



by Paul Haidet, M.D., MPH

Nurturing Patient-Centeredness in a Hectic World



IT COMES DOWN TO this: we physicians *want* to be patient-centered. We *want* to get to know our patients. We *want* to be agents of healing and, in so doing, nurture our own love of this work. We *want* to have those kinds of relationships that other doctors write about in *A Piece of My Mind* and *On Being a Doctor*.

The problem is that we only have 15 minutes with our patients. Fifteen minutes! Or less! That's the crux of the issue, isn't it? In today's practice, we have to address not only the patient's problem but also the problems we see that patients don't, all of the screening (more and more each day), social problems, education problems, literacy, etc. Those *Piece of My Mind* docs must have been born with some kind of mojo that can't be learned. Or can it?

The thing about patient-centered care is that anyone can do it when given two hours. It's easy to listen when there's lots of time; that doesn't take high degrees of skill. The skill comes in when there's not lots of time. That kind of skill wasn't taught to us in medical school. Communication courses can help, but at the end of the day we still have those 30-40 patients waiting on our schedule. We need a way to build skills at the same time that we are practicing. The communication scientists say that a person has a certain repertoire of communicative acts available in their brain and that they draw on these acts

naturally and subconsciously when they are communicating. Unfortunately, most physicians' repertoires are limited only to close-ended questions when confronted with a patient's chief complaint. After all, there's important history about pertinent positives and negatives to be taken, right?

Here's the deal. What the really patient-centered physicians do is efficiently facilitate the patient telling his or her story while quietly listening for both pertinent symptoms *and* the heart of that story. They then succinctly tell the story (containing the patient's main concerns and worries) back to the patient until they are sure that they have it right. From the patient's perspective, this feels "like my doctor is really listening to me." How can we do this in 15 minutes in our own practices? We can do it by building our communication toolbox one tool at a time. I am by no means a master communicator, but I am better than I was during my residency all of those years ago. Here are some of the things I did to expand my repertoire of communicative acts and become a more patient-centered physician:

Understand the patient's perspective: As good and experienced as we are, we can't read minds. And patients aren't always predictable (i.e., not all patients with chest pain are worried about a heart attack). We need to get the patient to tell us what they're thinking. But patients often won't tell us this right off the bat—they don't want to bias us or 'waste our time.' So we need to ask. And the question is: "What do you think is going on?"

Not that simple—we have to ask it in a way that works with our own personality and in a way that gets patients to actually answer, instead of saying: "You're the doctor, what do you think is going on?" Try this in your practice: With every patient for two weeks, ask the question (or some version of it that works for you—play with different versions). When the patient gives an answer that you didn't expect, follow it up to make sure you have the whole story. Keep your mind open to what's on the patient's mind and how that might be different from what you think is on the patient's mind. This should not add more than 30-40 seconds on average per patient. After two weeks (or when it starts to feel natural), ask the question when it feels like the right thing to do.

Increase your latency time: Latency is the time from when one person stops talking until the next person starts talking. Like most Americans, physicians have very low latencies (usually <1 second). The issue here is that patients often have more to say, if given the space. And what they say in those spaces can sometimes profoundly change the way we doctors are thinking about the problem. Try this with patients: With every patient for two weeks, pick one time when they seem to finish talking and wait 10 seconds. It will feel like an eternity. If they say something in that 10 seconds, follow it up. If they say nothing, go on with the next question you originally planned to ask. This should not add more than 30 seconds on average to the visit. After two weeks, do it when it feels like the right thing to do.

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Paraphrase more: Telling the patient their story back to them often feels corny; like a waste of time, but it is critically important. Patients report that they feel 'heard' more when physicians tell the story back to them. Try this: With every patient for two weeks, say a sentence that begins with "So what I hear you saying is..." As with the patient's perspective above, play with the wording of this to find a way that fits your style. Use that as an entrée to tell the patient their story back to them. If the patient confirms that you have it right, move on. If the patient says something like "No, that's not quite it..."; follow up on what was missed and repeat until they confirm that you have it right. This should take no longer than 30-40 seconds on

average per patient. Once again, when it starts to feel natural, do it when it feels like the right thing to do.

Patient-centered care is not a mystical art that only rare gurus possess. Rather, it is a set of skills that takes practice in real life settings to acquire, just like drawing blood or interpreting ECGs. Picking one skill at a time and working with it until it becomes a natural part of your repertoire will help to expand your communicative toolbox. It may also help your patients to be more satisfied and you to find more meaning in this work, despite the time constraints. For more information on communication resources and skills training, check out: www.aachonline.org, www.healthcare-comm.org, or www.each.nl ■

The opinions expressed are those of the author and do not necessarily represent the views of the US Department of Veterans Affairs, Baylor College of Medicine or the editors and staff of JAMA and The Annals of Internal Medicine.

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