the above (items), and identify constraints that could be overcome with supported innovation.</p> <p>Furthermore they add that any strategy should aim to promote interventions that address: the identity (meaning) of the consultation: the necessary relationships in it (and between it and the rest of the system); the information (in the widest sense, not just conventional data) around which the consultation should be structured.</p>	
(Gherardi 2006) Organizational Knowledge: The Texture of Workplace Learning	<p>This book explains a practice-based approach to organisational work and workplace learning. It illustrates how practices are woven together with the workplace and its members. It would be useful in examining the interrelationships between nurses, doctors and their patient-clinician communication practices in a range of settings. To implement such an approach would require extensive research studies.</p>	
(Gilles, Wakerman & Durey 2008) "If it wasn't for OTDs, there would be no AMS": overseas-trained doctors working in rural and remote Aboriginal health settings	<p>This study identifies one of the problems that exists for Aboriginal health in Australia. They point out that Australian-trained doctors are often reluctant to work in rural and remote areas and overseas trained doctors (OTDs) are recruited to practise in many rural Aboriginal medical services. This paper focuses on recent research carried out in Australia to analyse factors affecting OTDs' professional, cultural and social integration and examine their training and support needs. The authors conducted ten case studies throughout Australia with OTDs, which also included interviews with spouses/partners, professional colleagues, co-workers, and Aboriginal and Torres Strait Islander community members associated with the health service.</p> <p>Key themes emerging from the data across all informants include the need for providers/agencies to better address recruitment, orientation and cross-cultural issues; the importance of effective communication and building community and institutional relationships, both with the local health service and the broader. In relation to this review of literature, all cases identify communication as an issue. Doctors with an empathic, enquiring approach became "... part of the family", and those demonstrating individual resilience and optimism integrated well professionally. However, language difficulties are occasionally problematic, requiring interpreting services, which are often unavailable. The paper identifies a number of '[p]olicy implications of these findings [that] include the need for:</p> <ul style="list-style-type: none"> • Systematic cultural, historical and political orientation at a local level. • Dedicated resources for mentoring and training: both professional, from other GPs; educational for professional development, including exam preparation; and cultural, from Indigenous staff or community members. • Better "matching" of OTDs, their spouses and children to locations. Evidence from the United States demonstrates that if this occurs, retention of doctors improves (citing Pathman et al. 1992). • Consistent information to potential immigrants including: immigration and registration processes; • Australian Medical Council examination requirements; fellowship training options; and an introduction to the Australian health care system from a general practice perspective . • Support for OTDs to complete fellowship training. 	

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	<ul style="list-style-type: none"> Reducing our over-reliance on OTDs by enhancing strategies to attract Australian trained doctors to work in rural and remote areas' (2008, p. 662). 	
(Leonard & Frankel 2010) The path to safe and reliable healthcare	<p>The authors begin by outlining that the ability to deliver safe and reliable healthcare is the goal of all healthcare delivery systems. To bridge the current performance gaps in quality and safety, organisations need to apply a systematic model that effectively addresses both culture and reliable processes of care. The model described in this article provides a comprehensive approach to improving the quality of care in any clinical domain. The authors identify that what is required is leadership at all levels of the organisation, a safety culture, particular understanding of aspects of human performance in a complex environment, effective teamwork and communication, patient and family centered care, reliable processes of care, and an environment of continuous learning and improvement. The article provides a roadmap for people working in clinical improvement to assess the strengths and current needs in their care systems, so they can be strategic and systematic in their work, essential elements for success. The concepts and tools provided can be readily applied to improve the quality and safety of care delivered.</p>	
(Greenhalgh et al. 2009) Tensions and Paradoxes in Electronic Patient Record Research: A Systematic Literature Review Using the Meta-narrative Method	<p>The extensive research literature on electronic patient records (EPRs) presents challenges to systematic reviewers because it covers multiple research traditions with different underlying philosophical assumptions and methodological approaches.</p> <p>Using the meta-narrative method and searching beyond the Medline- indexed literature, this review uses “conflicting” findings to address higher- order questions about how researchers have differently conceptualised and studied the EPR and its implementation.</p> <p>The authors consider twenty-four previous systematic reviews and ninety-four further primary studies. They identify that key tensions in the literature centre on ‘(1) the EPR (“container” or “itinerary”); (2) the EPR user (“information-processor” or “member of socio-technical network”); (3) organizational context (“the setting within which the EPR is implemented” or “the EPR-in-use”); (4) clinical work (“decision making” or “situated practice”); (5) the process of change (“the logic of determinism” or “the logic of opposition”); (6) implementation success (“objectively defined” or “socially negotiated”); and (7) complexity and scale (“the bigger the better” or “small is beautiful”)’ (2009, p. 729).</p> <p>Conclusions: The findings suggest that EPR use will always require human input to recontextualise knowledge; that even though secondary work (audit, research, billing) may be made more efficient by the EPR, primary clinical work may be made less efficient; that using paper instead of an EPR may offer a unique degree of ecological flexibility; and that smaller EPR systems may sometimes be more efficient and effective than larger ones. The authors suggest an agenda for further research.</p>	
(Hanyok et al. 2012) Practicing patient-centered care: the questions clinically excellent physicians use to get to know their patients as individuals	<p>The authors begin by identifying that patient-centered care, which is dependent on knowing each patient as an individual, has been identified as a critical aspect of healthcare. They contend however that most effective and efficient methods to get to know patients as individuals have not been defined. The aim of their research is to identify questions and phrases that can be used by physicians to get to know their patients.</p> <p>They survey 15 physicians who have been formally recognised for their clinical excellence to determine what questions or phrases they use when interviewing patients to get to know them as individuals.</p>	

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	<p>They receive a total of 28 questions or phrases from 13 physicians and qualitatively analyse these and group them into six major themes: (i) appreciation of the patient's concerns; (ii) personal relationships; (iii) hobbies and pleasurable activities; (iv) open-ended questions to learn about the patient; (v) work; and (vi) the patient's perspective on the patient-physician relationship.</p> <p>This work therefore identifies questions and phrases used by clinically excellent physicians to get to know their patients as people. The authors suggest that future work should focus on obtaining the perspectives of patients, and on examining whether using the identified questions and phrases results in an improved patient experience as demonstrated by improved satisfaction ratings, ratings on the quality of physician-patient interaction, or patient outcomes.</p>	
(Iedema et al. 2011) Patients' and family members' views on how clinicians enact and how they should enact Open Disclosure – the '100 Patient Stories' qualitative study.	Iedema and colleagues interviewed 100 patients and family members about their experiences of incident disclosure. They found that incident disclosure happens rarely, and that patients and families are able to articulate principles for improved disclosure communication. The article presents 10 such principles.	
(Iedema 2011) Creating safety by strengthening clinicians' capacity for reflexivity	In this article Iedema explains the importance of frontline clinicians getting the opportunity to watch themselves at work on video. This 'watching yourselves' creates a distance from the work that makes possible immediate awareness and change. Iedema provides several examples from a range of video-based projects where clinicians have been able to come to terms with complexities affecting their work.	
(Iedema 2007) The discourses of hospital communication	This book brings together chapters from international authors concerned with the complexity of hospital communication processes, including nurses and surgeons arranging surgery lists, doctors determining the meaning of X-rays, corridor conversations, doctors negotiating patients' entry into research trials, anaesthetists talking to patients as they 'go under', among others.	
(Jerak-Zuiderent 2012) Certain uncertainties: Modes of patient safety in healthcare	Jerak-Zuiderent begins by outlining that the safety movement in healthcare approaches patient safety mainly by reducing uncertainty to prevent possible errors. This article is concerned with how this approach relates to other modes of conceptualising patient safety. Following the work of Georges Canguilhem, the author argues that, depending on how we conceptualise knowing, acting and error, a different mode of patient safety is possible: one that involves 'living with uncertainty'. Through ethnographic research on daily clinical work in Dutch primary care facilities, Jerak-Zuiderent shows that the assumption that clinical work can be made safe by reducing errors is not only problematic, it also creates new forms of 'unsafety'. Her observations at general practitioners' out-of-hours service units and other primary care facilities display a 'continuous stream of knowing and acting' in which care professionals adopt specific practices that avoid contradictions between uncertainty and safety. Although she identifies that these practices differed in the various locations she studied, she points out that there were some common dimensions of 'living with uncertainty'. By problematising the conceptions of safety and errors as antonyms the author suggests that a reappraisal is in order, particularly of the notion of how errors in healthcare are understood. She concludes that keeping and protecting room for errors in a situated way is crucial for knowing and acting in a field riddled with uncertainty and dealing with human life. This paper adopts a more recent view on practising and knowing in healthcare.	

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(Jones & Watson 2009) Complex Health Communication: A Language and Social Psychological Perspective (Special Issue introductory article)	<p>This is an introductory article on the special issue of articles were commissioned by the International Association of Language and Social Psychology Taskforce and presented at the 2008 International Communication Association in Montreal.</p> <p>The authors point out that all the articles in the special issue acknowledge the importance of a language and social psychological approach to improving general understanding of communication in the health context. They contend that a social psychological approach to health communication aims to elucidate the interpersonal and intergroup perceptions, motivations, norms, and contextual factors that influence interactants in the communication process. In particular, this approach involves an assumption of an intergroup context. Such an approach takes account of the characteristics of the patient, for example, cultural identity, chronic versus acute illnesses, and age. The authors suggest that there is also a need for models of communication that take account of the complexity of health communication involving multiple systems, such as multiple organisations being involved in a patient's care, different professions and specialties within a health care system, and family systems. More generally, they point out that the articles in this Issue grapple with describing or defining what is effective communication in the health context. Articles in the issue reinforce that competent communication in a health context necessitates adaptation of communication to the context— the characteristics of the patient (culture, age, and disability), the nature of the communication (open disclosure or medical records), and the broader systems as well as a recognition of the tensions that exist for health practitioners in difficult health contexts. They point out that competent communication in the health context is more than the exchange of information and must address patient concerns (Wright, Sparks, & O'Hair, 2008).</p>	
(Jones & Watson 2012) Developments in Health Communication in the 21st Century (Review of literature)	<p>In this article, five papers that formed the Special Issue for the fourth International Association of Language and Social Psychology Taskforce on health communication are revisited. These included papers by Iedema, Jorm, Wakefield, Ryan, and Sorensen (2009) and Hewett, Watson, Gallois, Ward, and Leggett (2009) who focused on the patient's experience in the hospital system and how adverse events occur and are subsequently dealt with in the hospital system. The authors then outline that Hewett <i>et al.</i> investigated how patient care can be adversely affected through ineffective communication between health professionals. They preface a new paper of Watson, Hewett, and Gallois (2012) relating to the diverse range of health professionals who work together in hospitals, but who come from different professions, specialties, and cultural backgrounds.</p> <p>Their starting point in this review of the literature is Gallois's epilogue (of the 2009 Special Issue) and the six themes Gallois identified from those papers. The first theme is the importance of a LSP (Language and Social Psychology) approach to health communication that describes the dynamic interplay between interactants in health communication, whereby individuals in the health setting shape and are shaped by communication. The second is the need to recognise the intergroup dynamic that exists in the health care arena. The following four themes include: the importance of patients being able to negotiate the health sector in which they find themselves; the role of patient voice, whereby patients should be heard by their health providers and influence the care provided (e.g., Trummer, Mueller, Nowak, Stidl, & Pelikan, 2006); (informal) carers, often family but sometimes close friends, who must speak on the patients' behalf; and finally, how communication affects a patient's quality of care and miscommunication leads to</p>	

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	<p>adverse outcomes.</p> <p>These themes are invoked to explore where health communication is moving in the 21st century. Burgeoning work on intergroup communication in this context, patient voice, minority groups, and the role of the carer are highlighted but more work is required.</p> <p>Conclusion(s): They conclude that an LSP approach is useful for both increasing general understanding of communication that occurs in the health context, as well as informing interventions to improve health communication between patients and health professionals, and between different groups of health professionals.</p>	
(Leong et al. 2005) Enhancing Doctor-Patient Communication Using Email: A Pilot Study	<p>The authors begin this paper by wondering whether e-mail might enhance the doctor-patient relationship, which has been eroded by many factors. They question whether e-mail might address some of the barriers inherent in medical practices?</p> <p>Methods: In their study four physicians offered e-mail communication to participating patients and the same number did not. They had both patients and physicians complete questionnaires regarding their satisfaction, perceived quality, convenience, and promptness of the communication.</p> <p>Results: The authors find that patient satisfaction significantly increased in the e-mail group compared with those in the control group in the areas of convenience and also the amount of time spent contacting their physician. They also find that doctor satisfaction increases in the e-mail group regarding convenience, amount of time spent on messages, and volume of messages. However, the response time is longer with e-mail. Most patients in the e-mail group and half the clinicians in the non-e-mail group respond “yes” when they are asked if patients should be able to e-mail their physicians.</p> <p>Conclusion: The authors conclude that e-mail communication is found to be a more convenient form of communication. Both patients and physicians are more satisfied in the e-mail group. The volume of messages and the time spent answering messages for the e-mail group physicians do not increase. They conclude that e-mail has the potential to improve the doctor-patient relationship as a result of better communication.</p>	
(Longtin et al. 2010) Patient participation: current knowledge and applicability to patient safety (Review of literature)	<p>This is a special article covering a literature review from 1966 to 2008 on patient participation. The abstract of this paper identifies that patient participation is increasingly recognised as a key component in the redesign of health care processes and is advocated as a means to improve patient safety. The authors suggest that this concept has been successfully applied to various areas of patient care, such as decision making and the management of chronic diseases. The authors review the origins of patient participation, discuss the published evidence on its efficacy, and summarise the factors influencing its implementation. They present patient-related factors, such as acceptance of the new patient role, lack of medical knowledge, lack of confidence, comorbidity, and various sociodemographic parameters, that affect willingness to participate in the health care process. They also identify that among health care workers, the acceptance and promotion of patient participation are influenced by other issues, including the desire to maintain control, lack of time, personal beliefs, type of illness, and training in patient-caregiver relationships. Social status, specialty, ethnic origin, and the stakes involved also influence patient and health care worker acceptance of patient involvement in safety.</p>	

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	<p>The London Declaration, endorsed by the World Health Organization World Alliance for Patient Safety, calls for a greater role for patients to improve the safety of health care worldwide. They discuss patient participation in hand hygiene promotion among staff to prevent health care infection — and discuss associated infection as an illustrative example.</p> <p>The authors propose a conceptual model including key factors that influence participation and invite patients to contribute to error prevention.</p> <p>Conclusion(s): This review concludes that patient participation can improve the decision-making process and the care of chronic illness. However, the authors identify that many patient and health care worker–related factors can influence its efficacy and implementation. They recognise that its use to decrease medical errors and to increase staff adherence with optimal practices is promising and deserves further study, but they can foresee several potential obstacles at patient, health care worker, and health care center levels. They say that given the controversial nature of this subject, it will be essential to conduct rigorous studies to answer the inherent questioning of the concept. They argue that further research is essential to establish key determinants for the success of patient participation in reducing medical errors and in improving patient safety.</p>	
(Lupton 1997) Consumerism, reflexivity and the medical encounter	<p>When the article is written, Lupton indicates that much emphasis has been placed in sociological, policy and popular discourses on changes in lay people's attitudes towards the medical profession that are labelled by some as a move towards the embracing of "consumerism". In the paper she points out that notions of consumerism tend to assume that lay people act as "rational" actors in the context of the medical encounter. These ideas of patients as rational actors tend to align with broader sociological concepts of the "reflexive self" which she identifies as a product of late modernity; that is, the self who acts in a calculated manner to engage in self-improvement and a self who is skeptical about expert knowledges.</p> <p>This study's findings are based on in-depth interviews with 60 lay people from a wide range of backgrounds living in Sydney as Lupton sought to explore ways that people think and feel about medicine and the medical profession.</p> <p>Findings/conclusion(s): Her conclusions based on the data, suggest that in their interactions with doctors and other health care workers, lay people can simultaneously pursue both the ideal-type "consumerist" and the "passive patient" or they might be these people at different times, depending on the context. She concludes by saying that 'late modernist notions of reflexivity as applied to issues of consumerism fail to recognize the complexity and changeable nature of the desires, emotions and needs that characterize the patient-doctor relationship' (1997, p. 373). In other words, we are not talking about a simplistic, template relationship.</p>	
(Manidis & Scheeres 2012) Towards understanding workplace learning through theorising practice: at work in hospital emergency departments	<p>This chapter explores the work of an interdisciplinary team of clinicians in an Australian Emergency Department (ED). The chapter is based on the consultation of one elderly female patient who spends 11 hours and 15 minutes in the ED. The chapter outlines how a junior doctor has available to him, a wide range of 'informational' sources about the patient he is attending. The chapter highlights that the interprofessional work between the junior doctor and the nurses who</p>	

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	<p>attend to the patient is minimal. The chapter raises questions as to whether this has to do with the junior doctor's developing expertise: has he learnt to utilise the expertise of the more senior nurses, or even the patient herself? Overall the chapter discusses how knowing occurs in practice (how a team of ED clinicians navigate what they need to know while they care for one patient) and illustrates the importance of connected care in the ED, which is difficult to achieve.</p>	
(Manidis & Scheeres, In press) Practising Knowing: emergence(y) teleologies	<p>This article presents a meta disciplinary and institutional framework of practices nurses and doctors use to manage the indeterminacy of knowing in emergency departments (EDs) in Australia. The authors draw on Schatzkian perspectives (a practice-theory approach to examining work) of how practices prevail and reflect particular site ontologies (Schatzki, 2005). This means that the work of nurses and doctors is understood as occurring in specific ways in specific contexts of practice.</p> <p>The authors suggest that in EDs, nurses and doctors undertake particular repetitive practices as they care for patients. In the ED, nurses and doctors work in a context where information is distributed and fragmented and in order to overcome both the fragility and indeterminacy of knowing exactly what is wrong with patients at any one moment in time, they <i>practise knowing</i>. The authors identify, drawing on conversational data with patients and clinicians' visits to bedsides, that nurses and doctors (re)check patient symptoms and statuses through exploratory comments. They tend not to rely on memory, already established information and or handover information etc. as they work. The authors identify that these practices are paradoxically risky, yet ensure safety at the same time. The chapter also identifies that as they communicate with each other, nurses and doctors' existing practice knowledges frequently get in the way of 'learning' from each other. The chapter examines the implications for organisational learning in the ED.</p>	
(Marwaha, Milch & Savas 2012) Biopharma in the coming era of 'connected health'	<p>The healthcare industry has not been at the leading edge of technology adoption. A number of factors, however, are pushing the sector toward greater "connectedness." This trend has implications for biopharma, where opportunities to follow the technology path of other industries are increasing rapidly. This article offers the authors' perspective on the emerging era of connected health and on how biopharma can respond.</p>	
(Mol 2008) The Logic of Care: Health and the Problem of Patient Choice	<p>Annemarie Mol in this book takes issue with choice as a major cornerstone of good care. The book concludes 'that good care is not a matter of making well-argued individual choices but is something that grows out of collaborative and continuing attempts to attune knowledge and technologies to diseased bodies and complex lives'.</p>	
(Nagel & Andenoro 2012) Healing leadership: the serving leader's impact on patient outcomes in a clinical environment	<p>This is an article about leadership and the contribution that good leadership can make to the health care industry. The authors point out that the future of health care is a topic that has significant importance to patients and caregivers alike. They suggest that optimising the patient experience will be paramount in a system that is becoming increasingly complex. In this regard, leadership and how to apply it to meet efficiency standards will be important. Through this paper the authors provide the foundation for meeting this need through an innovative and socially adept framework that identifies the critical character attributes of a serving leader and the powerful impact that serving leaders can have on patient outcomes in the health care setting. This framework is grounded in a leadership theoretical foundation and is contextually examined through qualitative methods. As the business of health care becomes more complex and more competitive, finding ways to improve processes and create healing environments conducive to improved patient</p>	

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	outcomes will differentiate average health care and excellent health care in the future. This paper provides the impetus for successfully addressing these needs through the development of serving leaders, and three specific characteristics: emotional care, presence, and awareness.	
(Nicolini 2011) Practice as the Site of Knowing: Insights from the Field of Telemedicine	<p>Nicolini's work is based on research in healthcare. He is useful in this study as he focuses on how practitioners (in the case of this paper, nurses) manage to work in telemedicine. From the data, he extracts how their practices reflect their knowing of what to do and say as they work with patients. The paper assists us to think about interventions in a different way – the focus is not on individuals, but rather on practices.</p> <p>Thus, this paper aims to shift the unit of analysis in the study of organisational knowledge from individuals and their actions to practices and their relationships. It introduces the concept of "site" to help advance an understanding of the relationship between practice and knowing. The notion of site supports the intuition that knowing is both sustained in practice and manifests itself through practice. It also evokes the idea of knowledge as being rooted in an extended pattern of interconnected activities that only when taken in its living and pulsating entirety constitutes the site of knowing.</p> <p>In this paper, the author reviews the different ways to conceptualise the relationships between knowing and practice, and he shows how the idea of site adds to the existing body of work. Building on the results of a longitudinal study in the field of telemedicine, Nicolini then offers suggestions on aspects of practice where knowing manifests itself, and he uses the concepts of "translation by contact" and "at distance" to explain how dispersed knowings are woven together and the power effect that can derive from these. The paper concludes by reflecting on the implications of this radical view and directions for future research.</p>	
(Nussbaum & Fisher 2009) A Communication Model for the Competent Delivery of Geriatric Medicine	<p>This paper addresses some of the challenges facing practitioners who care for older people in the community and thereby addresses the patient as uncertainty. The authors address the potential for miscommunication and misunderstanding; issues around the complex multidisciplinary approach to care; competency concerns of the older patient; how best to integrate Communication and Aging.</p> <p>The paper identifies the complex networks that surround older patients. For example they identify multiple health organisations, health specialists, frailties in the older patient, and their social network as part of this complexity. The authors suggest that a failure to identify and work with these complexities, can result in misdiagnoses, increased costs, the destruction of family relationships, the invisibility of the older patient and even mortality. The authors present a model for navigating this minefield placing communication at the centre of what is required to manage their care effectively and safely. They also provide a road map for developing quality practices to manage this. This includes placing the older patient in the middle of three networks: the network of healthcare professionals, the network of healthcare organisations and finally, the community of family and friends.</p>	
(Ovretveit 2012b) Summary of 'Do changes to patient-provider relationships improve quality and save money?'	The review and its summary document require reading in their own right. This is because Ovretveit undertakes a sophisticated analysis of the changes to patient-provider relationships, their costs and their benefits in terms of improving quality and saving money. The review does however give a clear message for researchers on the need to look further into how poor communication and inequitable relationships between patients and healthcare professionals add	

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	<p>to the costs of healthcare provision.</p> <p>Ovretveit's research also provides some evidence of solutions. He indicates that 'these are interventions and changes to promote patient-professional communication and collaboration to bring about a more active role for patients and to support self-care'. Importantly however he makes the point about how interventions are to be measured. 'There is little high-quality evidence of the effectiveness of different interventions and even less evidence of the costs and possible savings to different parties' (Ovretveit 2012b, p. 7). He goes on to say 'this does not mean that some interventions might not improve quality and save money. It means only that there is uncertainty about their effectiveness, if traditional systematic review standards of evidence of effectiveness are used to judge the strength of evidence' (Ovretveit 2012a, p. 7).</p> <p>The review was able to give useful information about changes that are likely to improve quality and reduce provider costs.</p> <p>For communications value improvements there was some evidence of improved quality and/or less use of resources that may cover the cost of the intervention for the following (Ovretveit 2012a, p. 15):</p> <ul style="list-style-type: none"> • Providing information: appropriate written and oral information prior to consultation or treatment, or post-treatment, if the information is matched to the patient's needs and abilities (citing Griffin <i>at al</i> 2004; Johansson <i>at al</i> 2005; Coulter and Ellins 2007; Johnson <i>at al</i> 2003); • Patient writes concerns before consultation: an intervention to enable patients to write a note of their concerns before a clinical consultation (he cites Griffin <i>at al</i>. 2004); • Mobile phone text messaging: to give patients reminders about a scheduled healthcare appointment (to reduce non-attendance; he cites Car <i>at al</i> 2008), to communicate results of medical investigations (he cites Gurol-Urganci <i>at al</i> 2008) and feedback on treatment success, especially for patients with chronic illnesses (he cites de Jongh <i>at al</i> 2008); • Mailed and telephone reminders: to reduce non-attendance, or move non-attenders to the bottom of the waiting list (he cites Can <i>at al</i> 2003; George and Rubin 2003; Reekie and Devlin 1998; Moser 1994; Quattlebaum <i>at al</i> 1991; Bech 2005); • Enable question asking: specific appropriate interventions to enable patients from low-income ethnic minority groups to ask their doctors more and better questions and to recognise the importance of asking questions in decision making (he cites Deen <i>at al</i> 2011); • Training doctors: a specific intervention using role playing, feedback and small group discussions to improve patient communication skills (he cites Haskard Zolnierrek and DiMatteo 2009); • Visual feedback: to patients of their medical imaging results for those who smoke, or who are at risk of UV-related skin cancer (he cites Hollands <i>at al</i> 2010); • Offering patient email access: to physicians or specialist nurses for specific patients for specific purposes (he cites Car and Sheikh 2004; Gagnon <i>at al</i> 2009); 	

Study and Authors	Study description/findings/practice implications	
	<ul style="list-style-type: none"> • Patient internet sites: specific systems established by the patient's provider or their health system, with patient access and ability to comment on personal health information – test results, problem summaries, medication lists and side effects (he cites Weingart <i>et al</i> 2008); • Patient-directed record tools: interventions to enable selected patients to use internet-based personal health record systems (PHRs) to create their own medical record and health diaries (he cites Archer <i>et al</i> 2011). <p>The reports also include cost/benefit analyses for patient role and participation and medication-related improvements. The author urges that research is needed which provides greater specificity in the descriptions of the interventions being studied, the underpinning logic models and how changes in the relationship improves quality and impacts upon costs. This needs to consider the different stakeholders and account for those costs over time, in particular, considering how effective implementation of an intervention links to the later experience and outcomes of a patient's care.</p>	
(PricewaterhouseCoopers 2012) Customer experience in healthcare: The moment of truth	<p>In healthcare, the consumerism movement gained traction as individuals were asked to spend more of their own money on services and products such as insurance premiums, deductibles and co- payments. Requirements in the 2010 Affordable Care Act to create state insurance purchasing exchanges opens up competition for membership in the individual and small group markets. And as providers and insurers join together to care for populations in a range of new delivery models, maintaining patient loyalty and engagement will require a more personalised approach.</p>	
(Pullen 2007) Tips for communicating with a patient from another culture	<p>This is a small article offering advice to health practitioners working in cross-cultural contexts. The author points out that a clinician's next patient may be from Laos, Haiti, or Peru, and he might not speak English. Pullen queries whether the clinician will know how to communicate with him and his family in a culturally sensitive way? In this article, the writer discusses specific techniques that will help clinicians become skillful at communicating with patients from other cultures.</p> <p>To build a good relationship with a patient from another culture, Pullen recommends a focus on conveying empathy and showing respect. Without stereotyping him, clinicians can build on their experiences to be more effective each time they communicate cross-culturally.</p>	
(Scott, Dawson & Jones 2012) Do older patients' perceptions of safety highlight barriers that could make their care safer during organisational care transfers?	<p>This paper identifies that healthcare is a series of complex, interwoven systems in which any discontinuities of care may affect the safety of patients, who have been reported to perceive safety differently to clinicians. This study aims to explore patient perceptions of safety and identify how they can be used to construct additional barriers to reduce safety incidents in organisational care transfers, which are known to be high in risk.</p> <p>The researchers use an Appreciative Inquiry (AI) methodology to develop semi-structured interviews, using the Discover and Dream processes of Appreciative Inquiry. The authors purposively recruit 14 patients (four men, 10 women; average age 76.2 years) from NHS community care teams, social care homes and private nursing homes, based on their experience of going through organisational care transfers. The researchers use thematic analysis to highlight key themes, which participants verify.</p> <p>Findings: They authors identify communication, responsiveness and avoidance of traditional safety risks as being</p>	

Study and Authors	Study description/findings/practice implications	
	<p>important for patients to feel safe. Communication and responsiveness are mapped onto the Swiss-Cheese model of safety, presenting two new barriers to safety incidents. The paper discusses traditional risks and the role of trust in relation to patients feeling safe.</p> <p>Conclusion(s): The authors find that perceptions of safety such as communication and responsiveness are similar to those found in previous studies. Mapping these perceptions onto the Swiss-Cheese model of safety identifies how further defences, barriers and safeguards can be constructed to make people feel safer by reinforcing communication and responsiveness. The paper therefore reinforces the role that patients can play in identifying and reporting what the authors themselves identify as traditional risks.</p>	
(Shahid, Finn & Thompson 2009) Barriers to participation of Aboriginal people in cancer care: communication in the hospital setting	<p>This study seeks to report Aboriginal patients' views about effective communication between Aboriginal people and health service providers in Western Australian hospital settings.</p> <p>The research undertakes a qualitative study in which they conduct in-depth interviews between 1 March 2006 and 30 September 2007 with 30 Aboriginal people affected by cancer from across WA. The authors canvass Aboriginal patients' views about the quality of communication in the hospitals, factors impairing communication and suggestions for improvement.</p> <p>Results: The authors identify that some factors crucial to effective patient-provider communication, such as language, shared understanding, knowledge and use of medical terminology, require attention. Additionally, communication between Aboriginal people and health care professionals needs to be understood in a broader sociocultural and political context. They find that key issues impairing communication are fear of the medical system and fear of being disempowered; mistrust; collective memories of the experience of colonisation and its aftermath; lack of understanding of Aboriginal customs, values, lifestyle and the importance of family and land; and experiences of racism. The authors also identify problems with health service providers' inability to interpret non-verbal communication and the symbolism of hospital environments.</p> <p>Conclusion(s): The authors conclude that key areas for the attention of health service providers in communicating and caring for Aboriginal people in the hospital setting include culturally sensitive and empathetic personal contact, acknowledgement and respect for Aboriginal family structures, culture and life circumstances, an understanding of the significant role of non-verbal communication, and the importance of history, land and community. They suggest that Aboriginal people's access to cancer treatment will be improved by employing more Aboriginal health workers in hospitals, and by allowing Aboriginal people to participate at a decision-making level in hospitals. Such initiatives will be important symbols of progress in this area.</p>	
(Street et al. 2005) Patient participation in medical consultations: why some patients are more involved than others	<p>The paper provides as background that patients vary in their willingness and ability to actively participate in medical consultations. The authors identify that because more active patient participation contributes to improved health outcomes and quality of care, it is important to understand the factors that affect the way patients communicate with healthcare providers. 'The objectives of the study were to examine the extent to which patient participation in medical interactions is influenced by 1) the patient's personal characteristics (age, gender, education, ethnicity); 2) the physician's communication style (e.g., use of partnership- building and supportive talk); and 3) the clinical setting (e.g.,</p>	

Study and Authors	Study description/findings/practice implications	
	<p>the health condition, medical specialty). The authors conducted a post hoc cross-sectional analysis of 279 physician–patient interactions from 3 clinical sites: 1) primary care patients in Sacramento, California, 2) patients with systemic lupus erythematosus (SLE) from the San Francisco Bay area, and 3) patients with lung cancer from a VA hospital in Texas’ (2005, p. 960).</p> <p>Main Outcome Measures: The outcome measures include the degree to which patients asked questions, were assertive, and expressed concerns and the degree to which physicians used partnership- building and supportive talk (praise, reassurance, empathy) in their consultations.</p> <p>Conclusion(s): The authors conclude that patient participation in medical encounters depends on a complex interplay of personal, physician, and contextual factors. Although more educated and white patients tend to be more active participants than their counterparts, the strongest predictors of patient participation are situation-specific, namely the clinical setting and the physician's communicative style. The authors identify however that physicians could more effectively facilitate patient involvement by more frequently using partnership-building and supportive communication. They make some suggestions that future research should investigate how the nuances of individual clinical settings (e.g., the health condition, time allotted for the visit) impose constraints or opportunities for more effective patient involvement in care.</p>	
(Swenson, Zettler & Lo 2006) ‘She gave it her best shot right away’: Patient experiences of biomedical and patient-centered communication	<p>The authors background this study by suggesting that medical educators and researchers recommend a patient-centered interviewing style, but they contend that there is little empirical data regarding what aspects of physician communication patients like and why. Therefore the researchers investigate patient responses to videotaped doctor–patient vignettes to ascertain what they like about patient-centered and biomedical communication. The authors conduct semi-structured interviews with 230 adult medicine patients who view videotapes depicting both patient-centered and biomedical physician communication styles. The authors use a mixed methods approach to derive, what they call, a “ground-up” framework of patient communication preferences.</p> <p>Results: Findings show that respondents who prefer ‘different communication styles’ articulate different sets of values, important physician behaviors, and physician–patient role expectations. They find that participants who prefer the patient-centered physician (69%) like the fact that the doctor works with and respects patients and explores what the patient wants. Results also show that participants who prefer the biomedical physician (31%) like that the doctor prevents harm, demonstrates medical authority, and delivers information clearly.</p> <p>Conclusion(s): The researchers conclude that patients like (and dislike) patient-centered communication for thoughtful, considered reasons that appear grounded in their values and expectations about physicians, patients, and the clinical encounter.</p> <p>Practice implications: The authors conclude that better understanding the diversity of patient communication preferences may lead to more effective and individualised care.</p> <p>See their Table 3 Model of biomedical and patient-centred communication (Swenson, Zettler & Lo 2006, p. 205).</p>	
(Towle, Godolphin & Alexander 2006) Doctor-patient communications in the aboriginal	<p>This is a study on Aboriginal people in Canada, who have poorer health than the rest of the Canadian population. Reasons for health disparities are many and include problems in communication between doctor and patient. The</p>	

Study and Authors	Study description/findings/practice implications	
community: Towards the development of educational programs	<p>objective of this study is to understand doctor–patient communication in Aboriginal communities in order to design educational interventions for medical students based on the needs and experiences of patients.</p> <p>The authors use semi-structured interviews or focus groups with 22 Aboriginal community members, 2 community health representatives and 2 Aboriginal trainee physicians to examine experiences of good and poor communication. They code the transcribed data and conduct thematic analysis of the transcripts.</p> <p>Results: They find that positive and negative experiences of communicating with physicians fall into three broad and interrelated themes: the Aboriginal people’s histories as First Nations citizens; the extent to which the physician is trusted; and time in the medical interview. They concluded that (Canadian) Aboriginal peoples’ history affects their communication with physicians and that barriers may be overcome when patients feel they have a voice and the time for it to be heard. This study did resonate with the (Shahid, Finn & Thompson) study in Australia, which also identified history as a factor that might impede communication with healthcare providers.</p> <p>Practice Implications: Physicians can improve communication with Aboriginal patients by learning about their history, building trust and giving adequate time during the consultation.</p>	
(Tran et al. 2004) Empowering communication: a community-based intervention for patients (Focus on pre and post consultation intervention)	<p>The “How to Talk to Your Doctor” community education forums operate under the assumption that information exchange and consumer involvement in healthcare can empower communities in need. This paper reports on the development and preliminary evaluation of this community based intervention designed to activate and enhance patients’ communicative abilities in the medical encounter. The aim of the intervention is to:</p> <ol style="list-style-type: none"> 1. ‘Recognize barriers to good patient–physician communication 2. Describe reasons for good patient–physician communication 3. Recognize examples of good physician and patient communication traits 4. Apply “tips” for improving patient–physician communication 5. Demonstrate good patient–physician communication techniques 6. Recall good patient–physician communication strategies’ (2004, p. 115). <p>In the study, the authors review evidence supporting the feasibility of and benefits that can be expected from improving patients’ communication competency. Their intervention is simple and flexible so, therefore, can be portable to a large number of communities. Their preliminary evaluation suggests that the intervention is well-received and produces improved self-perceptions of communication competence across diverse settings and participants. They describe their intervention and its development and dissemination as a model for improving patients’ communicative abilities through a community based, active learner approach. By sharing their experiences, the barriers they encountered, and their ongoing efforts to improve patient communication in the medical encounter, they hope to empower patients to communicate better with their physicians. As the paper itself says, ‘to the extent that these goals are met, the forums potentially represent a simple and inexpensive mechanism through which communities can enhance the health of their members’ (Tran et al. 2004, p. 120).</p>	
(Ubel 2012) Critical Decisions: How you and your doctor can make the right medical choices	In this book, the author reveals the hidden dynamics in the doctor-patient relationship that keep us from making good decisions. He shows us how patients and doctors can learn to work together; how doctors can explain better; how	

Study and Authors	Study description/findings/practice implications	
together	patients can listen better; how doctors and patients can understand each other better. See pages 337 – 340 for tips for patients. These include, recognise that you, as the patient, have a role to play in your decisions; realise that you are not alone; get informed about your alternatives; be an active listener; communicate what you care about; if you have time to decide, then take your time; seek out help from other patients; and stay informed.	
(Wallis 2011) Effective communication: Principle of nursing Nursing Practice	This is one of several articles describing the Principles of Nursing Practice developed by the Royal College of Nursing (RCN) in the United Kingdom in collaboration with patient and service user organisations, the Department of Health, the Nursing and Midwifery Council, nurses and other healthcare professionals. The authors identify principles of effective communication that include maintaining up to date, accurate documentation, giving standardised and timely reporting, handling complaints in open, honest and transparent ways, and maintaining confidentiality. Communication is conceptualised as a functional tool in this Principle – not necessarily as a complex negotiated process.	
(Wright Nunes et al. 2011) Associations among perceived and objective disease knowledge and satisfaction with physician communication in patients with chronic kidney disease	This is a specific study examining a patient group with a chronic kidney condition. The study examines patient satisfaction in this group based on the authors' identification of patients' perceived and objective knowledge of their illness. They posit that it is likely that patients with chronic kidney disease (CKD) have a limited understanding of their illness. Here the researchers studied the relationships between objective and perceived knowledge in CKD using the Kidney Disease Knowledge Survey and the Perceived Kidney Disease Knowledge Survey. They quantified perceived and objective knowledge in 399 patients at all stages of non-dialysis-dependent CKD. Demographically, the patient median age was 58 years, 47% were women, 77% had stages 3-5 CKD, and 83% were Caucasians. The overall median score of the perceived knowledge survey was 2.56 (range: 1-4), and this new measure exhibited excellent reliability and construct validity. Findings: In unadjusted analysis, perceived knowledge was associated with patient characteristics defined <i>a priori</i> , including objective knowledge and patient satisfaction with physician communication. In adjusted analysis, older age, male gender, and limited health literacy, were associated with lower perceived knowledge. Additional analysis revealed that perceived knowledge was associated with significantly higher odds (2.13), and objective knowledge with lower odds (0.91), of patient satisfaction with physician communication. Thus, the authors' results present a mechanism to evaluate distinct forms of patient kidney knowledge and identify specific opportunities for education tailored to patients with CKD.	
(Yamauchi 2006) Knowing and not knowing in work practice: three ethnographic studies	This is a doctoral thesis which illustrates how knowledge is a primary resource for organisations' capabilities. Individuals in organisations know how to get their jobs done. This dissertation seeks to understand this 'knowing' in the actual organisational settings. Particularly, it inquires into knowing in action, or how people know how to get their work done in each moment in each specific situation; as opposed to abstract ideas, opinions, or theories of such knowing. The author's overall concern is on what people do not know. The paper outlines how workers work with uncertainty and not knowing in practice. The study illustrates how knowledge in everyday work is not self-contained, clearly defined, or unproblematic; but in a constant flux of knowing and not knowing. This study has relevance for nurses and doctors who seek knowledge despite the fact that they do not know what they are seeking and may be applicable to working with	

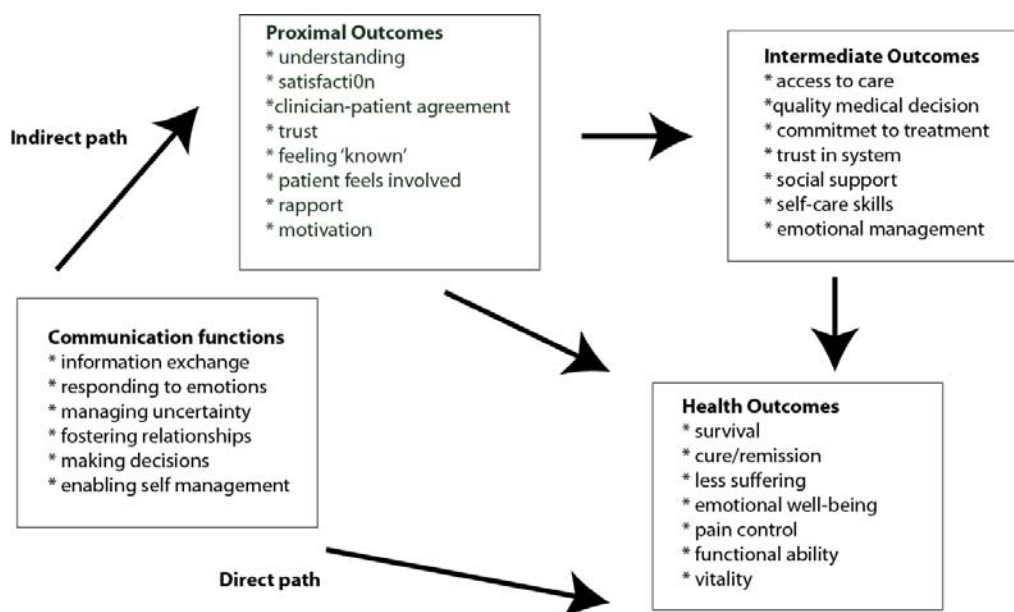
Study and Authors	Study description/findings/practice implications	
<p>(Zeno 2003) The ABCs of Empowered Communication: A Community-Based Intervention for Patients http://virtualmentor.ama-assn.org/2003/06/msoc1-0306.html</p>	<p>the uncertainty and complexity of patient presentations.</p> <p>This is another paper on the How to Talk to Your Doctor (HTTYD) community education initiative. The paper analyses findings of a community education about how patients can best communicate with their physicians. The intervention is based on a fully illustrated HTTYD guidebook (available in English and Spanish) and organised along the 4 main learning objectives outlined as (1) recognising barriers to good patient-physician communication; (2) recognising examples of effective patient-physician communication styles; (3) applying strategies presented in the forum for improving communication in the medical interaction; and (4) recalling good patient-physician communication strategies.</p> <p>The resource guide is entitled <i>How to talk to your doctor</i>. This kind of intervention has been successful in various communities, particularly when working with an ethnically diverse patient population. The paper addresses a review of strategies to promote patient involvement. Specifically, the 3 ABC tips suggested are: (a) Ask questions in order to receive information, (b) Be prepared for the appointment, and (c) Communicate and express health concerns.</p>	

What is the impact of (in)effective patient clinician communication?

Patient-clinician outcomes research – a brief summary

The association between communication and clinical outcomes is strong, even though absolute causality has been difficult to establish. Several studies highlight both indirect and direct outcomes of effective communication. Rao and colleagues published a systematic review of studies published over four decades, leading them to confirm that effective physician-patient communication makes a difference in patient satisfaction and in patient outcomes. These differences include the resolution of chronic headaches, changes in emotional states, lower blood sugar values in diabetics, improved blood pressure readings in hypertensives, and other important health outcomes (Rao et al. 2007). Similarly, a review by Makoul concluded that effective communication leads to “improved adherence to medical regimens, better decision making, fewer claims of malpractice, and increased satisfaction with the patient physician relationship” (Makoul 2006).

A prominent overview of trials conducted in this domain is by Griffin and colleagues (Griffin et al. 2004b). Despite the dearth of ‘rigorous studies’, Griffin and colleagues conclude that “[s]imple approaches to increasing the participation of patients in the clinical encounter, such as providing practitioners with a note from patients about their concerns beforehand, showed promise, as did more complex programs providing specific information about disease and attention to emotion” (Griffin et al. 2004). Griffin and colleagues’ overview provides a detailed and tabulated record of trial studies done in this domain right up until 2003.



Direct and indirect pathways from communication to health outcomes (Street et al. 2008, p. 297)

The most frequently cited summary of communication outcomes however is that by Street and colleagues (Street et al. 2009). Street and colleagues' article brings together a range of studies investigating the outcomes of effective communication on patients and clinicians. The diagram on the previous page separates indirect outcomes (understanding, satisfaction, etc.) from direct outcomes (survival, cure/remission, etc.).

Other critical overview studies listing evidence of improved outcomes resulting from improved communication include Stewart's rather older article from 1995 (Stewart 1995) and the 2008 article by Mauksch and colleagues (Mauksch et al. 2008). Mauksch and colleagues' summary table is reproduced below, outlining the nature of the intervention and the type and level of effect achieved. The relevant references have been included in our Bibliography below.

Source	Skill Domain	Findings Related to Association Between Communication Quality and Time Use	Limitations of Study
Gross et al, ⁴⁹ 1998	Rapport building	Small amount of time socializing with patient was associated with higher patient satisfaction with amount of time spent with physician.	Not an experimental design. Physician sample limited to family physicians in the United States.
Eide et al, ⁵⁰ 2003	Rapport building	Brief (5-second) informal talk with patient associated with higher patient satisfaction.	Not an experimental design. Small physician sample limited to oncologists in Norway.
Marvel et al, ²¹ 1999	Agenda setting	Late-arising patient concerns occurred in 15% of visits with complete solicitation of concerns vs 35% of visits without complete solicitation of concerns. Visit length was 6 seconds longer if patients were allowed to complete their statement of concerns. Physicians who completely solicited concerns used prioritization more often.	Not an experimental design. Physician sample limited to US family physicians. Nonverbal responses could not be assessed by methods, and results were not linked to outcomes.
White et al, ⁵¹ 1994	Agenda setting	Patients were less likely to raise new concerns during the closing phase of a visit if they had been oriented to the visit flow and the physician assessed patient beliefs and checked for understanding as the visit progressed.	Not an experimental design. Physician sample included US primary care physicians and was limited to attendees of an educational program on communication skills. Nonverbal responses could not be assessed by methods.
White et al, ⁵² 1997	Agenda setting	Patients were less likely to raise new concerns during the closing phase of a visit if they had been oriented to the visit flow.	Not an experimental design. Physician sample included US primary care physicians and was limited to attendees of an educational program on communication skills. Nonverbal responses could not be assessed by methods.
Deveugele et al, ³⁸ 2002	Agenda setting	A psychosocial concern disclosed by the patient did not prolong a visit, whereas if "diagnosed" by the physician, the visit was prolonged.	Physician sample included general practitioners in 6 European countries, but their workload was lower than average for their country. Not an experimental design or linked to outcomes.
Mauksch et al, ⁵³ 2001	Agenda setting	Physicians trained to fully elicit patient concerns and establish focus of visit with patients took no more time and had greater patient satisfaction.	Sample size for randomized controlled trial was 17 family medicine faculty and residents in the United States. No direct observation of physician behavior.
Henbest and Fehrsen, ⁴⁵ 1992	Agenda setting and understanding the patient's perspective	Primary care visits characterized by agenda setting and efforts to understand the patient's perspective were no longer but were associated with better resolution of the patient's concerns.	Not an experimental design. Practitioner sample was limited to primary care practitioners in South Africa. Of the patients, 82% were new to the practitioner.
Levinson et al, ²⁴ 2000	Patient clues	In visits with emotional clues that were not acknowledged by the physician, the visit was 2.5 minutes longer.	Not an experimental design. Physician sample selected for presence of malpractice claims and was mostly male. Nonverbal responses could not be assessed by methods, and results were not linked to outcomes.

The references used in Mauksch et al.'s table above are the following:

49. Gross DA, Zyzanski SJ, Borawski EA, Cebul RD, Stange KC. Patient satisfaction with time spent with their physician. *J Fam Pract.* 1998;47 (2):133-137.
50. Eide H, Graugaard P, Holgersen K, Finset A. Physician communication in different phases of a consultation at an oncology outpatient clinic related to patient satisfaction. *Patient Educ Couns.* 2003;51(3):259-266
21. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? *JAMA.* 1999;281(3):283-287.
51. White J, Levinson W, Roter D. "Oh, by the way . . .": the closing moments of the medical visit. *J Gen Intern Med.* 1994;9(1):24-28.

52. White JC, Rosson C, Christensen J, Hart R, Levinson W. Wrapping things up: a qualitative analysis of the closing moments of the medical visit. *Patient Educ Couns*. 1997;30(2):155-165.
38. Deveugele M, Derese A, van den Brink-Muinen A, Bensing J, De Maeseneer J. Consultation length in general practice: cross sectional study in six European countries. *BMJ*. 2002;325(7362): 472.
53. Mauksch LB, Hillenburg L, Robins L. The established focus protocol: training for collaborative agenda setting and time management in the medical interview. *Fam Syst Health*. 2001; 284(8):1021-1027.
45. Henbest RJ, Fehrsen GS. Patient-centredness: is it applicable outside the West? its measurement and effect on outcomes. *Fam Pract*. 1992; 9(3):311-317. 19(2):147-157.
24. Levinson W, Gorawara-Bhat R, Lamb J. A study of patient clues and physician responses in primary care and surgical settings. *JAMA*. 2000

Mauksch and colleagues conclude that rapport building and shared agenda setting

are associated with enhanced patient satisfaction [9], greater adherence to medication regimens [10], improved self-management [11], better health outcomes [17], reduced medical costs [13], and decreased risk of malpractice claims [14]. (Mauksch et al. 2008)⁹

Bensing and colleagues' 2011 study reports on a number of 'tips' formulated by patients for how to improve patient-clinician communication (Bensing et al. 2011) (see: Tips for doctors). Their findings confirm those reported in the professional literature, such as the importance of silence, listening and nonverbal communication (eye contact) in order to facilitate a dialogue instead of having monologues, the value of empathy and respect in creating an effective doctor-patient relationship, and the need to address patients as individual persons and not as 'a bundle of symptoms'. (Bensing et al. 2011).

Bensing and Verheul examined the impact of 'Affect Manipulation' on patient-clinician communication outcomes. Clinicians' consciously deploying emotional resources to improve communication showed that '[d]istress resulting from illness might decrease, for instance because a physician provides empathy and support, or increase when a patient feels misunderstood, is treated in a cold unfriendly manner or receives bad news" (Bensing and Verheul 2010) (p 297). Bensing and Verheul conclude that

[A]ffect can impact health or treatment outcomes, for instance by stress reduction: in human studies it was demonstrated that the down-regulation of the early inflammatory response by an increase in cortisol levels resulted in delayed wound repair. Moreover, in this study several potential cellular mechanisms linking stress and wound healing were identified. In pain patients, sympathetic activation by a sudden stressor can increase pain. Social support might decrease pain [51], and in the long term lead to a better health [54]' (Bensing and Verheul 2010) (p 297).

⁹ Mauksch et al.'s references are included here:

9. Williams S, Weinman J, Dale J. Doctor-patient communication and patient satisfaction: a review. *Fam Pract*. 1998;15(5):480-492.
10. Stewart M, Brown JB, Boon H, Galajda J, Meredith L, Sangster M. Evidence on patient doctor communication. *Cancer Prev Control*. 1999;3(1):25-30.
11. Glasgow RE, Davis CL, Funnell MM, Beck A. Implementing practical interventions to support support chronic illness self-management. *Jt Comm J Qual Saf*. 2003;29(11):563-574.
13. Epstein RM, Franks P, Shields CG, et al. Patient centered communication and diagnostic testing. *Ann Fam Med*. 2005;3(5):415-421.
14. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA*. 1997;277(7):553-559.
17. Yedidia MJ, Gillespie CC, Kachur E, et al. Effect of communications training on medical student performance. *JAMA*. 2003;290(9):1157-1165.

Roter, in her 2000 overview, lists the following summary of supportive micro-conducts producing improved patient outcomes:

Relationship-centered care objectives and supportive communication elements

Informative

Physician gives information (with emotional support)	Reduction in distress (26) ¹⁰ Symptom resolution (37) Blood pressure control (38)
Patient is given information (with informational package and programs)	Pain reduction (39) Improvement in mood (40) Improvement in function (41) Reduction in anxiety (40)

Participatory

Physician asks about patients' understanding, concerns and expectations. Physician asks for impact of the problem on functioning	Symptoms resolution (37) Reduction in anxiety (45)
Physician encourages patients to ask questions	Reduction in anxiety (45) Reduction in role limitations (45) Reduction in physical limitation (45, 47)
Patients perceive a full and open discussion of the problem	Symptom resolution (46)

Physician is willing to share decision making	Reduction in anxiety (45)
Physician and patient agree on the nature of the problem and the need for follow up	Problem resolution (45) Symptom resolution (37)

Facilitative

Full patient expression of feelings, opinions and information	Physical and social role limitations (42, 43) Health status, functional status and blood pressure control (38, 42)
Patient is successful at obtaining information	Improvement in physiologic status (39,44) Improvement in function (39, 43)

References:

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- [37] Haezen-Klemens K, Lapinska E. Doctor-patient interaction, patients' health behaviour and effects of treatment. *Soc Sci Med* 1984;19:9-18.
- [38] Orth JE, Stiles WB, Scherwitz, L. Interviews and hypertensive patients' blood pressure control. *Health Psychol* 1987; 6:29-42
- [39] Egbert, LD, Battit GE, Welch CE et al. Reduction of postoperative pain by encouragement and instruction of patients – a study of doctor-patient rapport. *N. Engl J Med* 1964;270:825-7.
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- [41] Rainey LC. Effects of preparatory patient education for radiation oncology patients. *Cancer* 198;56:1056-61.
- [42] Evans BJ, Kiellerup FD, Stanley RO et al. A communication skills programme for increasing patients' satisfaction with general practice consultations. *Br J Med Psychol* 1987;60:373-8.
- [43] Thompson SC, Nanni C, Schwankovsky L. Patient-oriented interventions to improve communication in a medical office visit. *Health Psychol* 1990;9:390–404.
- [44] Kaplan SH, Greenfield S, Ware Jr. JE. Assessing the effects. of physician–patient interactions on the outcomes of chronic disease. *Med Care* 1989;27:S110–27.
- [45] Greenfield S, Kaplan SH, Ware JE. Expanding patient involvement in care: effects on blood sugar control and quality of life in diabetes. *J Gen Intern Med* 1988;3:448–57.
- [46] Headache Study Group of The University of Western Ontario. Predictors of outcome in headache patients presenting to family physicians — a one year prospective study. *Headache* 1986;26:285–94.
- [47] Starfield B, Wray C, Hess K et al. The influence of patient– 50. practitioner agreement on outcome of care. *Am J Public Health* 1981;71:127–31.

What interventions have demonstrated improved patient-clinician communication?

[T]here were no magic bullets evident in our review [on patient compliance]; direct education, group processes, familial support, behavioral modalities, or provider interventions showed no substantial advantage over one another. Moreover, mixed programmatic focus interventions were more effective than single-focus interventions. The more comprehensive the program, the more effective the outcomes, and the most powerful combinations included all three elements - educational, behavioural, and affective. We agree with Mullen et al.'s conclusions based on their review of the health education literature that there is no obvious superiority of one strategy compared with any other. Two health education axioms, that people learn in different ways and that a variety of teaching approaches increases learner interest, have been validated. (Roter et al. 1998)

A great number of interventions to improve patient-clinician communication have been deployed and tested. 'Patient as object' interventions focus on enabling clinicians to improve their information gathering and information giving practices. Here, interventions tend to be highly structured and quite instrumental, and their measurements of success tend to be quite narrowly defined (Priebe et al. 2007). In a very early study, Svarstad tested the fundamental elements of what was termed the physician initial communication style, derived from the Health Communication Model (Svarstad, 1986). This model enabled investigation of the degree of friendliness during the visit, asking if the patient had questions or concerns, assisting with concerns relating to the use of medication, providing clear instructions on how to take medication, clearly explaining how the antidepressant would affect the patient and talking about things the patient can do to make them feel better. Key components of the follow up communication style were considered to be the extent to which the physician encouraged expression of concerns or problems with taking medication, asked about and listens to concerns about medication and helps solve problems related to the patient's use of medication.

For their part, 'patient as person' interventions target clinicians' interactive skills, and the dynamics that prevail between the clinician and the patient. Some interventions articulated within this framework start off with survey to test clinicians' appreciation of engagement as interactive issue. One is the 'Active Engagement Scale', a 15-item questionnaire, assessing primarily involvement in therapy and collaborative participation (Priebe S M. R., 2008). Above we referenced other instruments that are applied to the analysis of *in situ* dynamics to assess the relational dimensions of patient-clinician communication. Prominent examples of this are the Roter Interaction Analysis System or 'RIAS' scale (see below) and the Verona scale (Del Piccolo L et al. 2010). Such scales enable us to measure the effect of interventions that target communication training of physicians. Their specificity makes it possible to identify subtle emotional shifts in the interaction (Zimmermann C 2010), with this in turn providing targeted feedback to communicators.

For example, Roter and Larson argue that the Roter Interaction Analysis System or 'RIAS' when used as a teaching tool has improved interview communication skills. Roter (2004) suggests that "experiential methods of communication skill instruction" work in developing communication skills. Thus, when residents were given structured feedback on their skills they found "significant differences in three of the four core competencies that were targeted: increase in data gathering techniques using open-ended questions; increase in problem solving and negotiating skills; and decrease in verbal dominance" (Roter and Larson 2002). RIAS makes possible a detailed understanding of the turn-taking dynamics in talk. One way in which this has been applied is to measure the time clinicians allow patients to speak when introducing their complaint. Findings were

published in a landmark study by Beckman and Frankel, cited in (Roter and Larson 2002): “Patients’ statements regarding the reason for their visit were stopped and redirected by physician questioning after an average length of only 18 s [seconds]”. The RIAS system is reproduced below:

Table: Categories of Roter Interaction Analysis System (Roter et al. 2004)

Functional grouping	Communication behaviour	Example
Data gathering	Open-ended questions: medical (medical condition, therapeutic regimen)	<i>What can you tell me about the pain?</i>
	Open-ended questions: Psychosocial (lifestyle, social, and psychological)	<i>How are the meds working?</i> <i>What are you doing to keep yourself healthy?</i> <i>What’s happening with your father?</i>
Patient education and counseling	Closed-ended questions: medical (medical condition, therapeutic regimen)	<i>Does it hurt now?</i> <i>Are you taking your meds?</i>
	Closed-ended questions: psychosocial (lifestyle, social and psychological)	<i>Are you still smoking?</i> <i>Is your wife back</i>
	Biomedical information-giving (medical condition: therapeutic regimen)	<i>The medication may make you drowsy. You need it for 10 days.</i>
	Psychosocial and lifestyle information (feelings and emotions, lifestyle and self-care information)	<i>The community centre is good for company and you can get meals there</i>
	Biomedical counselling (persuasive statements regarding medical management and therapeutic regimen)	<i>It’s important to take those pills everyday. I don’t want you to miss any</i> <i>Watch that foot for infection.</i> <i>Be sure to keep it clean and you won’t have a problem.</i>
Responding to emotions	Psychosocial counselling (persuasive statements regarding lifestyle, social, and psychological issues)	<i>Getting exercise is a good idea, especially now.</i> <i>The most important thing you can do is just quit – just do it! It’s important to get out and do something with someone every day.</i> <i>How about O’s last night?</i>
	Social talk (nonmedical chi-chat)	
	Positive talk (agreements, jokes, approval, laughter)	<i>You look fantastic, you are doing great.</i>
Activation and partnership building	Negative talk (disagreements, criticisms)	<i>I think you are wrong, you weren’t being careful. No I do want that.</i>
	Emotional talk (concerns, reassurance, legitimation, empathy)	<i>I’m worried about that, I’m sure it will get better. We’ll get through this.</i>
	Participatory facilitators (asking for patient opinion, asking for understanding, restatement of patient disclosures, back-channels)	<i>What do you think it is?</i> <i>Do you follow me? I heard you say you didn’t like that. Let me make sure I’ve got it right...Uh-huh, right, go on, hmmm</i>
	Procedural talk (orientation; transitions)	<i>I’ll first look at your rash and then take your blood pressure. I’ll be back in a minute. Well, ok. Now...</i>

The coding system reproduced below is from Swenson and colleagues’ (2006) paper. Their analytical system operates with themes (on the left in the table) and categories (on the right) that they regard as realising effective patient-clinician communication.

Theme	Category
Works with patients	Came up with a good plan Offered alternatives or allowed patient choice Willing to work with patient Willing to help/look up information More open-minded
Responds to patient as person	Responded to/treated/interested in patient as an individual Interested in patient's concerns/reasons for CAM (complementary and alternative medicine) use Responsive to individual patient's concerns/problems
Gives patient attention	Gave patient a chance to say what's on mind Listened better More eye contact More present or attentive
Conveys concern	More empathic More concerned/cared more
Clear speak	Communicates clearly, comprehensible Uses simple language Explains thoroughly, in detail
Gives strong opinion	Willing to give advice/state opinion Emphasized more the risks of CAM
Bedside manner	Like a peer/friend Nicer/more personal/more humanistic/friendlier Better relationship with patient
Good medical knowledge or advice	Had/gave better knowledge/advice regarding CAM
Truthfulness	More honest/truthful/genuine/authentic
Relaxed, comfortable style	Not hurried/rushed Relaxed comfortable tone/style/manner
Respects patient	More respect for patient Not condescending/attaching
Prevents harm	Acted in patient's best interests
Straightforward delivery	Straightforward
Authoritative decisive	More authoritative Decisive/certain
Miscellaneous communication	Open-ended questions Positive presentation

Communication behaviour checklist (Swenson et al. 2006)

The focus on interpersonal dialogue in these coding schemes is reminiscent of therapeutic communication training (Egan 2006). Working in the area of mental health care, Epstein and Borrell (2000) summarise these skills as follows:

Using silence – allows client to take control of the discussion, if he or she so desires
Accepting – conveys positive regard
Giving recognition – acknowledging, indicating awareness
Offering self – making oneself available
Giving broad openings – allows client to select the topic
Offering general leads – encourages client to continue
Placing the event in time or sequence – clarifies the relationship of events in time
Making observations – verbalizing what is observed or perceived
Encouraging description of perceptions – asking client to verbalize what is being perceived
Encouraging comparison – asking client to compare similarities and differences in ideas, experiences, or interpersonal relationships
Restating – lets client know whether an expressed statement has or has not been understood
Reflecting – directs questions or feelings back to client so that they may be recognized and accepted
Focusing – taking notice of a single idea or even a single word
Exploring – delving further into a subject, idea, experience, or relationship
Seeking clarification and validation – striving to explain what is vague and searching for mutual understanding
Presenting reality – clarifying misconceptions that client may be expressing

Voicing doubt – expressing uncertainty as to the reality of client’s perception
Verbalizing the implied – putting into words what client has only implied
Attempting to translate words into feelings – putting into words the feelings the client has expressed only indirectly
Formulating plan of action – striving to prevent anger or anxiety escalating to unmanageable level when stressor recurs

Table: Therapeutic communication techniques for mental health patients (Epstein and Borrell 2000)

Another very different intervention involves patients themselves identifying participatory decision making styles in clinicians and assessing clinicians’ ability to involve patients in treatment decisions. Interestingly, patients involved in these assessments have been found to be more adherent at 6 months follow-up (Gonzalez, 2005) and 6–8 weeks post initial consultation (Madsen, 2008). Von Korff’s study involved training clinicians to provide a complex intervention comprised of a shared decision making (SDM) element. Intervention patients received an educational book, a videotape about effective management of chronic or recurrent depression, in-person visits and telephone monitoring. Following the intervention, patients were significantly more likely to refill antidepressant medication prescriptions than usual care patients during the one-year follow up period (Von Korff, 2003) (Ludmen, 2003).

We also identified a number of what can be classified as ‘patient as uncertainty’ interventions. These interventions are not as concerned as previous ones discussed to ascertain whether there is a causal association between an input (specific kinds of training, education) and an output (improved clinical outcomes). Instead, these interventions are more ‘open-ended’: they aim to set processes in train that are consonant with the principles and norms of ‘continuity of care’, ‘patient engagement’, and so forth. For instance, patient-centred care planning might be targeted using patients’ and clinicians’ accounts of how such planning might unfold between them. A good example of this is the recent NHS Midlands and East project titled ‘The Patient Revolution’. This intervention intends “to ensure that the patient and the public voice is heard and acted upon” (www.eoe.nhs.uk/strategicprojects). The intervention consists in devising different ways of “placing patients in the centre of care [and of] capturing patient experience”. The main concern of this initiative is to strengthen services’ feedback and responsiveness, and these are engendered using patient stories and other resources that make people’s care experiences.

The table below provides a summary table containing summaries of articles relevant to this domain of research.

Selected annotated bibliography of intervention studies/resources

Study and Authors	Study/intervention description and findings/practice implications
(Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011) National Safety and Quality health Service Standards	<p>The ten standards govern benchmarks for health care services. Many of the standards either explicitly or implicitly focus attention on accurate, timely, considered spoken and written communication in everyday practice at the individual and institutional level. The ten standards are intended to protect the public from harm and to improve the quality of health service provision:</p> <ol style="list-style-type: none"> 1. Governance for Safety and Quality in Health Service Organisations which describes the quality framework required for health service organisations to implement safe systems. 2. Partnering with Consumers which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care. 3. Preventing and Controlling Healthcare Associated Infections which describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences. 4. Medication Safety which describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients. 5. Patient Identification and Procedure Matching which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment. 6. Clinical Handover which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred. 7. Blood and Blood Products which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe. 8. Preventing and Managing Pressure Injuries which describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur. 9. Recognising and Responding to Clinical Deterioration in Acute Health Care which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates. 10. Preventing Falls and Harm from Falls which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.
(Bombeke et al. 2011) Medical students trained in communication skills show a decline in patient-centred attitudes: An observational study comparing two cohorts during clinical clerkships	<p>This is a key study that identifies an intervention discrepancy. The results show that training in communication skills had an adverse effect on patient-centered behaviour by clinicians. Bombeke <i>et al.</i>'s study show that students 'trained in patient-centred communication, seem to lose their patient-centred attitudes while untrained students remain stable. The reason given for this apparent discrepancy is what the researchers identify as 'the gap between 'ideal' training ground and 'real' world' realities. The students 'appear to be more vulnerable in the challenging reality of the hospital environment. There was too great a contrast between the safe, protected training ground on the one hand and medical practice reality on the</p>

Study and Authors	Study/intervention description and findings/practice implications
	<p>other. Role models did not speak the same....[] Real patients differed a lot from simulated patients. When faced with manifold system-based constraints, students felt the learned model was infeasible' (Bombeke et al. 2011, p. 317). The trained students also reacted against the goals of the trainers and were consequently reinforced 'by their new, powerful [sic] social environment' (Bombeke et al. 2011, p. 317) of <i>in situ</i> practice.</p>
<p>(Buckman et al. 1991) Doctor-patient communication: the Toronto consensus statement</p>	<p>This study points out that effective communication between doctor and patient is a central clinical function that cannot be delegated. This is because most of the essential diagnostic information arises from the interview, and the doctor's interpersonal skills also largely determine the patient's satisfaction and compliance and can positively influence health outcomes – they cite [Roter 1997; DiMatteo <i>et al.</i> 1942; Bartlett <i>et al.</i> 1984]. The authors cite research showing that such skills, including active listening to patients' concerns, are among the qualities of a physician most desired by patients [Matthews 1987]. They identify deficiencies in clinical communication as playing a big part in the increasing public dissatisfaction with the medical profession. They also point out that studies in many countries have confirmed that serious communication problems are common in clinical practice.</p> <p>Citing numerous studies, they point out that '[f]or example, 54% of patient complaints and 45% of patient concerns are not elicited by physicians [Stewart 1979]. Psychosocial and psychiatric problems are common in general medical practice, but these diagnoses are missed in up to 50% of cases [Schulberg & Burns 1988; Freeling <i>et al.</i> 1985]. In 50% of visits the patient and the doctor do not agree on the nature of the main presenting problem [Starfield 1979; 1981]. In one study patients are interrupted by physicians so soon after they begin describing their presenting problems (on average within 18 seconds) that they fail to disclose other significant concerns [Beckman & Frankel 1984]. Most complaints by the public about physicians deal not with clinical competency problems [Richards 1990], but with communication problems, and the majority of malpractice allegations arise from communication errors [Shapiro <i>et al.</i> 1989]. Residents or trainees [Platt & McMath 1979] and practising physicians have shown substantial deficiencies when studied [Byrne & Long 1984]. Only a low proportion of visits with doctors include any patient education [Waitzkin 1984], and a surprisingly high proportion of patients do not understand or remember what their physicians tell them about diagnosis and treatment [Ley 1988]. Cultural differences also impede the work with patients' [Kleinman <i>et al.</i> 1978; Waxler-Morrison 1990]' (Buckman et al. 1991, cited in paragraph 'Problems in Practice').</p> <p>This consensus statement addresses three issues: What are the most important facts we already know about doctor-patient communication? What are the most important things that could be done now to improve the situation? and, What are the most important unanswered questions?</p> <p>For question two, the statement proposes that physicians should first encourage patients to discuss their main concerns without interruption or premature closure. This, they contend, enhances satisfaction and efficacy of the consultation--yet, contrary to the expectation of many doctors, this need not take long: a maximum of 2 1/2 minutes, or an average of 90 seconds. Doctors should also strive to elicit patients' perceptions of the illness and associated feelings and expectations. Experience also supports the value of learning methods of active listening and empathy. The appropriate use of open ended questions, frequent summaries, clarification, and negotiation are factors that positively affect the quality and quantity of information gathered; factors with a negative impact include inappropriate use of closed ended questions and premature</p>

Study and Authors	Study/intervention description and findings/practice implications
	<p>advice or reassurance. Other important skills include giving clear explanations, checking the patient's understanding, negotiating a treatment plan, and checking patients' attention to compliance.</p> <p>Conclusion(s): The authors conclude that sufficient data are now available to show that problems in doctor-patient communication are extremely common and adversely affect patient management. Even though there are still questions around information exchange and therapy, around the best ways to teach these skills (if they are teachable at all) and around ways to research this problem, they argue that it has been repeatedly shown that the clinical skills needed to improve these problems can be taught and that the subsequent benefits to medical practice are demonstrable, feasible on a routine basis, and enduring. The authors therefore propose that the profession has a clear and urgent need for teaching of these clinical communication skills to be incorporated into medical school curriculums and continued into postgraduate training and courses in continuing medical education. They hope that if current knowledge is implemented in clinical practice, and if the priorities for research are addressed, there may be material improvement in the relationship between patient and doctor.</p>
(Conway et al. 2006) Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future - A Work in Progress (Focus on institutional intervention)	<p>A resource for leaders of Hospitals, Ambulatory Care Settings, and Long-Term Care Communities.</p> <p>Useful examples for partnering.</p>
(Crawford et al. 2002) Systematic review of involving patients in the planning and development of health care (Focus on institutional intervention: a Review)	<p>The study sought to examine the effects of involving patients in the planning and development of health care. The researchers examined published and grey literature. They undertook a systematic search for worldwide reports written in English between January 1966 and October 2000. They then undertook a qualitative review of papers describing the effects of involving patients in the planning and development of health care.</p> <p>Results: Of 42 papers identified, 31 (74%) were case studies. Papers described changes to services that were attributed to involving patients, including attempts to make services more accessible and producing information leaflets for patients. The findings also reported changes in the attitudes of organisations to involving patients and positive responses from patients who took part in initiatives.</p> <p>The review concluded that evidence supports the notion that involving patients does contribute to changes in the provision of services across a range of different settings. The authors concluded however, that an evidence base for the effects on use of services, quality of care, satisfaction, or health of patients does not exist.</p>
(Fein et al. 2005) A conceptual model for disclosure of medical errors	<p>This report of a research project is part of a compilation of research projects on patient safety supported by the Agency for Healthcare Research and Quality ('AHRQ'). Its aim was to construct a conceptual model of factors that would facilitate or hinder disclosure of medical errors, so that health systems become aware of errors and thereby enhance the trustworthiness of the system for patients.</p> <p>A qualitative method was used for the study, involving 25 separate focus groups with attending physicians, nurses, residents, patients and hospital administrators at five academic medical centres in a U.S. university health care system. A hypothetical scenario was used to elicit responses about disclosure.</p>

Study and Authors	Study/intervention description and findings/practice implications
	<p>All groups were aligned in their views that errors should be disclosed. There were four categories on influences on whether disclosure should occur. These were provider factors (perceived professional responsibility, fears and training); patient factors (desire for information, level of healthcare sophistication, rapport with provider); error factors (level of harm and whether patients and others were aware of the error or harm); and finally institutional culture (perceived tolerance for error and a supportive infrastructure).</p>
(Frampton 2008) Patient-Centered Care Improvement Guide	<p>In developing this Patient-Centered Care Improvement Guide, Planetree interviewed and then analysed patient-centered care across a stratified sample of more than 90 focus groups (representing 35 hospitals and more than 645 patients). The study was conducted over a three-year period. The Patient-Centered Care Improvement Guide was funded by the Picker Institute, and is designed as a practical resource for organisations striving to become more patient-centered, yet are perhaps struggling with how to do so.</p> <p>The Guide provides institutional assessment guides, practice implementation measures and a range of practical examples for improving patient-centredness in healthcare organisational settings. The Guide frames patient-centered care as a key catalyst for organisational culture change.</p>
(Frankel & Quill 2005) Integrating biopsychosocial and relationship-centered care into mainstream medical practice: A challenge that continues to produce positive results (Focus on institutional and pedagogical interventions)	<p>This intervention study begins by pointing out that Engel's (1977) biopsychosocial model of care although hailed as a breakthrough was criticised by some as being too complex, time-consuming, and difficult to master. Following Engel's original model, they outline that Herman (1989) proposed an alternative "transitional" model that uses both biomedical and biopsychosocial frames. Here in this study, the authors update applications of the biopsychosocial model since the publication of their book, <i>The Biopsychosocial Approach: Past, Present, Future</i> in 2003.</p> <p>They draw on a growing body of literature on patient safety documents that suggest that communication breakdowns between doctors and patients and between doctors and their colleagues, as well as ineffective systems of care, account for a significant percentage of harm done to patients. They also identify that finally medical licensing boards, accreditation bodies, educators, and policymakers agree that caring and compassion, as well as the ability to think and act multidimensionally, are qualities that graduating physicians must have in order to practice medicine effectively.</p> <p>They conclude by saying that changes in training programs and entire organisations will be necessary to bring about changes that introduce institutional improvements to care. Also see (Leonard & Frankel 2010) for further information on practitioners and organisational interventions.</p>
(Glueckauf & Ketterson 2004) Telehealth Interventions for Individuals With Chronic Illness: Research Review and Implications for Practice (Focus on technological intervention)	<p>This article reviews outcome research on telehealth interventions for individuals who are suffering from chronic illnesses. The researchers only selected randomised controlled trials that provided data on specific health, quality of care, or clinical interview outcomes.</p> <p>Findings: The overall findings suggest that telehealth interventions have shown promise as effective modes of treatment for people with chronic health conditions.</p> <p>The authors propose suggestions for improving the rigour and quality of future research. They propose the use of larger samples, control groups that are conceptually meaningful, cost analyses, strategies for enhancing ethnic minority recruitment, and experimental designs that examine interactions among different types of telecommunication technologies, specific health problems, and different patient populations. They also address implications for incorporating telehealth into</p>

Study and Authors	Study/intervention description and findings/practice implications
	<p>psychological practice. For example, in the routine use of telehealth technologies, they seek to emphasise that, similar to other clinical proficiencies, telehealth requires specific competencies and skills, such as knowledge about telecommunication systems, telehealth equipment, data security protocols, and practical skills in the use of these technologies. The authors also caution that psychologists need to be cognisant of ethical dilemmas in telehealth including licensure, and regulatory requirements related to the practice of telehealth. They refer to a previous study (Glueckauf, Pickett, <i>et al.</i>, 2003) in which they discuss the need for practitioner training in the delivery of telehealth. In that study they provide a preliminary set of self-assessment questions that highlight important technical and practice issues in telehealth. This could also help psychologists to identify areas in which their knowledge and skills may require further development.</p>
<p>(Gravel, Legare & Graham 2006) Barriers and facilitators to implementing shared decision-making in clinical practice: a systematic review of health professionals' perceptions (Focus on interventions to clinicians' behaviour)</p>	<p>Shared decision-making (SDM) is advocated because of its potential to improve the quality of the decision-making process for patients and ultimately, patient outcomes. However, the authors point out that current evidence suggests that shared decision-making has not yet been widely adopted by health professionals. Therefore, the authors undertook a systematic review on the barriers and facilitators that affect the implementation of shared decision-making in clinical practice as perceived by health professionals.</p> <p>They included thirty-one publications covering 28 unique studies, in the study. Eleven of those were from the UK, eight from the USA, four from Canada, two from The Netherlands, and one from each of the following countries: France, Mexico, and Australia. Most of the studies used qualitative methods exclusively (18/28). Overall, the vast majority of participants who took part (n = 2784) were physicians (89%).</p> <p>Findings: The three most often reported barriers to SDM are: time constraints (18/28), lack of applicability because of the patient characteristics (12/28), and lack of applicability because of the clinical situation (12/28). The three most often reported facilitators to SDM are: that the provider is motivated to implement SDM (15/28), the positive impact it has on the clinical process (11/28), and the positive impact it has on patient outcomes (10/28).</p> <p>This systematic review reveals that interventions to foster implementation of shared decision-making in clinical practice will need to address a broad range of factors in consultations. It also reveals that on this subject there is very little known about any health professionals others than physicians. The authors urge that future studies about implementation of shared decision-making should target a more diverse group of health professionals.</p>
<p>(Griffin <i>et al.</i> 2004) Effect on Health-Related Outcomes of Interventions to Alter the Interaction Between Patients and Practitioners: A Systematic Review of Trials (Review of RCTs)</p>	<p>In this review, Griffin <i>et al.</i> identify different kinds of interventions (or what Griffin <i>et al.</i> call 'taxonomies of intervention', (2004).</p> <p>The authors want to identify published randomised trials of interventions that have been undertaken aimed at altering the interaction between patients and practitioners. They also want to develop taxonomies of the interventions and outcomes, and assess evidence that such interventions improve patients' health and well-being. They undertake a systematic review of randomised trials, seeking trials in primary and secondary care with health-related outcomes. They search MEDLINE, HealthSTAR, and PsycINFO bibliographic databases through 1999. They also complete one round of manual citation searching.</p> <p>They include thirty-five trials in the review. Most of these are set in primary care in North America. The trials vary in terms of their populations, settings, interventions, and measures. They find that interventions frequently combine several poorly</p>

Study and Authors	Study/intervention description and findings/practice implications
	<p>described elements, explicit theoretical underpinning is rare, and only one study links intervention through process to outcome measures. They also identify that health outcomes are rarely measured objectively (6 of 35), and only 4 trials with health outcomes meet their predefined quality criteria. They find that interventions frequently alter the process of interactions (significantly in 73%, 22 of 30 trials).</p> <p>Findings: The principal outcomes favour the intervention group in 74% of trials (26 of 35), reaching statistical significance in 14 (40%). They conclude that positive effects on health outcomes achieve statistical significance in 44% of trials (11 of 25); and negative effects are uncommon (5 of 25, 20%). Simple approaches to increasing the participation of patients in the clinical encounter, such as providing practitioners with a note from patients about their concerns beforehand, show promise, as do more complex programs providing specific information about disease and attention to emotion. Apparently similar interventions vary in effectiveness across studies.</p> <p>Conclusion(s): They identify that successful interactions between patients and their practitioners lie at the heart of medicine, yet there are few rigorous trials of well-specified interventions to inform best practice. Trial evidence suggests that a range of approaches can achieve changes in this patient-clinician interaction, and they argue that some show promise in improving patients' health. In order to advance knowledge further, the authors contend they and others need to replicate the more promising studies using rigorous methods. These should include explicit theoretical frameworks designed to link effects on key communication and interaction characteristics through to effects on health outcomes.</p>
(Johnson et al. 2008) Partnering with Patients, Residents and Families (Focus on institutional interventions)	<p>This is a resource designed to accompany the video 'Partnerships with Patients, Residents, and Families: Leading the Journey'. The resource includes an introduction to patient-and family-centred care and resident-centred care. There is also an overview of how partnerships with patients, residents in long term care communities, and families have been essential to organisational change in different health care settings.</p> <p>The resource provides concrete and real-world examples of partnering with patients, residents and families from 130 best practices exemplary organisations.</p>
(Kinnersley et al. 2007) Interventions before consultations for helping patients address their information needs (Review of studies) (Focus on patient interventions)	<p>This Cochrane Collaboration Review identified 33 randomised trials, from 6 countries and in a range of intervention studies designed to help patients address their information needs. A total number of 8244 patients was randomized and entered into studies. The most common interventions were question checklists and patient coaching. Most interventions in the study are delivered immediately before the consultations. Commonly-occurring outcomes include: question asking, patient participation, patient anxiety, knowledge, satisfaction and consultation length.</p> <p>A minority of studies shows positive effects for these outcomes. Meta-analyses, however, show small and statistically significant increases for question asking and patient satisfaction. They found that there is a notable but not statistically significant decrease in patient anxiety before consultations following interventions. There are small and not statistically significant changes in patient anxiety after consultations (reduced), patient knowledge (reduced), and consultation length (increased).</p> <p>Further analyses show that both coaching and written materials produce similar effects on question asking but that coaching produces a smaller increase in consultation length and a larger increase in patient satisfaction.</p> <p>Findings: Interventions immediately before consultations lead to a small and statistically significant increase in consultation</p>

Study and Authors	Study/intervention description and findings/practice implications
	<p>length, whereas those implemented some time before the consultation have no effect. Both interventions immediately before the consultation and those some time before it lead to small increases in patient satisfaction, but this is only statistically significant for those immediately before the consultation. There appear to be no clear benefits from clinician training in addition to patient interventions, although the evidence is limited.</p> <p>Conclusion(s) Interventions before consultations that are designed to help patients address their information needs in consultations produce limited benefits to patients. The review suggests that further research could explore whether the quality of questions is increased, whether anxiety before consultations is reduced. More studies need to consider the timing of interventions and possibly the type of training provided to clinicians.</p> <p>The overall results from the Cochrane Collaboration Review are noteworthy and are reproduced verbatim. 'Patients still do not get the information they require in clinical consultations (Rogers 2005). Our meta-analyses show that although the individual effects found in particular trials may be small or non-significant, when combined there are small and statistically significant effects in terms of increased patient question asking and increased patient satisfaction. The result for patient anxiety before consultations demonstrated a large, but not statistically significant, effect. Results for patient anxiety after consultations and consultation length were also small and not statistically significant. The effects of the interventions on patient knowledge are unclear due to methodological difficulties. Assessing patient participation remained a challenge throughout the review; although commonly measured, a range of methods are used (from tapes of consultations and from patient questionnaires); additionally, participation could mean different things to different people' (Kinnersley et al. 2007, p. 27).</p>
(Leonard & Frankel 2010) The path to safe and reliable healthcare (Focus on institutional intervention)	<p>The ability to deliver safe and reliable healthcare is the goal of all healthcare delivery systems. To bridge the current performance gaps in quality and safety, the authors propose that organisations need to apply a systematic model that effectively addresses both culture and reliable processes of care.</p> <p>The model they describe in this article provides a comprehensive approach to improving the quality of care in any clinical domain. The authors identify that what is required is leadership at all levels of the organisation, a safety culture, particular understanding of aspects of human performance in a complex environment, effective teamwork and communication, patient and family centered care, reliable processes of care, and an environment of continuous learning and improvement. The article provides a roadmap for people working in clinical improvement to assess the strengths and current needs in their care systems, so they can be strategic and systematic in their work, essential elements for success. The concepts and tools provided can be readily applied to improve the quality and safety of care delivered.</p>
(Levinson, Lesser & Epstein 2010) Developing Physician Communication Skills for Patient-Centred Care	<p>This study outlines how growing enthusiasm about patient-centred medical homes, fuelled by the Canadian Patient Protection and Affordable Care Act's emphasis on improved primary care, has intensified interest in how to deliver patient-centered care. Essential to the delivery of such care are patient-centered communication skills. The authors propose that these skills have a positive impact on patient satisfaction, treatment adherence and self-management. The authors propose a progressive scale on the links between teaching patient-centered communication skills and outcomes. These move from immediate outcomes such as clinicians demonstrating these skills in the interview, to intermediate outcomes such as increased patient knowledge, increased patient self-efficacy, better informed decision making and increased adherence and</p>

Study and Authors	Study/intervention description and findings/practice implications
	<p>finally improved patient self care.</p> <p>Finally the scale addresses improved health outcomes which include improved biologic outcomes, improved quality of life and well-being, improved survival, reduced care disparities and reduced care costs.</p> <p>The authors argue that these skills can be effectively taught at all levels of medical education as well as to practicing physicians. Yet they point out that most physicians receive limited training in communication skills. They identify a number of ways to fund this training including having policy makers and stakeholders leverage training grants. They also propose payment incentives, certification requirements, and other mechanisms to develop and reward effective patient-centred communication.</p>
(Lewin et al. 2001) Interventions for providers to promote a patient-centred approach in clinical consultations (Focus on institutional interventions)	<p>This is a review of 17 studies (RCTs, CCTs, CBA's) examining the effects of interventions directed at health care providers that are intended to promote patient-centered care in clinical consultations, and the extent to which these interventions succeed in making consultations patient centered. It also examines the effects of the interventions on health care behaviours, health status and well-being and patient satisfaction with care.</p> <p>For the purposes of the review, the authors adopt a broad definition of Patient-Centered care. This definition includes that: 1) health care providers share control of consultations, decisions about interventions or the management of the health problems with patients, and/or 2) health care providers focus on the patient as a person, rather than solely on the disease, in consultations. The authors group and measure a number of outcomes in the following categories: 1) consultation processes, including the extent to which patient-centered care was judged to be achieved in practice; 2) other health care behaviours, including types of care plans agreed; providers' provision of interventions; patients' adoption of lifestyle behaviours; and patients' use of interventions and services; 3) health status and well-being, including physiological measures (i.e., blood pressure); clinical assessments (i.e., wound healing); patient self-reports of symptom resolution or quality of life; and patient self-esteem; 4) patient and/or families' satisfaction with care.</p> <p>Conclusion(s)/recommendations: They conclude that there is fairly strong evidence to suggest that some interventions to promote patient-centered care in clinical consultations may lead to significant increases in the patient centeredness of consultation processes. Twelve of the 14 studies that assess consultation processes show improvements in some of these outcomes.</p> <p>However, they say there is limited and mixed evidence on the effects of such interventions on patient healthcare behaviours or health status; or on whether these interventions might be applicable to providers other than physicians.</p> <p>According to the study, they identify that there is also some evidence that training health care providers in patient-centered approaches may impact positively on patient satisfaction with care. Of the eleven studies that assess patient satisfaction, six demonstrate significant differences in favour of the intervention group on one or more measures. It is important to note that none of the included studies use measures explicitly designed to assess the patient-centeredness of the consultation. However, the authors say there is currently no gold standard to measure patient centeredness, and the authors suggest that this area needs further work if the effects on consultation processes or interventions to promote patient-centered care are to be appropriately assessed.</p>
(Muething 2007) Family-centered bedside	In this study, the authors point out that the importance of patient-centered care and the role of families in decision-making

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rounds: a new approach to patient care and teaching (Focus on institutional intervention)	are identified as increasingly important. Starting with a single acute care unit, a multidisciplinary improvement team at Cincinnati Children's Hospital developed and implemented a new process that allowed families to decide if they want to be part of attending-physician rounds. The findings show that family involvement seems to improve communication, improves shared decision-making, and offers new learning for residents and students. Despite initial concerns of staff members, family-centered rounds have been widely accepted and spread throughout the institution. In this article, the authors report their experiences in the use of a potential model to improve family-centered care and teaching.
(O'Grady 2011) Teaching the communication of empathy in patient-centered medicine	This chapter draws on discourse analysis to outline how doctors can achieve 'clinically effective empathy' through their interactions with patients. The author suggests that authentic discourse data from GP consultations can be used to enhance empathy in consultations. Questions that can be posed, based on data, include: Why did the doctor choose to respond as she did; What was the effect of the doctor's attentive silence; What might have happened if she had shared the reasoning behind her diagnosis; How might this have impacted on the interaction and finally; How might a certain response have changed the course of the consultation? The data is drawn from consultations with doctors in Australia and is posited as pedagogically useful for doctors who do not have English as their first language. In this it is useful as a pedagogical resource as the chapter highlights strategies and real interactional examples of how doctors trained in a different medical culture can build knowledge on ways to achieve empathy in culturally-specific ways. The author suggests that professional expertise is built slowly and is based on experiences, images, what others do, and examples that illustrate, guide and inform reflexivity about their own practices. In this way novice doctors, and those trained overseas, can build 'communicative resources' to assist them in challenging consultations.
(O'Grady & Candlin In press) Engendering trust in a multiparty consultation involving an adolescent patient	This chapter traces the skilful way that a doctor uses empathy in a consultation that is attended by an adolescent man (as the patient) and his mother. The doctor manages to give autonomy to the patient, through her actions which are strategic, and include her gaze, the way she positions her body in relation to the patient, how she addresses the young man and how she manages to incorporate his input and his mother's into the consultation. The doctor builds the patient's independence and allows him to speak for himself, and finally positions him as responsible for his own health. The chapter uses discourse analysis to show how this is done by the doctor as she reflexively, and empathetically manages the young patient's privacy and develops his trust in her. The authors of this chapter draw on work they have conducted in other contexts on the benefits of using discourse analysis as a pedagogical intervention. They cite the value of discourse analysis which they posit can be used in training for medical practitioners to manage consultations more effectively. This procedure follows a 'pedagogically phased cycle of Awareness, Knowledge, Critique and Action' (see Candlin et al. 1994 in O'Grady & Candlin In press, p. xx) in which transcribed interactions can be used to jointly reflect on what has been said by the doctor and the patient, and thereby result in behaviour change of clinicians.
(Ovretveit 2012b) Summary of 'Do changes to patient-provider relationships improve quality and save money?'	The review and its summary document require reading in their own right. This is because Ovretveit undertakes a sophisticated analysis of the changes, their costs and their benefits in terms of improving quality and saving money. The review does however give a clear message for researchers on the need to look further into how poor communication and inequitable relationships between patients and healthcare professionals add to the costs of healthcare provision. Ovretveit's research also provides some evidence of solutions. He indicates that 'these are interventions and changes to

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	<p>promote patient-professional communication and collaboration to bring about a more active role for patients and to support self-care'. Importantly however he makes the point about how interventions are to be measured. 'There is little high-quality evidence of the effectiveness of different interventions and even less evidence of the costs and possible savings to different parties' (Ovretveit 2012b, p. 7). He goes on to say 'this does not mean that some interventions might not improve quality and save money. It means only that there is uncertainty about their effectiveness, if traditional systematic review standards of evidence of effectiveness are used to judge the strength of evidence' (Ovretveit 2012a, p. 7). The review was able to give useful information about changes that are likely to improve quality and reduce provider costs. For communications value improvements there was some evidence of improved quality and/or less use of resources that may cover the cost of the intervention for the following (Ovretveit 2012a, p. 15):</p> <ul style="list-style-type: none"> • Providing information: appropriate written and oral information prior to consultation or treatment, or post-treatment, if the information is matched to the patient's needs and abilities (citing Griffin <i>at al</i> 2004; Johansson <i>at al</i> 2005; Coulter and Ellins 2007; Johnson <i>at al</i> 2003); • Patient writes concerns before consultation: an intervention to enable patients to write a note of their concerns before a clinical consultation (he cites Griffin <i>at al</i>. 2004); • Mobile phone text messaging: to give patients reminders about a scheduled healthcare appointment (to reduce non-attendance; he cites Car <i>at al</i> 2008), to communicate results of medical investigations (he cites Gurol-Urganci <i>at al</i> 2008) and feedback on treatment success, especially for patients with chronic illnesses (he cites de Jongh <i>at al</i> 2008); • Mailed and telephone reminders: to reduce non-attendance, or move non-attenders to the bottom of the waiting list (he cites Can <i>at al</i> 2003; George and Rubin 2003; Reekie and Devlin 1998; Moser 1994; Quattlebaum <i>at al</i> 1991; Bech 2005); • Enable question asking: specific appropriate interventions to enable patients from low-income ethnic minority groups to ask their doctors more and better questions and to recognise the importance of asking questions in decision making (he cites Deen <i>at al</i> 2011); • Training doctors: a specific intervention using role playing, feedback and small group discussions to improve patient communication skills (he cites Haskard Zolnieriek and DiMatteo 2009); • Visual feedback: to patients of their medical imaging results for those who smoke, or who are at risk of UV-related skin cancer (he cites Hollands <i>at al</i> 2010); • Offering patient email access: to physicians or specialist nurses for specific patients for specific purposes (he cites Car and Sheikh 2004; Gagnon <i>at al</i> 2009); • Patient internet sites: specific systems established by the patient's provider or their health system, with patient access and ability to comment on personal health information – test results, problem summaries, medication lists and side effects (he cites Weingart <i>at al</i> 2008); • Patient-directed record tools: interventions to enable selected patients to use internet-based personal health

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	<p>record systems (PHRs) to create their own medical record and health diaries (he cites Archer <i>et al.</i> 2011).</p> <ul style="list-style-type: none"> • The reports also include cost/benefit analyses for patient role and participation and medication-related improvements. The author urges that research is needed which provides greater specificity in the descriptions of the interventions being studied, the underpinning logic models and how changes in the relationship improves quality and impacts upon costs. This needs to consider the different stakeholders and account for those costs over time, in particular, considering how effective implementation of an intervention links to the later experience and outcomes of a patient's care.
(Rao et al. 2010) Engaging communication experts in a Delphi process to identify patient behaviors that could enhance communication in medical encounters (Focus on patient interventions)	<p>This study identifies that the communication literature currently focuses primarily on improving physicians' verbal and non-verbal behaviors during the medical interview. The Four Habits Model is a teaching and research framework for physician communication that is based on evidence linking specific communication behaviors with processes and outcomes of care. The Model conceptualizes basic communication tasks as "Habits" and describes the sequence of physician communication behaviors during the clinical encounter associated with improved outcomes. Using the Four Habits Model as a starting point, the researchers asked communication experts to identify the verbal communication behaviors of patients that they saw as important in outpatient encounters.</p> <p>The authors conducted a Four-round Delphi process with 17 international experts in communication research, medical education, and health care delivery.</p> <p>The experts modified all but two of the 14 originally-proposed patient verbal communication behaviours, and they added 20 behaviours to the Model in round one. They were presented with 59 behaviors in round two and 14 options to remove specific behaviours for rating. After three rounds of rating, they retained 22 behaviors. This set included behaviors such as asking questions, expressing preferences, and summarising information.</p> <p>Practice implications: The process identified communication tasks and verbal communication behaviors for patients similar to those outlined for physicians in the Four Habits Model. The authors claim that this represents an important step in building a single model that can be applied to teaching patients and physicians the communication skills associated with improved satisfaction and positive outcomes of care.</p>
(Roberts et al. 2003) A discourse analysis study of 'good' and 'poor' communication in an OSCE: a proposed new framework for teaching students (Focus on pedagogical intervention)	<p>The study points out that there is still a great deal to be learnt about teaching and assessing undergraduate communication skills, particularly as formal teaching in this area expands. One approach they put forward is to use the summative assessments of these skills in formative ways.</p> <p>The authors conducted discourse analysis (DA) of data collected from final year examinations. The authors argued that results from identifying and examining good and poor communicators at a formative stage of their training, could feed into the teaching / learning of communication skills in the undergraduate curriculum. The study took place as part of a final year UK medical school objective structured clinical examination (OSCE). Students were presented with four scenarios, designed to assess communication skills in challenging contexts as part of the OSCE (a summative assessment). Video recordings of all interactions at these stations were screened. A sample covering a range of good, average and poor performances were transcribed and analysed. Discourse analysis methods were used to identify 'key components of communicative style'.</p> <p>Findings: Analysis revealed important differences in communicative styles between candidates who scored highly and those</p>

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	<p>who did poorly. These findings related to: empathetic versus 'retractive' styles of communicating; the importance of thematically staging a consultation, and the impact of values and assumptions on the outcome of a consultation.</p> <p>Conclusion(s): Roberts et al. conclude that detailed discourse analysis sheds light on patterns of communicative style and provides an analytic language for students to raise awareness of their own communication. This challenges standard approaches to teaching communication and shows the value of using summative assessments in formative ways (as part of the teaching process and not just at the end of the course).</p>
<p>(Roter et al. 2004) Use of an innovative video feedback technique to enhance communication skills training (Focus on pedagogical intervention)</p>	<p>Despite growing interest in medical communication by certification bodies, the study identifies that significant methodological and logistic challenges are evident in experiential methods of instruction.</p> <p>In this trial, there were three study objectives: 1) to explore the acceptability of an innovative video feedback programme to residents and faculty; 2) to evaluate a brief teaching intervention comprising the video feedback innovation when linked to a one-hour didactic and role-play teaching session on paediatric residents' communication with a simulated patient; and 3) to explore the impact of resident gender on communication change.</p> <p>The study compared pre/post residents' performance in videotaped interviews with simulated patients before and after the teaching intervention. By embedding the Roter Interaction Analysis System (RIAS) in a software platform that presents a fully coded interview with instant search and review features, individually tailored feedback on targeted communication skills was facilitated.</p> <p>Setting/participants: 28 first year residents in a large, urban, paediatric residency programme.</p> <p>Results: The findings demonstrated communication changes following the teaching intervention. There were significant improvements in residents' performance with simulated patients pre and post teaching and feedback. Using paired t-tests, differences in the pre and post intervention teaching included: reduced verbal dominance; increased use of open-ended questions; increased use of empathy; and increased partnership building and problem solving for therapeutic regimen adherence. Female residents demonstrated greater communication change than males.</p> <p>Conclusion(s): The RIAS embedded CD-ROM provides a flexible structure for individually tailoring feedback of targeted communication skills that is effective in facilitating communication change as part of a very brief teaching intervention.</p>
<p>(Safran, Miller & Beckman 2006) Organizational Dimensions of Relationship-centered Care: Theory, Evidence, and Practice</p>	<p>The authors begin by identifying that according to Beach & Inui 2006, four domains of relationship have been highlighted as the cornerstones of relationship-centered health care. These are: clinician-patient relationships: clinician-colleague relationships: clinician-community relationships: and clinicians' relationships to self. Of these, clinician-patient relationships have been most thoroughly studied. They say there is a rich empirical literature illuminating significant linkages between clinician-patient relationship quality and a wide range of outcomes. This paper explores the realm of clinician-colleague relationships, which they define to include the full array of relationships among clinicians, staff, and administrators in health care organizations. Building on a stream of relevant theories and empirical literature that have emerged over the past decade, the authors synthesize available evidence on the role of organizational culture and relationships in shaping outcomes, and posit a model of relationship centered organizations.</p> <p>The paper concludes that turning attention to relationship-centered theory and practice in health care holds promise for advancing care to a new level, with breakthroughs in quality of care, quality of life for those who provide it, and</p>

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(Schirmer et al. 2005) Assessing communication competence: a review of current tools (Focus on pedagogical intervention: a comparison of psychometric measurement tools)	<p>organizational performance.</p> <p>The study identifies that assessment of communication competence has become a major priority of medical educational, policy, and licensing organisations in the United States and Canada. The study points out that multiple tools are available to assess communication competence, but there are few studies that compare the tools. This study set up a consensus panel of six family medicine educators who evaluated 15 instruments measuring the physician-patient interview. The primary evaluation criteria came from the Kalamazoo Consensus Statement (KCS), which derived from a multidisciplinary panel of experts that defined seven essential elements of physician-patient communication. The researchers evaluated psychometric properties of the instruments and other assessment criteria felt to be important to family physicians (exploring family issues, interview efficiency, and the usability/practicality of the instruments).</p> <p>Results: Instruments that received the highest ratings on KCS (Kalamazoo Consensus Statement) elements were designed for faculty raters and varied in their practicality/usability ratings and psychometric properties. Few instruments were rated high on psychometric properties or exploring family issues.</p> <p>Conclusion(s): The process successfully reviewed and provided a framework for assessing communication skills instruments. The authors identify that there is a need to expand the study, including use of a larger cohort of reviewers to provide more validity to the results and minimise potential biases.</p> <p>See Table 2 specifying the Kalamazoo Consensus Statement: Essential Elements of Physician-Patient Communication (Schirmer et al. 2005, p. 185).</p>
(Swing 2007) The ACGME outcome project: retrospective and prospective (Focus on pedagogical intervention)	<p>The Accreditation Council for Graduate Medical Education began an initiative in 1998 to improve resident physicians' ability to provide quality patient care and to work effectively in current and evolving healthcare delivery systems. The initiative written up in this study, called the Outcome Project, seeks changes in residency programs that focus education on the competency domains, enhance assessment of resident performance and increase utilisation of educational outcomes for improving residents' education. Another important goal is increased emphasis on educational outcome measures in accreditation.</p> <p>Results: A considerable amount of development, dissemination and educational activity has been carried out to support the implementation of the project. Thus far, observed effects include changes to accreditation requirements and information collection and enhancements of the educational environments and curriculum of residency education programs.</p> <p>Conclusion(s): The author identifies that prospects for meaningful change are good. But he argues for further development of assessment methods needed to advance the in-training evaluation of residents and the ACGME goals for utilising performance data in accreditation and linking education and patient care quality.</p>
(Tran et al. 2004) Empowering communication: a community-based intervention for patients (Focus on pre and post consultation intervention)	<p>The "How to Talk to Your Doctor" community education forums operate under the assumption that information exchange and consumer involvement in healthcare can empower communities in need. This paper reports on the development and preliminary evaluation of this community based intervention designed to activate and enhance patients' communicative abilities in the medical encounter. The aim of the intervention is to:</p> <ol style="list-style-type: none"> 11. Recognize barriers to good patient–physician communication 12. Describe reasons for good patient–physician communication

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	<ol style="list-style-type: none"> 13. Recognize examples of good physician and patient communication traits 14. Apply “tips” for improving patient–physician communication 15. Demonstrate good patient–physician communication techniques 16. Recall good patient–physician communication strategies. <p>The authors review evidence supporting the feasibility of and benefits that can be expected from improving patients’ communication competency. Their intervention is simple and flexible so, therefore, can be portable to a large number of communities. Their preliminary evaluation suggests that the intervention is well-received and produces improved self-perceptions of communication competence across diverse settings and participants. They describe their intervention and its development and dissemination as a model for improving patients’ communicative abilities through a community based, active learner approach. By sharing their experiences, the barriers they encountered, and their ongoing efforts to improve patient communication in the medical encounter, they hope to empower patients to communicate better with their physicians. As the paper itself says, ‘to the extent that these goals are met, the forums potentially represent a simple and inexpensive mechanism through which communities can enhance the health of their members’.</p>
<p>(Trumble, O'Brien & Hartwig 2006)</p> <p>Communication skills training for doctors increases patient satisfaction (Focus on pedagogical intervention)</p>	<p>This Australian study sought to examine changes in patients’ satisfaction after their doctor had participated in a brief educational intervention on medicolegal risk management. Ambulatory patients completed questionnaires measuring satisfaction with their doctor’s communication skills before and three months after the doctor had participated in a three-hour workshop on a medicolegal risk management program. Seventy-five obstetrician/gynaecologists and 99 general practitioners were each rated by 60 of their patients following a consultation in their clinical rooms.</p> <p>The study sought to ascertain patient satisfaction as evidenced by change to “complete satisfaction” with the doctor’s communication skills and overall satisfaction with the clinical encounter.</p> <p>Practical implications: Participants had high initial patient satisfaction ratings and these were found to have improved across all parameters three months after the educational intervention.</p> <p>Originality/value: The authors found that the educational intervention was successful in improving doctors’ communication skills as evidenced by enhanced patient satisfaction in all key areas, including those most frequently associated with patient complaint, litigation and adverse outcome.</p> <p>The study concludes that ‘the link between doctor-patient communication, patient satisfaction and litigation is well-established. As demonstrated above, the “Mastering Your Risk” workshop and audit achieved the elusive outcome that Betz and Brown <i>et al.</i> 1999 believed so difficult. A brief educational intervention that results in improved performance across the full spectrum of doctors’ communication (as evidenced by improved patient satisfaction with the service they receive) is potentially a valuable asset in improving the quality of medical care. The authors argue therefore, that the statement that “communication is not an ‘add on’, it is at the heart of patient care” (Audit Commission (UK), 1993) – What Seems to Be the Matter: Communication between Hospitals and Patients? HMSO, London – is no less relevant thirteen years later’ (Trumble, O'Brien & Hartwig 2006, p. 299). They say that it is not feasible to demonstrate a direct link between workshop participation and a subsequent reduction in patient litigation, due to the extremely low incidence of such an outcome. However they point out that completely satisfied patients do not complain.</p>

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(Ubel 2012) Critical Decisions: How you and your doctor can make the right medical choices together (Focus on patients and clinicians working together)	<p>In this book, the author reveals the hidden dynamics in the doctor-patient relationship that keep us from making good decisions. He shows us how patients and doctors can learn to work together. How doctors can explain better. How patients can listen better. How we can understand each other.</p> <p>See pages 337 – 340 for tips for patients. These include, recognize that you, the patient, have a role to play in your decisions; realize that you are not alone; get informed about your alternatives; be an active listener; communicate what you care about; if you have time to decide, then take your time; seek out help from other patients; and stay informed.</p>
(Zeno 2003) The ABCs of Empowered Communication: A Community-Based Intervention for Patients http://virtualmentor.ama-assn.org/2003/06/msoc1-0306.html	<p>This paper analyses findings of a community education about how patients can best communicate with their physicians. The intervention is based on a fully illustrated HHTTYD guidebook (available in English and Spanish) and organized along the 4 main learning objectives outlined as (1) recognising barriers to good patient-physician communication; (2) recognising examples of effective patient-physician communication styles; (3) applying strategies presented in the forum for improving communication in the medical interaction; and (4) recalling good patient-physician communication strategies. The resource guide is entitled <i>How to talk to your doctor</i>.</p> <p>The paper argues that this kind of intervention has been successful in various communities, particularly when working with an ethnically diverse patient population. The paper addresses a review of strategies to promote greater patient involvement.</p> <p>Specifically, the 3 ABC tips suggested are: (a) Ask questions in order to receive information, (b) Be prepared for the appointment, and (c) Communicate and express health concerns.</p>

What is the impact of ineffective/poor communication on patient outcomes and experience?

A recent report in the USA showed that whilst many hospitals are actively pursuing patient-centred care and communication, recent findings from a survey of how Americans view their costs and quality of healthcare suggests the public is conscious of low quality and safety (Robert Wood Johnson Foundation, NPR and Harvard School of Public Health, 2012). The report found, among other things, that 30% of people in the general public believe they received poor communication from their health care provider. In addition, 72% of sick Americans want their health care providers to spend longer with them so they have the opportunity to discuss broader issue that may affect their long-term health. Other findings include:

- 13% of people in the general public believe they were given a wrong diagnosis in the last 12 months;
- 26% believe their condition was not managed well;
- 25% didn't believe they received all of the information relating to their treatment or prescriptions;
- 23% believe that when there are multiple health professional involved that no single doctors kept track of their medical issues/treatment;
- 18% of sick Americans do not believe they got the tests they required, and
- 13% of sick Americans believe they received unnecessary tests.

Recent data from Australia outlines the following findings in relation to communication and satisfaction with health providers. Because the findings are so relevant to the present overview, we quote verbatim from a 2011 Australian Bureau of Statistics report:

- "In any transaction with a health provider, the provision of information is an important aspect of communication and patient care.
- In Australia, two out of five persons admitted to hospital (40%) were given the choice to be treated as a private or public patient on their most recent admission. Of these, 89% of persons felt that they were given enough information to choose to be treated as a private or public patient. This varied by age, with 96% of persons aged 75 years or over feeling they were given enough information to choose, compared with 84% of persons aged 25-34.
- Also of importance to persons is the way they were treated by health professionals. All persons that had used health services were asked for their perceptions of whether the health professionals they saw over the previous 12 months listened carefully to them, showed respect for them, or spent enough time with them. Overall levels of satisfaction were high, with around

80% or more reporting that they always or often felt that the health professionals they saw listened carefully, showed respect or spent enough time with them .

- Levels of satisfaction for health professionals spending enough time with patients was higher for certain services than it was for others. For example, 95% of respondents that had seen a dental professional in the previous 12 months said that dental professionals always or often spent enough time with them, compared with rates for medical specialists at 90% and GPs at 88%.
- Perceptions of hospitals and emergency departments (EDs) differed regarding whether patients felt that staff had spent enough time with them. Four out of five persons that visited an ED for their own health in the previous 12 months (80%) felt that the doctors and specialists had always or often spent enough time with them, compared with 87% of persons that had been admitted to hospital. Similarly for ED nurses and hospital nurses, 84% and 88% respectively believed that they always or often spent enough time with them.
- Levels of satisfaction also differed by age. Of persons aged 75 years and over that visited an ED in the previous 12 months for their own health, 93% felt that ED doctors and specialists always or often spent enough time with them, compared with 73% of those aged 25-34. Similarly, 93% of persons aged 75 years and over, and 78% of persons aged 25-34 who had visited an ED felt the ED nurses had always or often spent enough time with them.
- When it came to whether hospital doctors and specialists always or often listened carefully, persons from areas of most disadvantage reported lower rates of satisfaction (87%) than those from areas of least disadvantage (92%).
- The proportion of people indicating that ED doctors and specialists always or often treated them with respect was lower in the most disadvantaged areas (83%) compared to the least disadvantaged area (90%)” (Australian Bureau of Statistics 2011).

For their part, Fallowfield & Jenkins in the UK found that “inadequate training in communication skills was acknowledged by senior hospital doctors as a major factor contributing to their high rates of burnout and psychological morbidity” (Fallowfield and Jenkins 2004). They further concluded that “if bad news is communicated badly it can cause confusion, long lasting distress, and resentment; if done well, it can assist understanding, acceptance, and adjustment” (Fallowfield and Jenkins 2004). De Haes and Bensing report that more complaints arise from poor communicators (Tamblyn et al. 2007 in de Haes and Bensing 2009), and that poor feedback between clinicians and patients can have a negative impact on the institution (de Haes and Bensing 2009).

A study by Margalit and colleagues highlighted that clinicians spent a quarter of their time during a visit gazing at the computer, with some as high as 42%. Computers can cause distancing between the clinician and patient, and these behaviours need to be addressed through targeted teaching and

education strategies to make clinicians conscious of the negative effects of excessive computer use (Margalit et al. 2006). Low quality patient-clinician communication likely negatively affects not just the patient, but also the clinician, the institution and ultimately the relationship between the citizen and the healthcare sector at large (Buetow et al. 2009; Fischer and Ereaut 2012).

A sociologist of medicine, Lupton found that patients who have less ‘respect’ for doctors do so for reasons of either the absence of interpersonal skills on the part of the doctor or because they were unimpressed by “the discourse of consumerism”: “The touch of the doctor and the way she or he interacts with the patient, the doctor’s tone of voice, the matter, the words chosen, are all central to the ‘consumption’ experience, as is how the patient ‘feels’ during and after the encounter” (Lupton 1997). Anticipating Mol’s argument in favour of a ‘logic of [ongoing, supportive] care’ (Mol 2008), Lupton uses these findings to argue against the notion that patients are ‘rational’ evaluators of the patient-clinician consultation experience. She talks about patients as more complex in that they may shift what they think about doctors during their treatment and according to the circumstances in which they find themselves. Lupton concludes that “Some people may respond to such situations in which loss of control seems imminent by adopting the consumerist position; others prefer to allow an authoritative figure to “take over”. Both subject positions may be viewed as “rational” responses to a distressing and frightening situation....” (Lupton 1997).

Wynia and colleagues conclude that “the presence, absence and/or quality of factors like patient educational tools, forms, interpreters, reimbursement practices and the legal environment, among others, all might have dramatic effects on whether effective communication takes place. To adopt the language of patient safety, such organizational and systemic factors should be seen as potential ‘root causes’ that might allow miscommunication errors to arise” (Wynia 2012).

What are the essential elements for effective patient clinician communication?

Recent research has created detailed lists of essential elements for effective patient-clinician communication. One of these is the *Kalamazoo Consensus Statement* (Schirmer et al. 2005). The Kalamazoo consensus outlines the following requirements: that the clinician establish rapport, open discussion, gather information, understand the patient’s perspective of illness, share information, reach agreement on problems and plans and provide closure (Schirmer et al. 2005). The table below is taken from Schirmer and colleagues’ 2005 article (Schirmer et al. 2005), listing the ‘Kalamazoo Consensus Statement: Essential Elements of Physician-Patient Communication’.

Essential Element	Tasks
Establishes rapport	Encourages a partnership between physician and patient Respects patient's active participation in decision making
Opens discussion	Allows patient to complete his/her opening statement Elicits patient's full set of concerns Establishes/maintains a personal connection
Gathers information	Uses open-ended and closed-ended questions appropriately Structures, clarifies, and summarizes information Actively listens using nonverbal (e.g., eye contact, body position) and verbal (words of encouragement) techniques
Understands patient's perspective of illness	Explores contextual factors (e.g., family, culture, gender, age, socioeconomic status, spirituality) Explores beliefs, concerns, and expectations about health and illness Acknowledges and responds to patient's ideas, feelings, and values
Shares information	Uses language patient can understand Checks for understanding Encourages questions
Reaches agreement on problems and plans	Encourages patient to participate in decision to the extent he/she desires Checks patient's willingness and ability to follow the plan Identifies and enlists resources and supports
Provides closure	Asks whether patient has other issues or concerns Summarizes and affirms agreement with the plan of action Discusses follow-up (eg, next visit, plan for unexpected outcomes)

For de Haes and Bensing (2008), the critical element is “Rogerian theory of ‘unconditional positive regard’” which manifests as “providing room for the patient to disclose his/her worries and emotions” (de Haes and Bensing 2008).

Table 2. Contrasting Efficient and Inefficient Interactions

	When the Physician Feels Pressed for Time	When the Physician Feels That There Is Sufficient Time
High-quality, efficient communication: recommended, less commonly observed	<ol style="list-style-type: none"> 1. Limited rapport building 2. Fewer problems addressed 3. Up-front collaborative agenda setting 4. High interview structure that is made transparent, with topic tracking 5. Patient's perspective on illness is solicited when necessary 6. Clues are acknowledged with nonverbal or verbal empathy 7. Education is customized 8. Patient is involved in creating the plan 9. Physician is person focused, reflective, and curious 	<ol style="list-style-type: none"> 1. Relationship development variable 2. More problems addressed or fewer problems addressed in greater depth (see item 7) 3. Up-front collaborative agenda setting 4. Interview structure is made transparent, with topic tracking 5. Patient's perspective on illness is solicited 6. Clues are acknowledged with nonverbal or verbal empathy 7. More time addressing 1 or more of the following: <ol style="list-style-type: none"> a. Prevention and chronic illness care b. Underlying psychosocial issues c. Health behavior change d. Family and cultural influences 8. Educational efforts are customized to accommodate patient, family, or cultural perspective 9. Patient is involved in plan creation 10. Physician is person focused, reflective, curious, and tolerant of silence
Low-quality, inefficient communication: commonly observed, not recommended	<ol style="list-style-type: none"> 1. No rapport building 2. Few problems addressed, no patient input on agenda 3. High interview structure without process transparency or topic tracking 4. No patient perspective on illness solicited 5. No patient input on plan 6. No acknowledgment of clues 7. No family or cultural perspective 8. Physician is disease focused, nonreflective, and not curious 	<ol style="list-style-type: none"> 1. May contain excessive nonmedical discussion 2. More problems addressed from physician's agenda and by eliciting or responding to concerns raised in the middle or closing phases of the interview 3. Patient's input on agenda, illness model, or plan is dependent on patient's assertiveness 4. Interview structure is unclear with minimal process transparency or topic tracking 5. Minimal or no acknowledgment of clues 6. Enhanced (automated) educational effort by physician, not customized due to limited understanding of patient, family, or cultural perspective 7. Physician is nonreflective, not present, and intolerant of silence

Already referred to above, Mauksch and colleagues distinguished skills with *ongoing influence* from skills used *sequentially*. Four skill sets provide ongoing influence: “relationship development and maintenance, mindful practice, topic tracking, and acknowledgement of patient clues” (Mauksch et al. 2008). Three skill sets apply to sequence building: “up-front, collaborative agenda setting, understanding the patient perspective, and reaching mutual agreement on a plan. The application of the skills at the beginning of the interview creates space for the use of important skills in subsequent interview phases and reduces the chance of using these later skills in redundant or inefficient ways” (Mauksch et al. 2008). The table above (‘Contrasting efficient and inefficient interactions’) summarises Mauksch and colleagues’ model (Mauksch et al. 2008).

Seen from the perspective of ‘patient as uncertainty’ research, of course, Mauksch and colleagues’ model pays insufficient attention to the organisational and inter-professional dimensions of patient-clinician communication, its potential CALD dimensions, its negotiated care trajectory dimensions, as well as those quality and safety dimensions that might require the patient to communicate about service problems with professionals who have a quality improvement responsibility. Even Coulter in her recent book leaves only little room, besides interpersonal and population-focused knowledge, skills and attitudes, for patients to communicate with their health service about organisational and inter-institutional knowledge, skills and attitudes (Coulter 2011). Aside from ‘working across

professional boundaries', Coulter makes no mention of 'managing the complexities emerging from caring for patients on an inter-professional- and team-basis' in her summation of competencies for modern professional practice (2011, p. 146).

Our review shows that critical to effective patient-clinician communication is not merely accurate information / knowledge, and relational / interpersonal skills, but also sophisticated communication to overcome the fragmentation resulting from staff turn-over, mobility, migration, and increasingly fast-paced care (Safran et al. 2006). This latter kind of sophisticated communication, we believe, is not something that can be pre-scripted, mainly because it is likely to pertain to *emergent* issues. For that reason, such communication is contingent on clinicians developing a reflexive stance on practice, and learning to speak reflexively. Speaking reflexively, here, means speaking in a way that acknowledges one's constraints and uncertainties with regard to practice, one's obligations and accountabilities to patients, and one's responsibilities with regard to ensuring the acceptability of the outcomes of the care that is provided. Such a stance may at once enable one to anticipate short- and long-term treatment trajectory hurdles and cross these before they turn into problems (Iedema 2011).

What interventions have demonstrated improved patient clinician communication? Are these interventions sustainable and transferable in different clinical contexts?

Each research modality ('patient as object', 'patient as person', 'patient as uncertainty') proposes its own unique interventions. Predictably, 'patient as object' research sets most store by the inculcation of behaviour and communication routines that have been shown to produce accurate and comprehensive information. For example, Gladding and colleagues used a pre-printed sticker as a treatment reminder for clinicians to use prophylactic heparin in medical inpatients with congestive heart failure and severe respiratory disease (Gladding et al. 2007). The study showed an increase in use from 11-47%. The use of pre-printed stickers in medical notes reminding clinicians to discuss medical notes or offer to discuss medical notes with patients is an effective method of increasing communication between patients and clinicians.

As noted, 'patient as person' research works at the level of personal and interpersonal behaviour. Here, attention, awareness and active listening are most valued (Roter and Hall 1992). Interventions frequently involve 'problem-based' interpersonal communication training, such as role plays and personalised feedback. Finally, 'patient as uncertainty' research centres on training clinicians for complexity and uncertainty. Here, what is valued is people's ability to negotiate practical constraints while aiming to achieve the best outcomes for patients. Interventions in this domain make use of

complex scenario simulations involving teams, case studies of complex cases, and especially for targeting 'difficult conversations', and one-on-one role plays.

Diefenbach looked at current theories and interventions and examined three interventions which he labels patient-directed interventions, provider-directed interventions and multimedia interventions (Diefenbach 2009). Patient-centred interventions include Presenting, Asking, Checking, Expressing or 'PACE'. The development of PACE (Presenting, Asking, Checking, Expressing) was initiated to address the problem of patients insufficiently seeking and gathering information they need during their medical interview. Used as a patient communication training tool, Diefenbach and colleagues describe PACE as improving proficiency in: "1) presenting detailed information about how patients feel emotionally; 2) asking questions if desired information has not been provided; 3) checking their understanding of information that is given; and 4) expressing any concerns about the recommended treatment". Further investigation by Cegala & Post utilising the PACE model demonstrated (as can be expected) that "physicians provided significantly more information when communicating with high-participation patients [] compared to interacting with low-participation patients" (Cegala and Post 2009).

The Cochrane Collaboration Review of *Interventions before consultations for helping patients address their information needs* (Kinnersley et al. 2007) provides a comprehensive overview of work designed to assist patients to gather information in their healthcare consultations. This review examined "33 randomized controlled trials, from 6 countries and in a range of settings". Most interventions involved question checklists and patient coaching and most of this was administered immediately before the consultation. While there were minor improvements in patients' question asking, patient participation, patient anxiety, knowledge, satisfaction and consultation length, a meta analysis "showed small and statistically significant increases for question asking [], confidence interval [] and patient satisfaction". More analysis indicated both coaching and written materials had similar results on question asking, but "coaching produced a smaller increase in consultation length and a larger increase in patient satisfaction". If the intervention took place some time before the consultation, this did not create benefit to the patients in terms of consultation length. But "both interventions immediately before the consultation and those some time before it led to small increases in patient satisfaction". Surprisingly, there appeared to be "no clear benefits from clinician training in addition to patient interventions, although the evidence is limited".

The authors' overall conclusion is that interventions before consultations designed to help patients address their information needs within consultations produce limited benefits to patients': "[t]he effects of interventions focused on patients prior to their consultations, designed to help them address their information needs within consultations, are small. Since written interventions are likely

to be much cheaper than coaching they should be perhaps be used in preference, although they may slightly increase consultation length” (Kinnersley et al. 2007).

Lin claims that modest improvements in patient-clinician communication can be achieved when patients have access to medical records. Improved communication, adherence, patient empowerment and patient education are all outcomes when patients are provided with the opportunity to review their medical records (Lin 2012). Ross and colleagues’ research suggests that clinical trials of patients being offered to review their medical records had a take up rate of 75-95%. For those that declined enrolment it was associated with anxiety (13% cancer patients, yet <5% for general medical and obstetrics patients). Over 80% of general medical and obstetric patients appreciated the experience and would review their records again (Ross and Lin 2003).

If patients appreciate the opportunity to review medical records then the opportunity to review medical records with their clinician may further encourage dialogue, understanding of medical treatments and care/discharge plans. Studies cite that providing the patient with their medical records did not increase workloads (Baldry et al. 1986). Touqmatchi’s study following operative delivery confirms however that ‘significant deficiencies’ occur in debriefing and review with patients (Touqmatchi et al. 2011).

Provider-directed interventions include *Oncotalk*, which was developed by Back to improve communication challenges, including breaking bad news (Back et al. 2007). A curriculum was developed for oncology fellows and the material was based on patient preferences.

The *Four Habits model* has been a useful framework for “describing the appropriate physician-communication behaviours during the course of a clinical interaction and serving as a research framework for interventions promoting patient-centered communication skills among physicians” (Stein et al. 2005). The ‘Four Habits Model has been adapted for use in several other topic areas including: cultural issues in the clinical setting, staff-to-staff communication, depression management, and leadership communication. (Stein et al. 2005). The diagram below is from Stein and colleagues’ original article (Stein et al. 2005).

Table 1

THE FOUR HABITS MODEL			
HABIT	SKILLS	TECHNIQUES AND EXAMPLES	PAYOFF
Invest in the Beginning	Create rapport quickly	<ul style="list-style-type: none"> • Introduce self to everyone in the room • Refer to patient by last name and Mr. or Ms. until a relationship has been established • Acknowledge wait • Make a social comment or ask a non-medical question to put patient at ease • Convey knowledge of patient's history by commenting on prior visit or problem • Consider patient's cultural background and use appropriate eye contact and body language 	<ul style="list-style-type: none"> • Establishes a welcoming atmosphere • Allows faster access to real reason for visit • Increases diagnostic accuracy • Requires less work • Minimizes "Oh by the way..." at the end of visit • Facilitates negotiating an agenda • Decreases potential for conflict
	Elicit the patient's concerns	<ul style="list-style-type: none"> • Start with open-ended questions: <ul style="list-style-type: none"> "What would you like help with today?" "I understand that you're here for ... Could you tell me more about that?" • Speak directly with patient when using an Interpreter 	
	Plan the visit with the patient	<ul style="list-style-type: none"> • Repeat concerns back to check understanding • Let patient know what to expect: "How about if we start with talking more about ..., then I'll do an exam, and then we'll go over possible tests/ways to treat this. Sound OK?" • Prioritize when necessary: "Let's make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can't get to the other concerns, let's..." 	
Elicit the Patient's Perspective	Ask for the patient's ideas	<ul style="list-style-type: none"> • Assess patient's point of view: <ul style="list-style-type: none"> "What do you think might be causing your problem?" "What worries or concerns you most about this problem?" "What have you done to treat your illness so far?" • Ask about ideas from loved ones or from community 	<ul style="list-style-type: none"> • Respects diversity • Uncovers hidden concerns and diagnostic clues • Reveals use of alternative treatments or requests for tests • Improves diagnosis of depression and anxiety
	Elicit specific request	<ul style="list-style-type: none"> • Determine patient's goal in seeking care: "How were you hoping I could help?" 	
	Explore the impact on the patient's life	<ul style="list-style-type: none"> • Check context: "How has the illness affected your daily activities/work/family?" 	
Demonstrate Empathy	Be open to the patient's emotions	<ul style="list-style-type: none"> • Respond in a culturally appropriate manner to changes in body language and voice tone 	<ul style="list-style-type: none"> • Adds depth and meaning • Builds trust, leading to better diagnostic information and outcomes • Makes limit-setting or saying "no" easier
	Make an empathic statement	<ul style="list-style-type: none"> • Look for opportunities to use brief empathic comments: "You seem really worried." • Compliment patient on efforts to address problem 	
	Convey empathy nonverbally	<ul style="list-style-type: none"> • Use a pause, touch, or facial expression 	
Invest in the End	Deliver diagnostic information	<ul style="list-style-type: none"> • Frame diagnosis in terms of patient's original concerns 	<ul style="list-style-type: none"> • Increases potential for collaboration • Influences health outcomes • Improves adherence • Reduces return calls and visits • Encourages self care
	Provide education	<ul style="list-style-type: none"> • Explain rationale for tests and treatments • Review possible side effects and expected course of recovery • Discuss options that are consistent with patient's lifestyle, cultural values, and beliefs • Provide resources (eg written materials) in patient's preferred language when possible 	
	Involve the patient in making decisions	<ul style="list-style-type: none"> • Discuss treatment goals; express respect towards alternative healing practices • Assess patient's ability and motivation to carry out plan • Explore barriers: "What do you think we could do to help overcome any problems you might have with the treatment plan?" • Test comprehension by asking patient to repeat instructions • Set limits respectfully: "I can understand how getting that test makes sense to you. From my point of view, since the results won't help us diagnose or treat your symptoms, I suggest we consider this instead." 	
	Complete the visit	<ul style="list-style-type: none"> • Summarize visit and review next steps • Ask for additional questions: "What questions do you have?" • Assess satisfaction: "Did you get what you needed?" • Close visit in a positive way: "It's been nice meeting you. Thanks for coming in." 	
©1996, 1999, 2003, 2004 The Permanente Medical Group, Inc. Physician Education & Development Revised April, 2005 in partnership with the Kaiser Permanente Institute for Culturally Competent Care		 Clinician Patient Partnership	http://kpnet.kp.org/cpc/

Clearly, the *Four Habits* model addresses 'patient as person' concerns, without offering much guidance for how to negotiate discontinuities in care. Equally, Roter and Larson's interaction analysis system (RIAS) targets the consult (Roter and Larson 2002) without allowing scope for negotiating complexity, fragmentation, and other trajectory-of-care destabilising effects. The RIAS is a tool that measures relationality, and could be used as an intervention in so far as it analyses and allows feedback on one-on-one communication performance. Roter and Larson have used the tool in nursing, dentistry, podiatry, genetic counselling and veterinarian science exchanges

Appendices

Appendix A – Assisting clinicians to engage in more effective consultations and improve patient outcomes

Understanding Australian requirements for practising

A Code of Conduct for Doctors in Australia (2010) (Medical Board of Australia, pp. 5-8)

This excerpt taken from Good Medical Practice – A Code of Conduct for Doctors in Australia (2010)

<http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx> (Medical Board of Australia)

Note: The Code has a section on ‘Effective Communication’, which is included elsewhere in this report.

3.4 Confidentiality and privacy

Patients have a right to expect that doctors and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations. Good medical practice involves:

- 3.4.1 Treating information about patients as confidential.
- 3.4.2 Appropriately sharing information about patients for their health care, consistent with privacy law and professional guidelines about confidentiality.
- 3.4.3 Being aware that there are complex issues related to genetic information and seeking appropriate advice about disclosure of such information.

3.5 Informed consent

Informed consent is a person’s voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved. The information that doctors need to give to patients is detailed in guidelines issued by the National Health and Medical Research Council. Good medical practice involves:

- 3.5.1 Providing information to patients in a way that they can understand before asking for their consent.
- 3.5.2 Obtaining informed consent or other valid authority before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research.
- 3.5.3 Ensuring that your patients are informed about your fees and charges.
- 3.5.4 When referring a patient for investigation or treatment, advising the patient that there may be additional costs, which patients may wish to clarify before proceeding.

3.6 Children and young people

Caring for children and young people brings additional responsibilities for doctors. Good medical practice involves:

- 3.6.1 Placing the interests and wellbeing of the child or young person first.
- 3.6.2 Ensuring that you consider young people’s capacity for decision making and consent.
- 3.6.3 Ensuring that, when communicating with a child or young person, you:

- treat them with respect and listen to their views
- encourage questions and answer their questions to the best of your ability
- provide information in a way that they can understand
- recognise the role of parents and when appropriate, encourage the young person to involve their parents in decisions about their care.

3.6.4 Being alert to children and young people who may be at risk, and notifying appropriate authorities, as required by law.

3.8 Patients who may have additional needs

Some patients (including those with impaired decisionmaking capacity) have additional needs. Good medical practice in managing the care of these patients involves:

3.8.1 Paying particular attention to communication.

3.8.2 Being aware that increased advocacy may be necessary to ensure just access to health care.

3.8.3 Recognising that there may be a range of people involved in their care, such as carers, family members or a guardian, and involving them when appropriate.

3.8.4 Being aware that these patients may be at greater risk.

3.9 Relatives, carers and partners

Good medical practice involves:

3.9.1 Being considerate to relatives, carers, partners and others close to the patient, and respectful of their role in the care of the patient.

3.9.2 With appropriate consent, being responsive in providing information.

3.10 Adverse events

When adverse events occur, you have a responsibility to be open and honest in your communication with your patient, to review what has occurred and to report appropriately. When something goes wrong, good medical practice involves:

3.10.1 Recognising what has happened.

3.10.2 Acting immediately to rectify the problem, if possible, including seeking any necessary help and advice.

3.10.3 Explaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences.

3.10.4 Acknowledging any patient distress and providing appropriate support.

3.10.5 Complying with any relevant policies, procedures and reporting requirements, subject to advice from your medical indemnity insurer.

3.10.6 Reviewing adverse events and implementing changes to reduce the risk of recurrence (see Section 6).

3.10.7 Reporting adverse events to the relevant authority, as necessary (see Section 6).

3.10.8 Ensuring patients have access to information about the processes for making a complaint (for example, through the relevant health care complaints commission or medical board).

3.11 When a complaint is made

Patients who are dissatisfied have a right to complain about their care. When a complaint is made, good medical practice involves:

3.11.1 Acknowledging the patient's right to complain.

- 3.11.2 Working with the patient to resolve the issue, where possible.
- 3.11.3 Providing a prompt, open and constructive response, including an explanation and, if appropriate, an apology.
- 3.11.4 Ensuring the complaint does not adversely affect the patient's care. In some cases, it may be advisable to refer the patient to another doctor.
- 3.11.5 Complying with relevant complaints law, policies and procedures.

3.12 End-of-life care

Doctors have a vital role in assisting the community to deal with the reality of death and its consequences. In caring for patients towards the end of their life, good medical practice involves:

- 3.12.1 Taking steps to manage a patient's symptoms and concerns in a manner consistent with their values and wishes.
- 3.12.2 Providing or arranging appropriate palliative care.
- 3.12.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.
- 3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.
- 3.12.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.
- 3.12.6 Respecting different cultural practices related to death and dying.
- 3.12.7 Striving to communicate effectively with patients and their families so they are able to understand the outcomes that can and cannot be achieved.
- 3.12.8 Facilitating advance care planning.
- 3.12.9 Taking reasonable steps to ensure that support is provided to patients and their families, even when it is not possible to deliver the outcome they desire.
- 3.12.10 Communicating bad news to patients and their families in the most appropriate way and providing support for them while they deal with this information.
- 3.12.11 When your patient dies, being willing to explain, to the best of your knowledge, the circumstances of the death to appropriate members of the patient's family and carers, unless you know the patient would have objected.

Australian nurses code of conduct

<http://www.ahpra.gov.au/Search.aspx?q=nurses%20code%20of%20conduct>

National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011, pp. 5-8)

The National Safety and Quality Health Service Standards recently developed in Australia provide an overview of individual and institutional benchmarks aimed at improving health service delivery to protect the public from harm. The standards are available in a booklet format and online at

<http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/>

The ten standards are:

1. Governance for Safety and Quality in Health Service Organisations which describes the quality framework required for health service organisations to implement safe systems.
2. Partnering with Consumers which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.
3. Preventing and Controlling Healthcare Associated Infections which describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.
4. Medication Safety which describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.
5. Patient Identification and Procedure Matching which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.
6. Clinical Handover which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.
7. Blood and Blood Products which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.
8. Preventing and Managing Pressure Injuries which describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.
9. Recognising and Responding to Clinical Deterioration in Acute Health Care which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.
10. Preventing Falls and Harm from Falls which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011).

Understanding the consultation

A guide to consultation analysis

<http://www.patient.co.uk/doctor/Consultation-Analysis.htm> – very useful history overview of GP consultation practices.

Understanding patient-centred care

Patient-Centred care: Improving quality and safety through partnerships with patients and consumers (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011, p. 3)

This is a recent publication with a range of resources, guidelines, and jurisdiction requirements in Australia etc.

Patient-centredness is not an intervention *per se* but an overarching approach. ‘The importance of embedding strategies for promoting self-management within the remit of professional practice and organizational arrangement of formal systems of health care is confirmed by this study. The failure to move beyond the clarification of medical instructions to a shared decision-making ethos can be seen as an interactive combination of the traditional practices of the consultants together with the acquiescence of attenders, which were reinforced by the way in which outpatient clinics operated’ (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011).

Essence of Care 2010 – Benchmarks for Communication (Department of Health 2010)

This is a Department of Health Publication outlining communication benchmarks for clinicians in the National Health Service. The publication outlines 11 factors including indicators that are required to demonstrate best practice in these factors.

What can clinicians do better?

Interventions by Clinicians - Biopsychosocial interventions from (Del Piccolo et al. 2004)

Del Piccolo and colleagues identified a number of content behaviours in the domains and functions of the GP medical interview (using the Verona Medical Interview Classification System) including psychological, social and biomedical ones. ‘Differences in content distinguished four factors (Psychological Inquiry, Social Inquiry, Biomedical Inquiry, and Referrals to Behaviours and Functioning), whereas speech acts characterised three (Management of Patient Agenda, Patient Education/Instruction, and Patient Relationship Building).

The Inquiry factors (Psychological, Social and Biomedical) each contain a matching set of patient and physician speech acts on the same topic. The Psychological Inquiry factor consists of GPs asking

questions (closed and open) about psychological and biopsychological topics and patients responding with cues and statements on these same topics. The Social Inquiry factor is identical except the topic is “social”. The Biomedical Inquiry factor contains the same set of physician questions (closed and open) and patient cues and statements on biomedical topics. In addition, it contains physician checks for accuracy. The factor Referrals to Behaviours and Functioning contains patients’ cues and statements about the impact of their illnesses on function and about behaviour style and life episodes. There were no physician categories associated with this factor’ (Del Piccolo et al. 2004, p. 51).

Interventions by clinicians (patient centredness)

‘[T]here are simple actions that clinicians can take in this respect. These include: actively listening to and taking seriously patients’ concerns; providing a clear explanation when concerns or views differ from those of the patient; appearing to have the time to talk by making eye contact and other non-verbal behaviours such as sitting by the patient’s bed; and if acceptable to the patient, involving relatives in their care. Reassuring patients that it is okay to ask by using posters or information leaflets helps to reinforce this message’ (Doherty & Stavropoulou 2012, p. 263).

Managing different/difficult consultations (talking to elderly patients, giving bad news, managing mental health consultations)

Therapeutic Communication And Problem-Solving

Goals are often achieved through use of the *problem-solving model*:

- Identify the client’s problem
- Promote discussion of desired changes
- Discuss aspects that cannot realistically be changed and ways to cope with them more adaptively
- Discuss alternative strategies for creating changes the client desires to make
- Weigh benefits and consequences of each alternative
- Help client select an alternative
- Encourage client to implement the change
- Provide positive feedback for client’s attempts to create change
- Help client evaluate outcomes of the change and make modifications as required.

Listening To The Patient

- To listen actively is to be attentive to what client is saying, both verbally and nonverbally (Epstein, Borrell & Caterina 2000).

Several nonverbal behaviours have been designed to facilitate attentive listening

- **S** – Sit squarely facing the client
- **O** – Observe an open posture
- **L** – Lean forward toward the client
- **E** – Establish eye contact
- **R** – Relax.

Process Recordings

- Written reports of verbal interactions with clients
- A means for the nurse to behavior the content and pattern of interaction
- A learning tool for professional development
- How do I give a patient feedback

Feedback is useful when it:

- is descriptive rather than evaluative and focused on the behaviour rather than on the client
- is specific rather than general
- is directed toward behaviour that the client has the capacity to modify
- imparts information rather than offers advice.

Nontherapeutic Communication Techniques

- **Giving reassurance** – may discourage client from further expression of feelings if client believes the feelings will only be downplayed or ridiculed
- **Rejecting** – refusing to consider client's ideas or behaviour
- **Approving or disapproving** – implies that the nurse has the right to pass judgment on the "goodness" or "badness" of client's behaviour
- **Agreeing or disagreeing** – implies that the nurse has the right to pass judgment on whether client's ideas or opinions are "right" or "wrong"
- **Giving advice** – implies that the nurse knows what is best for client and that client is incapable of any self-direction
- **Probing** – pushing for answers to issues the client does not wish to discuss causes client to feel used and valued only for what is shared with the nurse

- **Defending** – to defend what client has criticized implies that client has no right to express ideas, opinions, or feelings
- **Requesting an explanation** – asking “why” implies that client must defend his or her behaviour or feelings
- **Indicating the existence of an external source of power** – encourages client to project blame for his or her thoughts or behaviors on others
- **Belittling feelings expressed** – causes client to feel insignificant or unimportant
- **Making stereotyped comments, clichés, and trite expressions** – these are meaningless in a nurse-client relationship
- **Using denial** – blocks discussion with client and avoids helping client identify and explore areas of difficulty
- **Interpreting** – results in the therapist’s telling client the meaning of his or her experience
- **Introducing an unrelated topic** – causes the nurse to take over the direction of the discussion’ (Epstein, Borrell & Caterina 2000).

Cognitive impairment – aged care consultation

- Communication activities are improved when a chronic aphasia person interacts with trained communication partners. A systematic review of the literature (Nina *et al.* 2010, December).
- Turner & Whitworth provide a review of communication partner training (Turner & Whitworth 2006).

Mental health interventions in Australia

This is a list of available resources for mental health interventions in Australia. The list is not exhaustive.

Organisation	Major programs and/or main website	e-Intervention descriptors
Australian National University - e-mental Health Research and Development (e-hub) at the Centre for Mental Health Research	www.ehub.anu.edu.au BEACON - www.beacon.anu.edu.au BluePages/BlueBoard - www.bluepages.anu.edu.au e-couch - www.ecouch.anu.edu.au MoodGYM - www.moodgym.anu.edu.au	Youth, adult, health promotion, education, prevention, treatment, self-help and human-supported e-Interventions, depression, anxiety, online portal to e-Interventions
beyondblue	www.beyondblue.org.au Youth beyondblue - www.youthbeyondblue.com/depression-and-anxiety e-mental health services listing -	Youth, adult, health promotion, education, treatment and prevention information, forum-based e-Intervention, mood disorders, anxiety disorders, e-mental health listing

Organisation	Major programs and/or main website	e-Intervention descriptors
	www.beyondblue.org.au/index.aspx?link_id=107.1203	directory
depressionServices	www.depressionservices.org.au	Adult, treatment, human-supported e-Interventions, depression, wellbeing
Inspire Foundation	www.inspire.org.au ReachOut Central - http://roc.reachout.com.au/flash/index.html	Youth, health promotion, education and prevention information, gaming and forum-based e-Interventions, depression, anxiety, wellbeing, drug and alcohol
Queensland University of Technology - School of Psychology and Counselling	OnTrack Programs - www.ontrack.org.au/Programs.do	Adult, education, prevention, treatment, self-help and human-supported e-Interventions, depression, alcohol
Swinburne University - eTherapy Unit and the National eTherapy Centre (NeTC)	www.swinburne.edu.au/lss/swinpsyche/etherapy Anxiety Online - www.anxietyonline.org.au eTherapy Unit programs - www.swinburne.edu.au/lss/swinpsyche/etherapy/programs.html	Child, adult, health promotion, education, prevention, treatment, self help and human-supported e-Interventions, anxiety disorders, autism, wellbeing, physical health, online psychological assessment, virtual clinic
University of NSW - BlackDog Institute	www.blackdoginstitute.org.au Bipolar Education Project - www.blackdoginstitute.org.au/public/resources/bipolareducationprogram.cfm	Adult, health promotion, education, prevention, treatment, self-help e-Interventions, mood disorders
University of NSW - Clinical Research Unit for Anxiety and Depression (CRUFAD)	www.crufad.org Virtual Clinic - www.virtualclinic.org.au	Adult, education, prevention, treatment, self-help and human-supported e-Interventions, depression, anxiety disorders, virtual clinic
University of Queensland (and Griffith University for BRAVE-ONLINE)	BRAVE-ONLINE - www.brave.psy.uq.edu.au Online Anxiety Prevention Project - www2.psy.uq.edu.au/~jkweb/register.html	Child/adolescent, prevention, treatment, human-supported e-Intervention, anxiety disorders, adult, prevention, self-help e-Intervention, anxiety
University of Tasmania - Faculty of Health Science	Fear drop - www.feardrop.com	Adult, treatment, self-help e-Intervention, specific phobia

American Academy on Communication in Healthcare

<http://www.aachonline.org/?page=ClinicianPatient>

This website provides access to multiple resources regarding communication in healthcare.

Communicating cancer

US Department of Health and Human Services - Patient-Centred Communication in Cancer Services -Promoting Healing and Reducing Suffering

http://outcomes.cancer.gov/areas/pcc/communication/pcc_monograph.pdf

This website includes communication resources of health service providers.

Avoiding unintended negative communication outcomes

BOX

Unintended negative suggestion in everyday clinical practice (after 15, e5, e6)

- **Causing uncertainty**

“This medication may help.”

“Let’s try this drug.”

“Try to take your meds regularly.”

- **Jargon**

“We’re wiring you up now.” (connection to the monitoring device)

“Then we’ll cut you into lots of thin slices.” (computed tomography)

“Now we’re hooking you up to the artificial nose.” (attaching an oxygen mask)

“We looked for metastases—the result was negative.”

- **Ambiguity**

“We’ll just finish you off.” (preparation for surgery)

“We’re putting you to sleep now, it’ll soon be all over.” (induction of anesthesia)

“I’ll just fetch something from the ‘poison cabinet’ (secure storage for anesthetics), then we can start.”

- **Emphasizing the negative**

“You are a high-risk patient.”

“That always hurts a lot.”

“You must strictly avoid lifting heavy objects—you don’t want to end up paralyzed.”

“Your spinal canal is very narrow—the spinal cord is being compressed.”

- **Focusing attention**

“Are you feeling nauseous?” (recovery room)

“Signal if you feel pain.” (recovery room)

- **Ineffective negation and trivialization**

“You don’t need to worry.”

“It’s just going to bleed a bit.”

Table from Hauser, Hansen & Enck (2012, p. 461)

Improving consent processes

Informed consent & shared-decision making

Regulating Informed consent

The legal principles echo ethical principles set out in health professionals' Codes of Conduct. For example:

Good Medical Practice: A Code of Conduct for Doctors in Australia

http://www.amc.org.au/images/Final_Code.pdf sets out ethical requirements in relation to informed consent (outlined above).

General Guidelines on providing information to patients (NHMRC Guidelines

The National Health and Medical Research Council's documents, General Guidelines for Medical Practitioners on Providing Information to Patients (NHMRC 2004).

Information to be given

Doctors should normally discuss the following information with their patients:

- the possible or likely nature of the illness or disease;
- the proposed approach to investigation, diagnosis and treatment:
 - what the proposed approach entails
 - the expected benefits
 - common side effects and material risks of any intervention
 - whether the intervention is conventional or experimental
 - who will undertake the intervention
- other options for investigation, diagnosis and treatment;
- the degree of uncertainty of any diagnosis arrived at;
- the degree of uncertainty about the therapeutic outcome;
- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all;
- any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention;
- the time involved; and
 - the costs involved, including out of pocket costs.

<http://www.nhmrc.gov.au/publications/synopses/e57syn.htm> and Communicating with Patients: Advice for Medical Practitioners (2004)

<http://www.nhmrc.gov.au/publications/synopses/e58syn.htm> sets out further guidance on the requirements for informed consent.

The *NHMRC Guidelines* note that a practitioner's judgment about how to convey risks will be influenced by a number of factors. These include:

- the seriousness of the patient's condition, the nature of the intervention (complex interventions require more information);
- the likelihood of harm and the degree of possible harm;
- the questions asked by the patient;
- the patient's temperament, attitude and level of understanding (including literacy and intelligence level);
- and accepted medical practice.

The *Guidelines* state that information should be provided in a form and manner which helps patients to understand the problem and the treatment options available, and which is appropriate to the patient's circumstances.

The Ethical requirements and Guidelines form the basis for Public and Private providers' policies for ensuring informed consent. See for example:

NSW Health (2004) Patient Information and Consent to Medical Treatment

http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_406.pdf

WA Health (2011) Consent to Treatment Policy for the WA Health System

<http://health.wa.gov.au/circularsnew/attachments/564.pdf>; WA Health (2011) *Consent to Treatment Policy for the Western Australian Health System 2011 Operational Directive 0324/11*

Queensland Health (2011) Informed Decision-making in Health care Policy at

<http://www.health.qld.gov.au/qhpolicy/html/index-i.asp>

ACT Health (2008) Consent to Treatment Policy (see ACT Health website) or look at

<http://health.act.gov.au/c/health?a=da&policy=-350745344&did=10107160&sid=>

A number of medical specialties also issue Guidelines. For example:

The Australian and new Zealand College of Anaesthetists

http://www.safetyandquality.health.wa.gov.au/docs/consent/ANZCA_Guidelines_PS26_2005.pdf

The Royal Australasian College of Surgeons

http://www.surgeons.org/media/8329/FES_PST_2032_P_Informed_Consent_Policy.pdf

In addition there are specific consent laws for different types of populations such as those who are dying, those who are incompetent and minors. For example see: *Consent to Medical Treatment Act 1995* (SA); see

South Australia Consent to Medical Treatment and Palliative Care Act 1995 (place the url below in your browser)

<http://www.legislation.sa.gov.au/LZ/C/A/CONSENT%20TO%20MEDICAL%20TREATMENT%20AND%20PALLIATIVE%20CARE%20ACT%201995/CURRENT/1995.26.UN.PDF>

The challenges to implementing informed consent

Despite the plethora of laws, codes of conduct, policies and guidelines regulating informed consent, emerging research suggests that as a communicative process, informed consent is variably practiced and rarely achieves the theoretical ideal (Hall, Prochazka & Fink 2012).

Arguably, the failure to appropriately communicate the information informed consent seeks to ensure a patient understands and acts upon stems from a lack of appropriate education and training of clinicians at university. In a study in 2003, Coldicott et al. (2003) conducted at one medical school in the UK found that 24% of intimate examinations of anaesthetized patients recalled by students had been undertaken without valid consent. More recently and closer to home, in a study examining medical students attitudes and behaviours in relation to informed consent, Rees & Monrouxe (2011) found that despite clear policies at each school studied (one in Australia and one in the United Kingdom) in 63% of the 112 'dilemmas associated with intimate examination' studied, students observed or performed intimate procedures without valid consent. In 85% of the cases where consent was lacking, students observed or conducted the procedure because they were instructed to do so by their medical supervisor.

One reason for this may be that clinicians, especially surgeons, are often unsure which clinical risks they should disclose and discuss with patients before treatment (Bismark et al. 2012). According to a recent study conducted by the authors, the most common justifications doctors gave for non-disclosure were that the risk was too rare to warrant discussion or the specific risk was covered by a more general risk that was discussed. The authors concluded that doctors may routinely underestimate the importance of a small set of risks that vex patients.

Hall et al. (2012) found that studies to date suggest the main factors affecting obtaining informed consent are:

- *Patient comprehension*: patients remember little of the information disclosed during the informed consent process. Their level of comprehension is often overestimated, and they have differing levels of health literacy;
- *Patient use of the information disclosed*: Informed consent presumes that patients use the information disclosed in autonomous and rational ways. This is not generally the case – there are a number of ways in which patients make decisions about their treatment ranging from a linear,

rational fashion, considering specific risks and benefits, though to other factors including instincts, the doctor's reputation and social forces surrounding the proposed treatment;

- *Patient autonomy*: another assumption surrounding informed consent is that patients exercise their autonomy independently. Studies suggest that many patients prefer to delegate or defer their decision to others, or that they prefer to make decisions collaboratively with their support systems;
- *Demands on providers*; informed consent takes time. Such time commitments are rarely recognized by administrators and managers; and
- *Clinicians meeting minimal standards*: A review of the research suggests that clinicians rarely meet even minimal standards of disclosure for the purposes of obtaining informed consent.

Addressing the challenges of shared decision making

Hall et al. (2012) argue that the way to address the deficits in implementing informed consent is to focus on a shared process of decision making – a process that emphasizes the critical importance of patient input while recognizing that it should be tailored to each patient's ability for and interest in participation, and that the clinician's contribution to the decision is important and deserving of its own respect. However, in applying this general principle, clinicians' need to determine the precise legal standard for disclosing material risks in their jurisdiction and adapt their practice accordingly (as the article is written for an international audience and laws vary from jurisdiction to jurisdiction). Support for this approach was recently articulated by an international consensus panel in the "Salzburg statement on shared decision making" which calls on clinicians, patients and policy makers to change their practices, expectations and laws to more thoroughly share the responsibility for decision making between clinician and patient (cited in Hall, Prochazka & Fink 2012). They offer the following guiding principles for implementing informed consent, developed from the literature:

- Develop a practice of involving patients in decisions. This practice should be:
 - sensitive to patients' preferences for information and their decision-making styles;
 - consistently applied to all patients;
 - designed to systematically address not only the risks of care, but also the expected benefits, relevant alternatives and what to anticipate before and after the procedure.
 - Designed to ensure:
 - the decision-making capacity of the patient or surrogate;
 - a voluntary choice free of undue influence;
 - comprehension (e.g., ask patients to repeat what they heard).
- Explicitly establish the goals of care, and prioritize them in the context of *the patient's other life goals*:
 - Commonly understood goals of care may require little clarification;
 - More explicit discussion will be needed as decisions become more complex.

- Recognize that the informed consent process serves more than one purpose. Allow the process sufficient flexibility to fulfill its varied purposes:
 - legal purpose to protect patient rights;
 - ethical purpose to support autonomous self-determination and decision-making;
 - administrative compliance to promote efficiency in health care;
 - interpersonal purpose to build the trust necessary to proceed with therapeutic intervention.
- Document the process thoroughly, using an electronic medical record whenever possible to ensure permanence. This may require more than one approach depending on your local legal, ethical and compliance standards. Techniques may include:
 - procedure-specific consent forms;
 - patient education materials (written and electronic);
 - narrative notes describing the informed consent process and the goals of care;
 - decision aids for particularly complex decisions (e.g., treatments for breast cancer).

Additional practical factors articulated by Schenker & Meisel (2011) and Schenker et al. (2011) based upon a systematic review of interventions to improve patient comprehension in informed consent for medical and surgical procedures include:

More is not always better: there is a need to synthesize and simplify complex medical information in a balanced manner that is meaningful to the patient. Thus efforts must focus on not simply what information is given, but on how such information is delivered and received. The authors advocate for the use of the “teach-back” technique in which patients repeat key elements of the discussion to demonstrate understanding and to focus all parties on what is important (Schenker & Meisel 2011):

- *Timing matters:* Often in clinical practice, the consent process occurs immediately before the procedure, i.e., after the decision to undergo the procedure has been made and the time for weighing risks and benefits has passed. Additional information is unlikely to be of value at this point, because patients are psychologically committed to undergoing the procedure. Patients may feel pressure to sign the consent form because the clinician is waiting and feel hesitant to ask questions because a delay may disrupt the flow of a busy clinic or operating suite. If patients are expected to engage in informed consent as a meaningful process of shared decision making, they must be given time for contemplation before having to decide. When the procedure in question is already a fait accompli, informed consent becomes formalistic—little more than a warning. Lengthening mandated expiration times for informed consent while instituting mechanisms to confirm that ongoing consent remains valid may help to facilitate preprocedure informed consent workflow (Schenker & Meisel 2011);
- *Technology Can Help:* Strategies that do not involve clinicians are needed to improve informed consent. Although the traditional model of informed consent emphasizes a discussion with the clinician performing the procedure, and many health care systems limit authority to obtain informed consent to this individual, in reality, clinician-led informed consent discussions are often ill-timed or ineffective. Given the constraints of clinical practice, this is not surprising. Although clinicians must establish trust and be available to answer questions, interactive, computer-based programs—possibly under the tutelage of a nurse or other educated health care professional—may be more

suitable and practical vehicles for improving patient understanding. Such programs, such as the iMedConsent software currently used by the Department of Veterans Affairs hospitals, may free up physicians to address individual patient concerns more effectively. The content of these programs can be updated to include new medical information, as deemed appropriate by expert panels, and personalized to reflect individual patient risks. Mandating the use of interactive technology can help keep costs down and reduce variation in the quality of informed consent across institutions (Schenker et al. 2011; Schenker & Meisel 2011);

- Overall, Schenker et al. (2011) state that communication interventions should be promoted, as studies have demonstrated the effectiveness of wide range of written, oral and video techniques as a mean to improve patient comprehension. Also, particular attention should be paid to implementing interventions that are accessible to patients with limited literacy. In this regard, Miller et al. (2011) found that implementing a health-literacy based informed consent process promotes patient safety and supports health providers in communicating with patients.
- In addition, and similar to Bismark et al.'s (2012) findings, Schenker et al. (2011) state that important aspects of patient understanding in informed consent are not routinely addressed and may not be well understood by clinicians. Accordingly, conceptual clarity regarding the key elements of informed consent will improve the process.

Implementing responsiveness

World Health Documentation and key websites on clinician responsiveness

- <http://www.who.int/responsiveness/en/>
- http://www.who.int/health-systems-performance/current_work/cw_responsiveness.htm
- <http://www.biomedcentral.com/1472-6963/11/325>

Accessing communication videos

Canada:

http://healthsci.queensu.ca/education/oiepe/oiepe_resources/communication_workshop_video

Accessing basic principles/tools/checklists/benchmarks

USA – IOM Patient-Clinician Communication: Basic Principles and Expectations (Paget et al. 2011)

Basic Principles

1. Mutual respect
2. Harmonized goals
3. A supportive environment
4. Appropriate decision partners
5. The right information
6. Transparency and full disclosure
7. Continuous learning

Drawing from these principles, the basic individual and mutual expectations of both patients and their clinicians can be identified. These expectations are discussed and summarized as:

17. Mutual respect

Each patient (or agent) and clinician engaged as full decision-making partners.

Communication should seek to enhance health care decision making through the exchange of information and by supporting the development of a partnership relationship— whenever possible—based on trust and focused on the whole patient. This includes considering psychosocial needs, identifying and playing to the patient’s strengths, and building on past experience to meet immediate needs and anticipate future concerns.

Respect for the special insights that each brings to solving the problem at hand.

Information exchange should be characterized by listening, inquiry, and facilitation that is both active and respectful on the part of both the patient and the clinician. Information needs include patients’ ideas, preferences, and values; living and economic contexts that may affect patients’ health or decision making; the basis and evidence for alternative choices and recommendations; and uncertainties related to the proposed course of action.

18. Harmonized goals

Common understanding of and agreement on the care plan.

Full understanding—to the extent practicable—of care options and the associated risks, benefits, and costs, as well as patient preferences and expectations, should lead to an explicit determination of the shared agenda and goals. Factors should include health, lifestyle, and economic preferences and should accommodate language or cultural differences and low health literacy.

19. A supportive environment

A nurturing and secure services environment.

The success of the care plan depends on the attention paid in the service setting to patient culture, skills, convenience, information, costs, and implementation of the care decision.

A nurturing and secure decision climate. The comfort and ability of the patient and clinician to speak openly is paramount to discussion of potentially sensitive issues inherent to many health decisions.

20. Appropriate decision partners

Clinicians, or clinician teams, with skills appropriate to patient circumstances. With increasingly complex problems, and time often a factor for any individual clinician, it is important to ensure that the patient has access to clinicians with skills appropriate to a particular encounter; that, as

indicated, alternative clinician opinions are embraced; and that provisions are made for the communication needed among all relevant clinicians.

Assurance of competence and understanding by patient or agent of the patient. Understanding by both patient and clinician is crucial to arriving at the most appropriate decision. Understanding of patient options is important: how specific they are to circumstances; the associated risks, benefits, and costs; and the needed follow-up. If indicated, an appropriate family member or similar designee should be identified to act as the patient's agent in the care process.

21. The right information

Best available information at hand, choices and trade-offs thoroughly discussed. The starting point for shared decision making should be the sharing of all necessary information. When working collaboratively to craft an appropriate care plan, clinicians should provide evidence concerning risks, benefits, values, and costs of alternative options. All options should be discussed to bring out patient preferences, goals, and concerns and to explicitly consider the impact of various options on these issues.

Presentation by patient of relevant perceptions, symptoms, personal practices.

The clinician's appreciation and understanding of patient circumstances depends on accurate sharing by the patient of perceptions, symptoms, life events, and personal practices that may have a bearing on the condition and its management.

22. Transparency and full disclosure

Candid and explicit acknowledgment to patient of limits in science and system.

A basic element of the care process is comprehensiveness and candor with respect to the limits of the evidence, delivery system constraints, and costs to the patient that may affect the range of options or the effectiveness of their delivery.

Patient openness to clinician on all relevant circumstances, preferences, medical history.

Only by understanding the patient's situation can the most appropriate care be identified.

Patient and family or agent openness in sharing all relevant health and economic circumstances, preferences, and medical history ensures that decisions are made with complete understanding of the situation at hand.

23. Continuous learning

Effective approach established for regular feedback on progress.

Identification and implementation of a system of feedback between patients and clinicians on status, progress, and challenges is integral to the development of a learning relationship that is flexible and can adapt to changing needs and situations.

Established periodicity for course assessment and alteration as necessary.

Early specification of treatment strategy, expectations, and course correction points is important for ongoing assessment of care efficacy and to alert both clinician and patient to possible need for care strategy changes.

Appendix B – Assisting patients to engage in more effective consultations and improve their outcomes

Understanding the consultation

<http://www.patient.co.uk/doctor/Consultation-Analysis.htm>

This is a useful guide to the history of the way the consultation has developed and would be useful for patients to read.

Assisting patients to self-manage their health

The Victorian Health Service in Australia has identified Integrated Chronic Disease Management (ICDM) as a priority for Primary Care Partnerships (PCP). Their goal is to work with and support agencies to enhance the provision and coordination of self-management approaches across their catchments. All PCPs have now collected information that maps the self-management approaches used in their local catchments. A statewide summary of this activity is available to be downloaded at http://www.health.vic.gov.au/pcps/publications/self_management.htm

Training for patients

‘Interventions including components directed at activation of patients, activation of practitioners by preconsultation note or questionnaire from patient, and provision of information and attention to emotion, all showed promised.....’ (Griffin et al. 2004, p. 605).

‘Patients who simply provided practitioners with written information about their needs, emotional concerns, and functional status in advance of the consultation were significantly less anxious, or showed improvement in functional status afterwards. Such written information may work as a substitute for the failure of doctors to elicit patients’ ideas, concerns, and expectations, a failure that is well documented’ (Campion 2002 in Griffin et al. 2004, pp. 605-6).

‘Health literacy began as a focused topic area and has now become a stand-alone research field throughout North America, Europe, Africa, Asia and Australia’ (Clayman et al. 2012, p. 357).

Different styles of communication - patients differ in what they want (Swenson, Zettler & Lo 2006); and ‘although a majority of patients prefer patient-centred communication, a significant proportion of patients prefer a biomedical, or “doctor-centred” style’ (Swenson, Zettler & Lo 2006, p. 200).

Incentive Based Behaviours (Community – healthy living)

- A Canadian loyalty program called BestLifeRewarded (BLR – www.bestliferewarded.com) encourages and rewards healthy living. Participants can earn points by engaging in healthy lifestyles and/or improve their health education and literacy etc. Redemption of points can be used for gym memberships, healthy cook books and the like.
- While loyalty programs have been long affiliated with consumers purchasing habits Higgins *et al.* (2011), suggest that identifying new interventions is critical to health communication applications that combine health information with behavioural strategies (Williams 2011).

Aged Care pre-visit booklets (consultation questions)

- Wetzels *et al.* (2008) cite that there is sparse evidence of aged care interventions that improve a patient's involvement in their primary care. One study undertaken by Kimberlin *et al.* (2001) uses an interview prior to a visit (undertaken by a medical student) to assist patients to identify and capture questions in a booklet that they take with them to their next visit.

Physical interventions

- The elderly with poor eye sight could potentially lead to barriers in effective communication with their Clinician and being able to read treatment plans, prescriptions and the like. Research undertaken by Day (2002) required a pre-determined criterion to be met regarding a participant's vision and referral for treatment if a problem was identified.

Community intervention (old age)

- Strategies to improve older patient- trainee interaction (Bonney, Jones & Iverson 2012) by strengthening interpersonal continuity of care with the patient's usual GP around trainee consultations, and open communication regarding having trainees involved in their care, appear key to such models.

Community (lifestyle) intervention

- Increased flu vaccination rates by provide clear leadership and using effective communication strategies (lead staff member plans flu campaign and produces a written report of practice performance and sends a personal invitation to all eligible patients and only stopping vaccination when Quality and Outcomes Framework targets are met) (Dexter *et al.* 2012).

Community – aged care continuity of care

- Analysis of the process and intervention of the two-armed study "Continuum of care for frail elderly people". The intervention contributes to early recognition of both the elderly peoples' needs of information, care and rehabilitation and of informal caregivers' need of support and

information. This study is expected to show positive effects on frail elderly peoples' health care consumption, functional abilities and satisfaction with health and social care. The intervention – including an early geriatric assessment, early family support, a case manager in the community with a multi-professional team and involvement of the elderly people and their relatives in the planning process – contributes to early recognition of the elderly peoples' needs of information, care and rehabilitation and of informal caregivers' need of support and information (Wilhelmson et al. 2011, p. 24).

- Integrated care programs are important to reduce fragmentation, improve continuity and coordination of care including case management, geriatric screening and multidimensional assessment at EDs (Wilhelmson et al. 2011).
- Three interventions from pre frail to very frail addressing the different phases of disablement. 1) Elderly persons in the risk zone, 2) The care chain: from emergency ward to own housing and 3) Palliative teams as support for staff in elderly care (Dahlin-Ivanoff Unpublished).

Community – aged care dementia support for nurses

- Assess receptive and expressive abilities in dementia patients and facilitate communication by a number of tools (The Hartford Institute for Geriatric Nursing, New York University, College of Nursing) (Zembrzuski 2013).

Community – aged care consultation interventions

- Nurse conversation strategies reflecting in encouraging resident participation levels. Strategies include clarifying, exploring, moderation, exploring (Perry et al. 2005).
- Caregivers to modify their language and context of communication when caring for Alzheimer's patients (Small & Gutman 2002).
- Willingness to participate in error reduction strategies appeared to be associated with having higher education (the authors cite Abbate et al. 2008; Davis et al., 2008; Dowell et al. 2005; Lozowski, Chesler, & Chesney 1993; Murray et al., 2004; Schwappach & Wernli 2010c). Other studies failed to confirm education as a factor increasing willingness and ability (the authors cite Cromheecke et al. 2000; Menéndez-Jándula et al. 2005; Schwappach 2008; Watt et al. 2009)' (Doherty & Stavropoulou 2012, p. 259).
- Also severity of illness 'reduced patients' ability to participate actively in the reduction of error, often these factors resulted in people's exclusion from participation in the study' (Doherty & Stavropoulou 2012, p. 259).

Community Education Intervention (Tran et al. 2004)

Ashton et al. (2003) research suggests that different racial and ethnic groups in the community use medical services (diagnostic and preventative) at different rates. The difference is largely due to difficulties in communicating.

As a result of the above finding, the Houston Center for Quality of Care and Utilization Studies designed a communication intervention to improve the patient-clinician interaction. A patient-centered community education intervention, the How to Talk to Your Doctor (HTTTYD) program was developed in the format of a two-hour teaching forum (Tran et al. 2004).

The forum pro-actively empowers patients to ask the right question and be their own best health advocates. It also provides the patient with the necessary communication skills so that optimal medical care is provided.

The program is structured around three central premises: ' (1) patients who are active communicators achieve better health outcomes; (2) it is less resource-intensive to effectuate change in a patient's communication style than in a physician's; and (3) ethnically diverse populations often have a more pronounced need for effective communication interventions'.

There are four main learning objectives: by using flip charts the participants can shout out their communication difficulties experienced creating a lively discussion, the participants look at different communication styles and identify good communication strategies, the participants then learn how to use those communication styles and the fourth objective is role playing.

At the end of the forum, the participants are given a 20-page guidebook (with illustrations) outlining the learning objectives in multiple languages.

The intervention was run across seven sites and it was found that confidence levels in all seven sites were similar despite the diverse audience. Participant confidence increased post intervention independently of the site and/ or facilitators making one the program strengths being it's adaptability to a diverse audience.

- The Right Question project - Mental Health study (Alegría et al. 2008) provided teaching across three individual sessions that would help patients 'identify questions that would help them consider their role, process and reasons behind a decision; and empowerment strategies to better manage their care'. This resulted in patients being twice as likely to be retained in treatment and three times are likely to schedule one visit in the next six months.

- Steinwach et al.'s (2011) intervention's to increase patient question asking regarding evidence based treatment options and undertaking interventions in the waiting room all contributed to increased communication between patient and clinician.
- Patients who are resistant to asking questions or lack confidence to ask could use the web based tools 'YourSchizophreniaCare', that simulates (using actors) treatment concerns. Showing an educational video prior to a routine follow up appointment increases dialogue and another suggested intervention.
- Steinwachs et al. (2011) suggest that there are proportionally more engagements by patients to seek information and be involved in disclosure when there is patient-centered communication as opposed to when conversations are biomedically focused and centered on disease management.
- Delivering a communication education intervention rather than a clinician education intervention broadens the scope of the population who can benefit from the program. Many support groups and various patient lead forums/conferences would benefit from specific communication theory based programs. It would promote improved patient- clinician communication and lead a change in culture, which is community/ patient lead.

New Zealand – Health passports: A Health Passport is a booklet patients can carry with them when they go to hospital or when they use other health and disability services, such as their GP or a new carer. It contains the information they want people to know about how to communicate with them and support them. The Health and Disability Commissioner is working with hospitals around the country to introduce the Health Passport <http://www.health.govt.nz/yourhealth-topics/health-care-services/health-passport>

New Zealand – Cultural competency online training tool: The free online training tool – the Foundation Course in Cultural Competency – provides a basic understanding of cultural competency and health literacy. The multimedia, interactive course is a voluntary programme and has three modules. They provide an understanding of New Zealand's culturally diverse population, with an in-depth emphasis on Māori culture. The modules also focus on the importance of health literacy and how health professionals can make a difference to outcomes. Each training module has related videos, video transcripts, additional reading resources and library references <http://www.health.govt.nz/news-media/news-items/cultural-competency-training-tool-available>

Health Literacy Report from New Zealand

Health Literacy and Medication Safety Environmental scan of tools, resources, systems, repositories, processes and personnel (New Zealand Guidelines Group 2011). This report researched the ways

health providers and other organisations in New Zealand were working towards improving people's understanding of their health and the services available to them. They discovered that while more information was being written in plain language, this did not go far enough to reach people with low health literacy. The report said the most effective way of improving understanding was to change the way health professionals communicate with patients. For example the following were considered successful:

- providing education courses for community and Māori health workers who would then be able to share information with their clients;
- improving communication between pharmacists and their patients to ensure patients understood why their medication had been prescribed and how it should be taken.

To improve health literacy the report recommended a number of different approaches, including additional training for health workers on open questioning styles to double check patients understood the information they had been given <http://www.hqsc.govt.nz/our-programmes/consumer-engagement/projects/health-literacy/>

Reducing medication errors

NZ health Quality and Safety Commission programs on improving communication around medication error – Take your medicine safely pamphlet: <http://www.hqsc.govt.nz/our-programmes/medication-safety/publications-and-resources/publication/516/>

UK – NPSA 'Ask about medicines' week. A MORI poll in 2003 showed that up to 50% of people in the UK do not take their medicines as prescribed. Almost one in three people say they do not know enough about the potential side effects of medicines. Knowing what questions to ask is key to prompting discussion and increasing awareness around medication use. To facilitate this process the NPSA has sponsored an 'ask about medicines' card in a shared effort to encourage patients and health professionals to discuss their medication. The card features five key questions and five top tips to help patients learn more about the medicines they are prescribed.

Playing a bigger part in consultations – checklists for involvement

Noted below are questions that may stimulate thought, conversation, and innovative approaches to their successful implementation in various settings and circumstances. In the discussion paper by Paget *et al.* (2011) they pose the following questions:

For clinicians and health care organizations

How are we doing now with respect to the principles and expectations?

For which of them is our current culture and practice pattern most challenging?

What initial steps might be good starting points for systems changes necessary?

How can we enlist patients and staff working together to help develop and lead?

How can we take advantage of initiative and help from professional societies?

What community tools or resources might be adaptable for us?

How can we measure the impact for feedback to patients and staff on the results?

For patients, consumers, and advocates

What makes a clinician a good listener?

What should we expect in conversations about health care with clinicians?

How can available care and condition-specific materials be more easily understandable?

Are there helpful ways to judge a care setting's support of effective communication?

What should we expect from clinicians to help interpret medical evidence?

The Paget *et al.* (2011) discussion paper is available at:

<http://iom.edu/Activities/Quality/~media/Files/Activity%20Files/Quality/VSRT/PCCwLogos.pdf>

UK DOH – Essence of Care – Benchmarks for Communication UK DOH 2010

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119973.pdf

This resource sets out Best Practice General factors as:

- Interpersonal skills
- Opportunity for communication
- Assessment of communication needs
- Information sharing
- Resources to aid communication and understanding
- Identification and assessment of principal carer
- Empowerment to perform role
- Co-ordination of care
- Empowerment to communicate needs
- Valuing people's and carers' expertise and contribution
- People's and/or carers' education needs

In the resource there are indicators for each factor.

AHRQ – "Questions are the Answer" <http://www.ahrq.gov/questions>

AHRQ – "Questions are the Answer," a new initiative from the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) and the Ad Council, encourages clinicians and patients to engage in effective two-way communication to ensure safer care and better health outcomes. An original series of new videos on the AHRQ Web site, <http://www.ahrq.gov/questions>, features real patients and clinicians discussing the importance of asking questions and sharing information. The Web site also features new resources to help patients be prepared before, during, and after their medical appointments. The resources include:

An interactive "Question Builder" tool that enables patients to create, prioritize, and print a personalized list of questions based on their health condition.

A brochure, titled "Be More Involved in Your Health Care: Tips for Patients," that offers helpful suggestions to follow before, during, and after a medical visit.

Notepads to help patients prioritize the top three questions they wish to address during their appointment <http://www.ahrq.gov/research/nov11/1111RA19.htm>

Patient and Clinician Videos

<http://www.ahrq.gov/questions/pcvideos.htm>

<http://www.youtube.com/watch?v=mOsM6fTMrNQ> (video on biopharma)

My Questions for This Visit

<http://www.ahrq.gov/consumer/questionscard.htm>

Question Builder

<http://www.ahrq.gov/questions/qb/>

Be More Involved in Your Health Care: Tips for Patients and Families

<http://www.ahrq.gov/consumer/beinvolved.htm>

Appendix C – Assisting institutions to improve patient-clinician consultations, continuity of care and improve patient outcomes

Understanding Australian benchmarks for health care

National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011)

The National Safety and Quality Health Service Standards recently developed in Australia provide an overview of individual and institutional benchmarks aimed at improving health service delivery to protect the public from harm. The standards are available in a booklet format and online at <http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/>

The ten standards are (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011, p. 3):

1. Governance for Safety and Quality in Health Service Organisations which describes the quality framework required for health service organisations to implement safe systems.
2. Partnering with Consumers which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.
3. Preventing and Controlling Healthcare Associated Infections which describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.
4. Medication Safety which describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.
5. Patient Identification and Procedure Matching which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.
6. Clinical Handover which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.
7. Blood and Blood Products which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.
8. Preventing and Managing Pressure Injuries which describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.

9. Recognising and Responding to Clinical Deterioration in Acute Health Care which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.
10. Preventing Falls and Harm from Falls which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.

Institutional interventions

Provider interventions, e.g. in the ED, take on the disciplinary territories, e.g. doctor led triage, rounding person, task redefinition; spatial changes (material arrangements), patients to stay in one place, move from mobility to stationary - more control; change divisions of labour; flexible tasks (role definitions); change training of junior doctors; technological constraints; commitment by staff to the coherence of care, video reflexivity, positioning from task to relation.

Pharmacist interventions

Tan et al. (2012) examined the under-utilisation of the pharmacist in reducing medication errors in Australia. The study is set against a background of Australian collaborative general practitioner-pharmacist services, which the authors contend are limited and underused. Tan et al. suggest that the co-location of pharmacists in GP clinics will improve the quality use of medicines by patients and clinicians.

Eggs in one basket - breaking down the barriers

Patient centred care revolves around the inclusion of patients and family members when making decisions about their care and treatment options. Further to this however, family members are made up of a diverse mix of individuals and specific communication styles are required.

Depending on their role in the family there is a requirement to further develop patient centred care to be more specific in nature to the role of the family member rather than a generic communication style that covers the whole of the family. General sweeping communication for the whole family is commendable however more flexible communication styles and further dissertation is required.

Garfield (2006) prescribes that communication and, 'comprehensive involvement of both parents is ideal for the child's well-being'. The role of the father however and how they are communicated with in the healthcare setting is often different to that of the mother.

The negative experiences that were mentioned by the fathers included: 'feeling viewed suspiciously by health care staff, being perceived as having a lesser emotional bond with their child than the mother, and the perception that they were receiving a lower quality of service compared with the

mother'. Coupled with the responsibilities of work and relationships with the mother and possibly extended family members such as grandparents, Garfield (2006) suggests that more creative ways to engage fathers in the healthcare system is required.

Moore (2004), also suggests that, 'Providers should focus on encouraging greater involvement early, especially for younger fathers and those with older children' to improve a child's healthcare.

Accessing case studies – institutional care

Case Study 1

An 81-year old lady with close family support was admitted to hospital with internal bleeding (as a result of taking the wrong medications). The patient had a stent for her heart inserted at the age of 80 and was on heart medication. Upon admittance, the family noticed deterioration in their mother's condition including increased confusion. The patient couldn't tell her family what procedure she was having the next day. The family made an appointment to see the doctor the next morning as the nurses referred all questions to the consulting doctor but he came in early and left.

The patient told her family that she had a dreadful night and that they put her on an oxygen mask, she was having breathing trouble, they gave her injections and she was in dreadful pain. When the family enquired with the nurses if the patient was still receiving their heart medication, the nurse told the family 'that she wasn't a pharmacologist'.

After writing to the hospital upon discharge the Director of the hospital responded that the patient was able to comprehend and that they didn't need to confer with anyone else. The family took the patient back to their regular Cardiologist as the patient couldn't walk 10 paces without being out of breathe and the Cardiologist said you have had a heart attack. The Cardiologist advised that the patient would have been in considerable pain and they pinpointed the attack to the time spent in hospital. This patient then went onto having a triple heart by-pass at 81 ½ years of age.

The family when attending their solicitors regarding another matter asked if there was anything they could do to ensure they were communicated with in regards to their mother's medical condition and decisions. It was then determined to appoint the daughter as an Enduring Guardian on top of the existing Power of Attorney duties.

Improving institutional responsiveness

Hospital settings can be stressful places and we need to provide positive distractions for Patients and Staff. Anxieties regarding walking into a particular unit and what lies behind that door are very real. By shutting down feelings, which then in turn inhibits communication we need to explore other

hospital settings that are more conducive to providing a more relaxed environment to openly discuss care plans or questions that both patients, their families and staff may have face to face.

Four key factors, which if applied in the design of a healthcare environment, can measurably improve patient outcomes (Smith 2010). They include:

- Reduce or eliminate environmental stressors
- Provide positive distractions
- Enable social support
- Give a sense of control.

Positive Distractions

Labyrinth Gardens

Learning can occur outside conference rooms and lecture theatres. Labyrinth gardens date back to medieval times and are a special type of maze with only one path in and out. 'They play an important role in healthcare by helping patients overcome anxieties associated with treatment or illness and also it provides the family with a time to reflect and relax'. In Australia there is only 1 hospital with a Labyrinth garden (The Children's Hospital at Westmead NSW opened 23 June 2012) but there over 200 Labyrinth gardens in hospitals around the USA.

As described in the brochure The Labyrinth at The Children's Hospital at Westmead, there are five paths through the Labyrinth:

- 'The Path of Silence-Quieten your mind and open your heart to the silence of the walk
- The Path of Image-Follow the images or dreams that arise in your imagination
- The path of Memory-Walk the sacred path in the memory of a friends or family member
- The Path of Prayer-Recite a prayer, a bible verse or a line of poetry
- The Path of Questioning-Concentrate on a question. Do not expect an answer. Simply be content to explore the possibilities'.

Labyrinth gardens are also usually surrounded by bench seating. The garden can be used in the following ways to encourage communication between clinicians and patients:

- Using it as a place to escape the sterile/ clinical feel of the hospital and provide a more relaxed environment to discuss care plan notes or methods of treatment - a breath of fresh air.
- By taking the patient outside of the Hospital unit then the patient is on more neutral territory and the power equilibrium is restored so that the patient and their family is more relaxed/inclined to ask more questions.

- Typically the bedside or an interview room is very small, cramped, uninviting, beige and non-confidential. By using the Labyrinth garden you are opening up the feelings of confinement and for families with children, you are providing an avenue to have a more relaxed discussion.
- Patients and their families have an expectation that bad news is delivered when they're called into another room by the clinician. Sometimes bad news isn't delivered but the expectation is always unsettling. By changing the environment, you alleviate anxieties for both staff and patients by introducing a healthcare setting that is more relaxing for all involved.
- For some people the trauma of their situation is too difficult to re-enter the unit where they were a patient or where their loved one was treated. So, by providing an alternative to review notes face to face and ask questions in a far less intimidating environment is very beneficial.

In Amsterdam, a publication called *Literature Research on influences of the Hospital Environment on Patient Outcomes* promotes that, '[p]eople who are feeling comfortable and stress-free, have more opportunities to use their self-healing power. All energy can be used for the healing process. Therefore, fewer complications will occur and the healing process will develop faster'.

Davidson et al. (2007), also recommended that 'early and repeated care conferencing to reduce family stress and improve consistency in communication' is required. If the patient and their families go home with a more relaxed outlook on how clinicians can communicate with them and that alternatives are available (i.e. they can go out to the garden) then if further medical complications arise, they will be more inclined to return to that same hospital/healthcare facility. The alternative would be for the patient to not seek medical advice, to travel to another facility further from home, for symptoms to continue or visit another healthcare who then needs to invest in obtaining medical history and putting the patient through more x-rays etc.

Improving hospital procedures

Peak Advisory Councils

The prevalence of Consumers being invited to participate in Advisory Councils has gained momentum over the last 5-10 years. Advisory Councils provide formal opportunities for a patient's or a family's perspectives to be included when clinicians are considering operational planning, policies, communication, developments and improvement at a particular facility.

Consumer representation has provided additional insight into how the unit or facility can improve communication between clinician and patient by means of information booklets, DVD orientation videos, libraries and the like. Advisory Councils are a peak body to provide a pathway where patients and clinicians can co-partner and work together to ensure that effective and instrumental patient

centred care is achieved and to ensure that their input is put on the table for evaluation. Newsletters about the Unit including tips, patient and staff profiles etc. are produced (often by a consumer) and suggestions are discussed about how to improve facilities e.g. review of plans are put on the table. This is an effective instrument to encourage dialogue where ideas can be put forward and discussed formally so that more effective communication and strategies can be implemented in the future.

There are currently no registers of the number of Advisory Councils in Australia however, as a guide approximately 5% of the total hospital units engage with patients through Advisory Councils. The Advisory Councils cover main focus units such on Oncology, Rehab, Neonates, Spina Bifida but there are also other Councils that are generic in nature and are facilitated online e.g. Families Online (The Children's Hospital at Westmead) who has a membership of approximately 40. The majority of the Advisory Councils have been established for 10 years or less so their level of interaction is still quite new and evolving. Advisory Councils are only implemented with the staffs support.

Typically, terms of reference for an advisory Council may include:

- What does the Advisory Council do?
- How do we do it?
- What are the responsibilities of members?
- What are the responsibilities of staff members?
- What are the responsibilities of the Secretariat?
- Project leaders
- How do we communicate with each other?
- How do we recruit new members?
- Concerns or issues
- How long do memberships last?
- How can a member stop being a member?

The success of the Advisory Councils can be determined by not only the patient/family membership but by the involvement and buy in from the executive and board members. While clinicians can represent the hospital and present ideas the buy in of executive and board member staff is critical to effecting real change in approaches. Arms length involvement and reporting back to executives and board members is still fostering an idea of tokenism and true buy in will only affect outcomes if genuine involvement is achieved.

Smith's (1978) research indicates that when management provided high one on one interaction with employees that the industry safety standards were improved and they experienced low accident rates. Conversely the opposite occurred when the one on one interaction was not experienced and

resulted in higher accident rates. This industry research translates across many sectors, health being one of them and there are many lessons to be learnt indicating that when management become involved, it does affect safety standards and rates of compliance. Flin & Yule go on to say that communication is, 'vital to maintaining safety performance' (2004, p. ii49) and that management with high accident rates relied on committees for communication rather than becoming personally involved.

The 'Patient Centred Care Improvement Guide' (Frampton et al. 2008) has recommended that we take it one step further and have the board member participate in patient rounds or at the very least turn up one hour to the Advisory Council meetings and get to know the patients stories and their background, ideas and suggestions. Board members should take an interest in the consumers and at the very least know them by name.

Face to face relationships are pinnacle in developing improved communication. Strategies for staff such as breakfast/ working lunches where a small group are selected once a month to discuss ideas should be harnessed and facilitated by board members. Anniversary luncheons where staff are invited on their Anniversary of their commencement date to have lunch with the board members/ CEO should be encouraged to present ideas and issues and have direct contact with someone in authority. Board members should also attend Birthdays/ Anniversaries of Advisory Councils to improve communication and be willing participants in openings of new gardens etc. that are supported by consumers. Planetree gives the example of a quarterly breakfast with a randomly selected small group of employees at the Fauquier Health System's 'Breakfast with the President' program.

Understanding Advanced Directives of Care using Enduring Guardianship

The Guardianship Act 1987 (NSW) makes it possible for a person to appoint an Enduring Guardian. An Enduring Guardianship (EG) is a 'substitute decision maker of your choice with legal authority to make health and lifestyle decisions on your behalf if needed. The type of decisions might include where you may live, the services you need, what health care you receive, or consenting to medical and dental treatment on your behalf' (as cited on Public guardian website). Most states have Enduring Guardianship laws however Tasmania is the only jurisdiction in Australia to require that Enduring Guardianships are registered with Advanced care directives for them to be considered valid.

Very low levels of formal advance directives were found in residential care and only 2.8% had Enduring Guardianship (Nair et al. 2008). In this study it reported that 65% had a 'person responsible' recorded to make decisions for them while in 13% of cases, there was 'staff consensus' as to the

optimal care for the patient. However, in 10.6% there was no clear process for medical decision making identified. Organ donation registers are referred to by clinicians when seeking clarification regarding the patient's wishes regarding organ donation however Advanced Care Directives are not readily available. Lack of information in relation to Advanced Care Directives for clinicians to refer to further impedes the communication channels between Patient, clinicians and their families.

The Respecting Patient Choices program chose the Royal Hobart Hospital (Tasmania) as a pilot site in 2006/7 for reviewing the take up of examples and what insights they can ascertain as far as future developments in advanced care planning. Since the EG Act was established some 15 years ago, only 2% of the Tasmanian population had EGs however further media promotions were suggested which did increase take up rates. For those that did take up EGs 95% chose a relative/ friend as their Enduring Guardian and 47% provided a statement regarding end of life decisions, which also included preferences for palliative care. The research cited that predominantly older retired persons took up EGs and their primary concern was with providing instructions in relation to palliative care. It was therefore recommended to not only have an Enduring Guardianship but to attach an Advanced Directive of Care form as well.

The elderly patients in the healthcare system are an 'at risk group' (Fu, Liu & Christensen 2004) who need effective communication strategies to guide and help them. Enduring Guardianship would deliver a communication tool for the elderly, their family and their Clinician to provide clear directions as to their wishes in regards to health and lifestyle choices. It also provides the family an avenue to seek clarification of medical care should they require it.

Communicating with the family and providing options

Information to make financial decision on someone's behalf as Power of Attorney is widely known in the community. However the formal process to become an Enduring Guardian to make medical or lifestyle decisions on someone's behalf is relatively unknown.

To communicate and provide literature to families (especially those in aged care facilities or with disabilities) to plan for their loved ones future care is essential to promote increased communication between patient/families and their clinicians. The promotion of Enduring guardianship also ensures that the patient's family have the right to receive information regarding their loved ones treatment and to partner with the clinicians to provide appropriate care in the future. If there is a clear health plan then the patient's safety and quality is not compromised.

http://www.guardianship.tas.gov.au/_data/assets/pdf_file/0003/79221/Enduring_Guardian_Infosheet_07.pdf

http://www.publicguardian.lawlink.nsw.gov.au/publicguardian/pg_contactus.html

http://www.publicguardian.tas.gov.au/_data/assets/pdf_file/0007/181672/EG_Research_Report_Dec_2010.pdf

Appendix D: A brief history of patient-clinician communication

The way that medicine defines disease plays an important role in how clinicians position their patients, and this bears on how they communicate with their patients. It is significant therefore to consider changes in how medicine has defined disease, how the medical definition of disease predominates in how health care is structured and provided, and, concomitantly, how health care and health care professionals position patients.

To begin, the nineteenth century saw the ‘birth of medicine’. According to Foucault, this event was marked by the emergence of a new ‘medical gaze’ (Foucault 1973). This gaze emerged when those studying anatomy (i.e. dissecting corpses) and those experimenting with herbs and drugs combined their skills and resources. This synergy produced a new medicine, with its practitioners turning their attention to the treatment of lesions affecting living bodies.

In large part because of its origin in the dissection of corpses, and due to its concern with pathological lesions, medical practice in its earliest incarnations tended to treat patients as ‘inert anatomical creatures’ (Armstrong 2002). What the patient had to say was largely immaterial, and what the clinician might see reason to communicate remained restricted to their technical knowledge about the hidden diseases of the body. While doctors had already started to practise ‘bedside medicine’ (Foucault 1973), the nineteenth century saw a multiplication of clinical investigations into patients’ hidden lesions, including X-rays, pathology reports, and blood tests. Together, these investigative techniques lent the newly emerging medicine special power and significance, a process that was further aided by its institutionalisation into the modern hospital and the academy (Abel-Smith 1964; Porter 1999). (Szasz & Hollender 1987 [1956])

Early medicine’s investigations however confirmed the patient and therefore the patient’s body as a discrete entity and a static object, as yet unaffected by personal idiosyncrasies, social influences, or cultural confounders. The patient’s object status was reinforced by medical diagnosis relying predominantly on the identification of body signs, established through inspection (scanning the body with the eye), palpation (laying on hands to identify abnormalities), percussion (to identify different densities of the lesion) and auscultation (listening to internal processes) (Armstrong 2002).

Confirming the patient’s object status was that “the clinical teaching manuals that were published in the nineteenth and early twentieth centuries reflected the dominance of [such] signs in medical diagnosis, barely mentioning the process of obtaining reports of symptoms (‘the medial history’) from the patient” (Armstrong 2002, p. 59). In sum, medical science proceeded as if sufficient unto itself, positioning the patient as **body object**. Patient-physician communication was quite arbitrary to the success of medical diagnosis and its treatment of the body. For their part, nurses were to complement medical-technical care, inviting besides nurse submission to and militant execution of medical authority and doctors’ decisions, inter-professional conflict that had considerable

detrimental consequences for patient-clinician communication (Thompson & Stewart 2007; Wicks 1999).

The advent of the twentieth century, Armstrong states, saw disease being 'released from its prison of the body' (Armstrong 2002, p. 149). The intensification of social mobility and techno-cultural change contributed to clinicians' realisation that patients interact with neighbouring bodies and therefore likely be subject to forces other than intrinsic anatomical and bio-physiological ones. This realisation mitigated medicine's view that patients were body objects, and it altered its view that afflictions were fully explainable with reference to body-internal lesions alone.

Around the 1930s and 1940s, this development culminated in patients being formally inaugurated as important and credible source of information. Indeed, patients could help doctors identify and explain the signs, symptoms and progress of their disease. Patients thus gained a new role as informants about the world external to them and about how it impacted on them, their behaviour, and their bodies. Perhaps as much due to general societal change as to developments in medicine proper, patients were now allowed, and increasingly expected, to reveal bodily and extra-bodily clues as to the nature and causes of their disease.

Early on, this recognition of the patient as speaking person was counterbalanced as the clinician was advised to ensure that they maintain an objective view of the patient's body. To achieve this, they were to practise 'detached concern' (Lief & Fox 1963). Here, the principal priority was scientific-medical accuracy, and this accuracy was best assured when the clinician kept their distance from the patient as person. It was left to nursing to attend to the subjective needs of the patient (Radcliffe 2000; Stein 1967).

During and after the second-world war, another important shift occurred. As patients were increasingly expected to report on their disease and their specific life world circumstances, realisation grew among medical clinicians in particular that the patient's disease, at least in part, might be an expression of the individual's personal lifestyle and unique psychology. With this originated a need to understand the patient, their motivations, and their behaviour, necessitating a new approach to clinician-patient communication:

In the new schema, the old 'personal history', which had been more concerned with the patient's physical environment and habits, was replaced by an occupational history, a social history, which enquired after such personal experiences as worries, adjustments and disappointments, and a marital history. (Armstrong 2002: 62)

Here, then, we witness the birth of the 'psycho-social' patient. This more complicated view of the patient was most evident in Michael Balint's work. During the 1950s and 1960s in the UK, Balint began to promote an approach to patient-clinician communication that emphasises the

psychological dimension of their relationship as being at the heart of the health care process. He emphasised the importance of the clinician not just enabling the patient to speak, but also communicating in a reflexive manner, assessing their own responses and their effects.

To a large degree, the rise to prominence of the psycho-social patient occurred as a counterpoint to overwhelming and taken-as-given doctor paternalism, itself buttressed by nurse maternalism (Wilson-Barnett 1986). As Ubel explains in a rather medicine-centred book:

In the pre-revolutionary days of physician paternalism, [a prostate cancer] patient's urologist would have told him that he had a small growth in his prostate and needed surgery. Or, if the surgeon felt that the patient was too frail to benefit from the surgery, he would have withheld information about the tumour and monitored it without the patient's knowledge. As the word *paternalism* suggests, the old days were modelled on parent-child relationships, with the doctor acting as the all-powerful and knowing parent, benevolently protecting the child-like patient from worry and responsibility. If the patient were deemed too fragile for bad news, the doctor would turn to euphemism or out-and-out evasion. The tumour would be described as 'an X-ray shadow' or 'an infection'. In those days, doctors made decisions and patients were expected to follow orders. (Ubel 2012, p. 3)

At the time, researchers began to ask questions however about how health care processes and relationships were enacted, inquiring into the ethical limitations of accepted practice. For example, they queried why patients (or their relatives) were not being informed about their impending death (Glaser & Strauss 1965). Glaser and Strauss reassessed the degree to which clinicians speak openly with their patients some years later, noting that limited progress towards information sharing had been achieved (Glaser & Strauss 1968).

For their part, Balint and colleagues distinguished between 'illness-centred' medicine, which tended towards paternalism and maternalism, and 'person-centred' medicine, which was defined as paying increasing attention to patients' unique needs, feelings and preferences, and necessitating unique responses on the part of the caring clinicians (Balint et al. 1970). Balint's distinction was the origin of a range of 'patient-centred' communication practices and research that seek to confirm and maintain the centrality of the patient and their concerns to patient-clinician communication. Among these emerging practices we find informed consent, shared decision-making, patient choice, and patient involvement.

Collectively, these latter notions reference clinician *responsiveness*, a skill increasingly expected to be displayed on the part of the clinician when dealing with patients. Of course, responsiveness became an important concern for health services generally during the 1980s and 1990s. This concern culminated in the publication in 2000 of the WHO report on this issue (see:

<http://www.who.int/responsiveness/en/>). The WHO's interest in service responsiveness paralleled growing interest around the western world in health care professionals' and services' responsive attitude towards their patients. This attitude was promoted to counter-balance the prevailing

scientific, supply-driven and mostly disease-control orientation on the part of most clinicians and services towards their patients with care and communication that were more attuned to patients' 'life world' (Mishler 1984). This responsiveness and attentiveness were to ensure that patients' personal needs, preferences and desires were acknowledged and accommodated in their care, rendering care more congenial with the patient and their circumstances, and thus leading to better clinical outcomes.

Now, in the new century, we are witnessing yet another modality of patient-clinician communication and research. This modality results from patient-clinician communication being increasingly subject to a *multiplier effect* brought about by factors referred to earlier: the multiplication of diseases and attendant multi-morbidity particularly for patients with chronic diseases; the rising number of chronic disease patients *per se*; the increasing specialisation and technologisation of care (providing clinicians and patients with more options for testing and treating); the intensification of social and linguistic difference due to migration and mobility, and therefore clinicians and services having to accommodate a broader range of service users (including those with low levels of health literacy due to migration and those with very high levels of literacy and access to health related information resulting in rising levels of social-professional expectation), and the rise in the number of stakeholders claiming a say in the dynamics of care provision (including the bureaucracy, policy makers, the media, and so forth).

Collectively, these factors produce situations where patients and clinicians are having to communicate more frequently about a greater number of tragic circumstances and 'wicked problems'. Often, tragic circumstances and wicked problems become evident when we become aware of patients needing or desiring a customisation of treatment options to suit their personal and constantly developing circumstances, and these claims are made on clinicians and services that are not always in a position to provide such care, necessitating delicate conversations and negotiations.

These dilemmas become particularly visible in chronic care situations, with patients needing ongoing and uniquely tailored care. End-of-life care is another domain where increasingly complex communication needs to take place, navigating the rising capability of technological medicine and the increasingly unpredictable ethical implications of such care (Kearney 2000). Especially in intensive care, dying may require curative options to be balanced against and at times harnessed to palliative care options, leading to very complex conversations (Seymour 2000, 2001). This problem is articulated with some urgency in a recent report by Leadbeater and Garber, titled *Dying for Change*:

Unless we can devise ways to get people to talk about how they want to live while they are dying, our efforts to improve services will be like groping in the dark. (Leadbeater & Garber 2010)

By the same token, complex ethical dilemmas flow forth from the increasingly detailed information available to pregnant mothers about their fetuses, their birthing conditions, their neonatal states, genetic tests, and so forth. These kinds of situations can only be negotiated by deploying highly sophisticated and deeply complex kinds of communication (Ubel 2012). Heralding the advent of the complex patient, with the patient representing considerable **uncertainty**, this modality of patient-clinician communication places extraordinary demands on clinicians, besides responsiveness and relationship building.

Here, patients are to be granted room to talk and display their insights and opinions. This is particularly the case now that patients' lay knowledge is expanding to encompass aspects of expert professional knowledge (Wilcox 2010). In essence, these developments oblige clinicians and patients to navigate through considerable degrees of social, cultural, economic, educational, health literacy and linguistic difference. This further means that patient-clinician communication is increasingly likely to depart from prefigured models of communication and pre-established genre scripts, and unfold in situationally unique ways. Consider the negotiation of an end-of-life pathway (Sorensen & Iedema 2006), for example, or the disclosure of an incident (Iedema & Allen 2012) – both scenarios where, at best, general resources and strategies can be provided, but where step-by-step procedures are likely to fall short.

We point to this complexity and uncertainty as an emerging dimension of communication, notwithstanding the large numbers of patients who still prefer authoritative clinicians using illness-centred, medicine-focused and paternalistic-cum-maternalistic kinds of communication (Roter & Hall 1992). We do so to highlight what is different about this most recent modality of communication and communication research. Unique about contemporary patient-clinician communication is that it operates not so much as information exchange medium ('tell them what they need to know'), but as *a fast feedback dynamic*, or, put differently, as a *complexity management resource* ('what can we do now?'). This latter facet becomes particularly apparent when patients and clinicians face never-before-seen problems that demand quick, tailor-made and easily changeable decisions. Communication here functions as shared medium for patients and clinicians to work out on an ongoing and extended basis together what is happening, and what is possible, acceptable and workable. This is the kind of communication that underpins what Mol refers to as 'the logic of care' (Mol 2008), differentiating it from the supply-driven disease control orientation of the prevailing 'logic of cure'.

Construed as a developmental pathway, the principal shifts in how patients and clinicians communicate about care can now be summarised as follows. The main shifts have been from illness-centred and paternalistic-cum-maternalistic styles to patient-centred or consumerist styles, and

from there towards collaborative or ‘mutualistic’ styles (Mol 2008; Roter & Hall 1992). Paralleling these shifts, the pre-occupations of researchers have branched out from describing and testing patient-clinician communication in terms of fixed scripts and pre-determined skills (Byrne & Long 1976; Coulthard & Ashby 1976), to focusing on whether and to what extent clinicians are responsive to their patients and build relationships (Roter & Frankel 1992; Roter et al. 1997), to tracing the ways in which clinicians, patients and, increasingly, third parties (relatives and other informal carers, guardians, translators, health service managers), conduct complex negotiations about difficult care issues in contexts characterised by fast-paced health reform (Iedema 2006b; Mol 2008). The diagram below schematises this development.

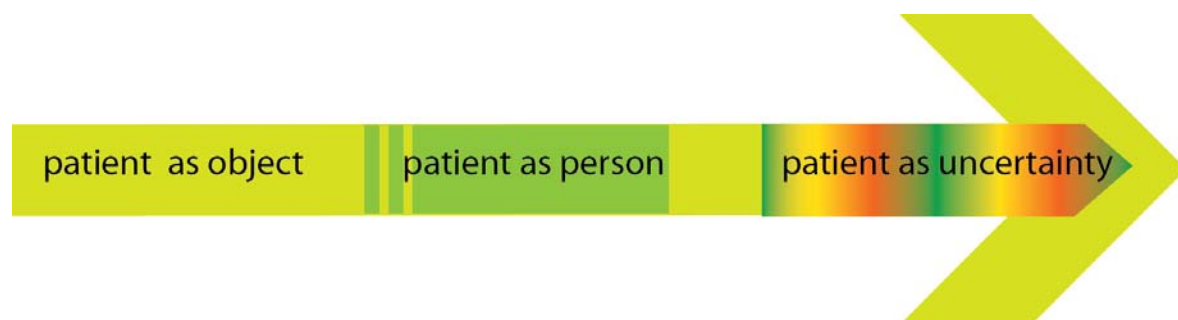


Figure: Changing health care conceptions about the position and role of the patient

As already intimated, these developmental shifts can be mapped onto specific periods in the history of health care provision (Armstrong 2002). However, rather than regarding earlier conventions as now superseded and left behind by later ones, we should instead see them as layerings that may be present, to greater or lesser degree, in all contemporary patient-clinician communication.¹¹



Picture these developments therefore as sedimentary strata in a rock formation: they may be present, they may not be, in patient-clinician communication taking place today. Some or one may predominate over others at different times. Or they may all manifest at once, in the one interaction.

¹¹ Strata diagram attributed to (Rosen 2010)

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