

Annotated Bibliography

Treating Patients with C.A.R.E.



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Adams A, Realpe A, Vail L, Buckingham CD, Erby LH, Roter D. (2015). **How doctors' communication style and race concordance influence African-Caribbean patients when disclosing depression.** *Patient Educ Couns*, 98(10):1266-73. doi: 10.1016/j.pec.2015.08.019.

OBJECTIVE: To determine the impact of doctors' communication style and doctor-patient race concordance on UK African-Caribbeans' comfort in disclosing depression.

METHODS: 160 African-Caribbean and 160 white British subjects, stratified by gender and history of depression, participated in simulated depression consultations with video-recorded doctors. Doctors were stratified by black or white race, gender and a high (HPC) or low patient-centred (LPC) communication style, giving a full 2×2×2 factorial design. Afterwards, participants rated aspects of doctors' communication style, their comfort in disclosing depression and treatment preferences

RESULTS: Race concordance had no impact on African-Caribbeans' comfort in disclosing depression. However a HPC versus LPC communication style made them significantly more positive about their interactions with doctors (p=0.000), their overall comfort (p=0.003), their comfort in disclosing their emotional state (p=0.001), and about considering talking therapy (p=0.01); but less positive about considering antidepressant medication (p=0.01).

CONCLUSION: Doctors' communication style was shown to be more important than patient race or race concordance in influencing African Caribbeans' depression consultation experiences. Changing doctors' communication style may help reduce disparities in depression care.

PRACTICE IMPLICATIONS: Practitioners should cultivate a HPC style to make African-Caribbeans more comfortable when disclosing depression, so that it is less likely to be missed.

*Allen MH, Carpenter D, Sheets JL, Miccio S & Ross R. (2003). **What do consumers say they want and need during a psychiatric emergency?** *Journal of Psychiatric Practice*, 9(1):39-58.

Behavioral emergencies are a common and serious problem for consumers, their families and communities, and the healthcare providers on whom they rely for help. In recent years, serious concerns about the management of behavioral and psychiatric emergencies-in particular, the misapplication and overuse of physical and chemical restraints and seclusion-have become a focus of attention for mental health professionals and policy makers as well as for the lay public, the media, and patient advocacy organizations. Policy leaders and clinicians are searching for ways to balance the rights of consumers with considerations of safety and good care in an area in which it is difficult to conduct research. A survey of mental health professionals who are experts on the treatment of psychiatric and behavioral emergencies identified consumer input and collaboration between patient and clinician whenever possible as being extremely important in achieving the best short-term and particularly the best long-term outcomes for patients. The survey of consumer perspectives described in this article was undertaken in response to the need to better understand consumer experiences and preferences. The authors describe four emergency services forums conducted in 2002, which involved a total of 59 consumers. Each forum involved a written consumer survey as well as a workshop to develop and prioritize recommendations for improving psychiatric emergency care. The authors present the results of the consumer survey and summarize the top recommendations from the workshops. In both the survey and the workshops, the consumers repeatedly stressed the importance of having staff treat them with respect, talk to them, listen to them, and involve them in treatment decisions. There were a number of important areas of agreement between the recommendations of the consumer panel and those of the experts in emergency psychiatry surveyed for the Expert Consensus Guidelines on the Treatment of Behavioral Emergencies. These include the desirability of verbal interventions, the use of a collaborative approach, and the use of oral medications guided by the individual consumer's problems, medication experiences, and preferences. The majority of the consumer panel reported adverse experiences with general hospital emergency rooms and, in fact, called for the development of specialized

psychiatric emergency services such as those recommended in the Expert Consensus Guidelines. One-fifth of the consumer panel attributed their emergency contact to lack of access to more routine mental healthcare. The consumers clearly do not reject medications categorically. Almost half indicated they wanted medications and a similar number indicated benefit from medications, although many complained of forced administration and unwanted side effects. The consumer panel preferred benzodiazepines and ranked haloperidol as a least preferred option. Among their key recommendations for improving psychiatric emergency care, the consumer panel stressed the development of alternatives to traditional emergency room services, the increased use of advance directives, more comfortable physical environments for waiting and treatment, increased use of peer support services, improved training of emergency staff to foster a more humanistic and person-centered approach, increased collaboration between practitioners and patients, and improved discharge planning and post-discharge follow-up. The implications of these findings for improving psychiatric emergency care are considered.

*Ambady N, Koo J, Rosenthal R, Winograd CH (2002). **Physical Therapists' Nonverbal Communication Predicts Geriatric Patients' Health Outcomes.** *Psychology and Aging* 17(3): 443–452. DOI: 10.1037//0882-7974.17.3.443. <http://web.stanford.edu/group/ipc/pubs/2002AmbadyPhys.pdf> [Accessed 9-13-2016]

Two studies explored the link between health care providers' patterns of nonverbal communication and therapeutic efficacy. In Study 1, physical therapists were videotaped during a session with a client. Brief samples of therapists' nonverbal behavior were rated by naive judges. Judges' ratings were then correlated with clients' physical, cognitive, and psychological functioning at admission, at discharge, and at 3 months following discharge. Therapists' distancing behavior was strongly correlated with short- and long-term decreases in their clients' physical and cognitive functioning. Distancing was expressed through a pattern of not smiling and looking away from the client. In contrast, facial expressiveness, as revealed through smiling, nodding, and frowning, was associated with short- and long-term improvements in functioning. In Study 2, elderly subjects perceived distancing behaviors of therapists more negatively than positive behaviors.

*Ambady N, Laplante D, Nguyen T, Rosenthal R, Chaumeton N & Levinson W. (2002). **Surgeons' tone of voice: A clue to malpractice history.** *Surgery*, 132(1):5-9, 2002.

BACKGROUND: Interpersonal aspects of care, such as the communication behaviors of physicians, are often cited as central to patients' decisions to initiate malpractice litigation. Relatively little is known, however, about the impact of the communication behaviors of surgeons. In the current study, we investigated the relationship between judgments of surgeons' voice tone and their malpractice claims history.

METHODS: We examined the relationship between surgeons' voice tone during routine office visits and their history of malpractice claims. Surgeons were audio-taped while speaking to their patients during office visits, and very brief samples of the conversations were rated by coders blind to surgeons' claims status. Two 10-second clips were extracted for each surgeon from the first and last minute of their interactions with 2 different patients. Several variables were rated that assessed warmth, hostility, dominance, and anxiety from 10-second voice clips with content and 10-second voice clips with just voice tone.

RESULTS: Controlling for content, ratings of higher dominance and lower concern/anxiety in their voice tones significantly identified surgeons with previous claims compared with those who had no claims (odds ratio [OR] 2.74, 95% confidence interval [CI] 1.16 to 6.43 for dominance; OR 0.46, 95% CI 0.21 to 1.01 for concern/anxiety).

CONCLUSIONS: Surgeons' tone of voice in routine visits is associated with malpractice claims history. This is the first study to show clear associations between communication and malpractice in surgeons. Specific types of affect associated with claims can be judged from brief audio clips, suggesting that this method might be useful in training surgeons.

*Amer A & Fischer H. (2009). **“Don’t call me ‘mom’”: How parents want to be greeted by their pediatrician.** *Clinical Pediatrics* (Phila), 48(7):720-2 (ISSN: 1938-2707).

BACKGROUND: Physician-patient interaction during the medical interview is essential in establishing the rapport necessary for a successful relationship. Physicians are generally encouraged to shake hands with patients, address patients by name, and identify themselves. **OBJECTIVE:** To define parents’ expectations for greetings by pediatricians and to determine the frequency with which these expectations are met.

DESIGN AND METHODS: A total of 100 parents visiting the General Pediatric Clinic at Children's Hospital of Michigan were recruited. Parents were interviewed at the end of their medical encounter to determine expectations for greeting by their doctor. They were questioned about preferences for shaking hands, the doctors' use of their names, and the way doctors should introduce themselves. They were then asked if the experience at this visit conformed to these expectations.

RESULTS: Overall, 81% of the parents were the children's mothers and 86% were African-American. Over 80% of parents expected physicians to shake hands; 70% of residents and 66% of attendings did. 88% of parents wanted to be addressed by their names; only 14% of residents and 24% of attending physicians did so. All of the parents wanted the physicians to introduce themselves; 84% of residents and 93% of attendings did so.

CONCLUSIONS: Physicians neither shook hands with many parents who expected it, nor did they address parents by their last names. About 90% of physicians introduced themselves. These disappointingly low results may predispose to parent dissatisfaction. Attending physicians need to teach these small, but important features, and to model them as well.

*Anhang Price R, Elliott MN, Zaslavsky AM, Hays RD, Lehrman WG, Rybowski L, Edgman-Levitan S & Cleary PD. (2014). **Examining the role of patient experience surveys in measuring health care quality.** *Med Care Res Rev*, 71(5):522-554

Patient care experience surveys evaluate the degree to which care is patient-centered. This article reviews the literature on the association between patient experiences and other measures of health care quality. Research indicates that better patient care experiences are associated with higher levels of adherence to recommended prevention and treatment processes, better clinical outcomes, better patient safety within hospitals, and less health care utilization. Patient experience measures that are collected using psychometrically sound instruments, employing recommended sample sizes and adjustment procedures, and implemented according to standard protocols are intrinsically meaningful and are appropriate complements for clinical process and outcome measures in public reporting and pay-for-performance programs.

Bein, B. (2011, March 23). **Empathy Is 'powerful tool' in improving patient outcomes, say family physicians.** Retrieved December 2, 2015.

Family physicians often have to make a point of displaying empathy to each of their patients while also striving to meet the demands of everyday practice. But, according to a recent study by family physicians and others, when a physician is highly empathetic, his or her patients' clinical outcomes are likely to improve. "Empathy is one of the most powerful tools that physicians have at their disposal," said Richard Wender, M.D., professor and chair of the department of family and community medicine at Jefferson Medical College in Philadelphia and president of the Association of Departments of Family Medicine.

Boggs, W (2018). **Physicians' empathetic statements often buried in other information.** *Medscape*, July 11, 2018.

Bonvicini KA, Perlin MP, Bylund CL, Carroll JG, Rouse R, & Goldstein MG. (2008). **Impact of communication training on physician expression of empathy in patient encounters.** *Patient Educ and Couns.* Available online 10 Dec. 2008.

OBJECTIVE: To examine whether an educational intervention that focused on physician communication training influenced physician empathic expression during patient interactions.

METHODS: This study used a quantitative research method to investigate influence of communication training on physician-expressed empathy using two measures (global and hierarchical) of physician empathic behavior.

RESULTS: The differences in global empathy scores in the physician training group from baseline to follow-up improved by 37%, and hierarchical scores of physician empathic expression improved by up to 51% from baseline scores for the same group.

CONCLUSIONS: The results strongly supported the hypotheses that training made a significant difference in physician empathic expression during patient interactions demonstrated by both outside observer measures of global ratings and hierarchical ratings of physician empathic behavior.

PRACTICE IMPLICATIONS: These findings have significant implications for program design and development in medical education and professional training with the potential to improve patient outcomes.

*Boodman SG (2015). **Efforts To instill empathy among doctors are paying dividends.** Blogpost from Kaiser Health News, March 12, 2015. Retrieved December 02, 2015, from <http://khn.org/news/efforts-toinstill-empathy-among-doctors-is-paying-dividends/> [Accessed 3-13-2017]

Increasingly, empathy is considered essential to establishing trust, the foundation of a good doctor-patient relationship. Studies have linked empathy to greater patient satisfaction, better outcomes, decreased physician burnout and a lower risk of malpractice suits and errors.

Bothell TW & Harrell G. (2001). **Treating Veterans with CARE Impact Report.** Department of Veterans Affairs Employee Education System.

PROJECT DESCRIPTION: The Jack Phillips Center for Research and Assessment of the Franklin Covey Company has partnered with the Department of Veterans Affairs Employee Education System to complete return on investment evaluations on certain training programs and to educate EES personnel about return on investment.

The C.A.R.E. training program was selected as a program to be evaluated because the program is highly visible, reaches a large and diverse audience and was intended to be a national effort across VISN's. Additionally, the C.A.R.E. program meets strategic criteria because improving patient satisfaction is critical to the future strategies of the VHA.

SUMMARY OF THE EVALUATION FINDINGS: The results reported in this evaluation study describe how C.A.R.E. training makes a positive difference for VISN 8 employees and veteran patients. Similarly, the results show how trainers are well received, how participants of C.A.R.E. learn about VHA customer service standards, and how the participants of C.A.R.E. can apply what they learn to make a difference in patient satisfaction. This study estimates the monetary value of each patient at VISN 8 and suggest the monetary value of improving patient satisfaction scores. In short, a positive return on investment can be received from C.A.R.E. training. For further information concerning this project, contact any of the major contributors listed on the cover page.

SUMMARY OF CONCLUSIONS: The findings of this study are encouraging. The participants' react positively to the program and learn about skills that affect patient satisfaction. However, the reported improvements in participants' skills are not as great as they could be. Participants face many barriers that keep them from applying C.A.R.E. skills. Yet, even with participants' limited applications, participants report that key organizational results are influenced by the program. Those improvements in organizational results produce a positive return on investment. These

findings are positive. The value of improving patient satisfaction can be illustrated using this study as an example. This study can be a tool for future improvements in veteran patient service and employee training.

*Boudreaux ED, Ary RD, Mandry CV, & McCabe B. (2000). Determinants of patient satisfaction in a large, municipal ED: the role of demographic variables, visit characteristics, and patient perceptions. *AJEM*, 18(4): 394-400.

We investigated predictors of patient satisfaction in a large, municipal emergency department (ED). Patients were telephoned 10 days post-visit, and satisfaction was assessed using a structured survey with 22 items measuring several domains, as well as the estimated length of stay. The dependent variables consisted of ratings of overall satisfaction and likelihood of recommending the ED to others. Data were obtained from 437 (38.7%) patients. Univariate statistics revealed strong relations between indicators of perceived care and both dependent variables, with weaker and mixed findings pertaining to demographics and visit characteristics. The final logistic regression predicting overall satisfaction included the following items ($P < .05$): degree to which staff cared for the patient as a person, perceptions of safety, understandability of discharge instructions, nurse's technical skills, and satisfaction with wait for physician. Likelihood to recommend was associated with ($P < .05$): degree to which staff cared for the patient as a person, understandability of discharge instructions, perceptions of safety, age, and insurance status. Patients' perceptions of care, rather than demographics and visit characteristics, most consistently predicted satisfaction. However, differences were observed between the specific predictors for overall satisfaction and likelihood to recommend, providing a possible explanation for inconsistencies observed in the literature.

*Bourquin C, Stiefel F, Mast MS, Bonvin R, Berney A. (2014). **Well, you have hepatic metastases: Use of technical language by medical students in simulated patient interviews.** *Patient Educ Couns*. 98(3):323-30.

OBJECTIVE: This research explored medical students' use and perception of technical language in a practical training setting to enhance skills in breaking bad news in oncology.

METHODS: Terms potentially confusing to laypeople were selected from 108 videotaped interviews conducted in an undergraduate Communication Skills Training. A subset of these terms was included in a questionnaire completed by students ($N = 111$) with the aim of gaining insight into their perceptions of different speech registers and of patient understanding.

Excerpts of interviews were analyzed qualitatively to investigate students' communication strategies with respect to these technical terms.

RESULTS: Fewer than half of the terms were clarified. Students checked for simulated patients' understanding of the terms *palliative* and *metastasis/to metastasize* in 22–23% of the interviews. The term *ambulatory* was spontaneously explained in 75% of the interviews, *hepatic* and *metastasis/to metastasize* in 22–24%. Most provided explanations were in plain language; *metastasis/to metastasize* and *ganglion/ganglionic* were among terms most frequently explained in technical language.

CONCLUSION: A significant number of terms potentially unfamiliar and confusing to patients remained unclarified in training interviews conducted by senior medical students, even when they perceived the terms as technical.

PRACTICE IMPLICATIONS: This exploration may offer important insights for improving future physicians' skills.

*Brandes K, Linn AJ, Smit EG, van Weert JC. (2015). **Patients' reports of barriers to expressing concerns during cancer consultations.** *Patient Educ Couns*. 98(3): 317-22.

OBJECTIVE: To identify cancer patients' most influential barriers to expressing concerns during cancer consultations in a new manner by examining patients' reports of perceived barriers and perceived occurrence of barriers in consultations.

METHODS: Two online focus groups ($N=16$) and an online survey ($N=236$) were conducted among cancer patients and cancer survivors. The online focus groups and survey were used to

examine two elements of patients' barriers, i.e., patients' reports of perceived barriers and perceived occurrence of barriers in consultations. Composite scores of these two elements were calculated to determine influential barriers.

RESULTS: Results showed that the most influential barriers were related to providers' behavior (e.g., providers do not explicitly invite patients to express concerns) and the environment where the consultation takes place (e.g., perceived lack of time).

CONCLUSION: The results of this study indicate that influential barriers to expressing concerns are barriers that patients cannot overcome themselves (i.e., they are related to providers' behavior or the environment of the consultation). A collaborative approach between researchers, providers and policy makers is needed to overcome these barriers.

PRACTICE IMPLICATIONS: The results of this study can be used to develop strategies to overcome barriers to patients expressing concerns.

*Bristowe K, Patrick PL. (2014). '**Any questions?**'-- **Clinicians' usage of invitations to ask questions (IAQs) in outpatient plastic surgery consultations.** *Patient Educ Couns.* 97(3): 347-51.

Three types of invitation to ask questions (IAQ) were identified in this study – overt (e.g. 'do you have any questions?'), borderline (e.g. 'was there anything else?') and covert (e.g. 'okay?').

OBJECTIVE: To explore use of 'Invitations to Ask Questions' (IAQs) by plastic surgeons in outpatient consultations, and consider how type of IAQ impacts on patients' responses to, and recollection of, IAQs.

METHODS: Descriptive study: 63 patients were audio recorded in consultation with 5 plastic surgeons, and completed a brief questionnaire immediately after the consultation. Consultation transcripts were analyzed using inductive qualitative methods of Discourse Analysis and compared with questionnaire findings.

RESULTS: A taxonomy of IAQs was developed, including three types of IAQ (Overt, Covert, and Borderline). Overt IAQs were rarely identified, and almost all IAQs occurred in the closing stages of the consultation. However, when an overt IAQ was used, patients always recollected being asked if they had any questions after the consultation.

CONCLUSIONS: Patients are rarely explicitly offered the opportunity to ask questions. When this does occur, it is often in the closing stages of the consultation. Clinicians should openly encourage patients to ask questions frequently throughout the consultation, and be mindful that subtle differences in construction of these utterances may impact upon interpretation.

PRACTICE IMPLICATIONS: Clear communication, of message and intention, is essential in clinical encounters to minimize misunderstanding, misinterpretation, or missed opportunities for patients to raise concerns.

*Brown AD, Sandoval GA, Levinton C & Blackstien-Hirsch P. (2005). **Developing an efficient model to select emergency department patient satisfaction improvement strategies.** *Annals of Emergency Medicine.* 46(1):3-10.

STUDY OBJECTIVE: Patient satisfaction is an important performance measure for emergency departments (EDs), but the most efficient ways of improving satisfaction are unclear. This study uses optimization techniques to identify the best possible combination of predictors of overall patient satisfaction to help guide improvement efforts.

METHODS: The results of a satisfaction survey from 20,500 patients who visited 123 EDs were used to develop ordinal logistic regression models for overall quality of care, overall medical treatment, willingness to recommend the ED to others, and willingness to return to the same ED. Originally, 68,981 surveys were mailed, and 20,916 were returned, representing an overall response rate of 30.3%. We then incorporated these regressions into an optimization model to select the most efficient combination of predictors necessary to increase the 4 overall satisfaction measures by 5%. A sensitivity analysis was also conducted to explore differences across hospital peer groups and regions.

RESULTS: Results differ slightly for each of the 4 overall satisfaction measures. However, 4 predictors were common to all of these measures: "perceived waiting time to receive treatment," "courtesy of the nursing staff," "courtesy of the physicians," and "thoroughness of the

physicians." The selected predictors were not necessarily the strongest predictors identified through regression models. The optimization model suggests that most of these predictors must be improved by 15% to increase the overall satisfaction measures by 5%.

CONCLUSION: This study introduces the use of optimization techniques to study ED patient satisfaction and highlights an opportunity to apply this technique to widely collected data to help inform hospitals' improvement strategies. The results suggest that hospitals should focus most of their improvement efforts on the 4 predictors mentioned above.

*Brugel S, Postma-Nilsenová M, Tates K. (2015). The link between perception of clinical empathy and nonverbal behavior: the effect of a doctor's gaze and body orientation. *Patient Educ Couns*, 98(10):1260-5. doi: 10.1016/j.pec.2015.08.007.

OBJECTIVES: Clinical empathy is considered to be one of the most important skills for medical professionals. It is primarily conveyed by nonverbal behavior; however, little is known about the importance of different types of cues and their relation to engagement and sincerity as possible correlates of perceived clinical empathy (PCE). In this study, we explored the effect of doctor's gaze and body orientation on PCE with the help of 32 video vignettes.

METHODS: Actors impersonating medical interns displayed different combinations of gaze and body orientation while uttering an empathetic verbal statement. The video vignettes were evaluated in terms of the perceived clinical and general empathy, engagement and sincerity.

RESULTS: A principal component analysis revealed a possible single-factor solution for the scales measuring the two types of empathy, engagement and sincerity; therefore, they were subsumed under general perceived empathy (GPE). An analysis of variance showed a main effect of gaze and body orientation, with a stronger effect of gaze, on GPE. We subsequently performed a linear random effects analysis, which indicated possible gender-related differences in the perception of gaze.

CONCLUSIONS: The outcomes of our experiment confirm that both gaze and body orientation have an influence on the GPE. The effect of gaze, however, appears to be gender-dependent: in the experiment, males were perceived as slightly more empathetic with patient-centered gaze, while for females averted gaze resulted in higher GPE scores.

PRACTICE IMPLICATIONS: The findings are directly relevant in the context of medical communication training. Perception of clinical empathy supports medical information transfer, diagnosis quality and other patient outcomes.

*Burgio LD, Allen-Burge R, et al. (2001). Come talk with me: improving communication between nursing assistants and nursing home residents during care routines. *Gerontologist*, 41(4): 449-461.

Presents information on a study that examined the effects of communication skills training and the use of memory books by certified nursing assistants (CNA) on verbal interactions between CNA and nursing home residents during care routines. A staff motivational system encouraged performance and maintenance of communication skills. Compared to a control group, trained CNAs talked more, used positive statements more frequently, and gave specific instructions to patients more frequently, without increasing the time giving patients care. CNA behavior change was maintained at 2-month follow-up.

OBJECTIVE: To examine the effects of communications skills training and the use of memory books by Certified Nursing Assistants and nursing home residents during care routines.

DESIGN: Two-group (treatment/no-treatment) comparison design with an intra-group comparison component embedded in each group. Nursing home units were randomly selected for inclusion in study, and randomly assigned to treatment or control condition.

SETTING: Five nursing homes with an average of 120 residents on three units.

SUBJECTS: Certified nursing assistants (n=64); Nursing home residents (n=67). Residents were assessed on mental function (Mini-Mental Status Examination, Short Portable Mental Status Questionnaire, Functional Independence Measure) and Activities of Daily Living (ADL), and were included in the study only if they met certain criteria.

INTERVENTION: Baseline data on residents, staff, and their behavior were gathered for 4 weeks.

During week 5, communication-memory book skill in-service workshops were conducted on the treatment units. Role-play, discussion of real-life examples, and discussion of written vignettes were part of the communication-skills training. Staff were trained in using the memory books to increase communication among residents and between residents and staff, to increase residents' independent functioning, and to distract residents to decrease disruptive behaviors. Memory books contain images and brief sentences that provide cognitive stimulation to patients and facilitate communication with staff and others. After the initial in-service training, resident were given a personalized, 12-page memory book with biographical, orientation, and daily schedule information. Hands-on training in communication and memory book use continued for 4 weeks. Supervisory staff and researchers observed each CNA once a day during their shift and provided feedback on their use of the communication skills taught during the in-service (staff motivational system). Supervising LPNs were also observed by the project manager and were given feedback on their supervision of the CNAs. Thirty-nine CNAs in the treatment group were taught to monitor and record their skill performance to both track their skill-usage and to motivate them. Trained CNAs who met 80% of the skills criteria received public recognition on the CNA honor role once a week and were entered into a lottery for a prize.

DATA COLLECTION: After the 4-week hands-on training, the next 8 weeks included evaluation of the intervention's effectiveness and continued use of a staff motivational system. Measures included the CNA Communication Skills Checklist (CSC) and the Observations of the LPN's Supervisory Activities (OLSA). Follow-up data were collected two months post-intervention. Computer-Assisted Behavioral Observation System (CABOS) hardware and software were used to record and analyze behavior during care-giving interactions.

DATA ANALYSIS: CSC outcome data included the rate of CNA use of specific, one-step instructions, positive statements, biographical statements, multiple-step instructions, total duration of care. CABOS outcome data included total percentage of time of resident coherent verbal interaction, staff speech directed to resident, rate per hour of positive statements made by residents or CNAs. Descriptive statistics were used to assess the treatment delivery and enactment. A 2 (group) X 3 (time) ANOVA assessed behavior change of staff and residents at baseline, post-intervention training, and during the 8-week evaluation period. A 2(group) X 2(time) ANOVA assessed behavior change between the 8-week evaluation period and the 2-month post-intervention follow-up.

FINDINGS: The majority of CNAs (92%) passed a final evaluation with a performance score of at least 80% on the CSC. There were no baseline differences between the treatment and control groups on the CSC. The 2 X 3 ANOVA revealed significant main effects for group and time and a significant group X time interaction, indicated that CNAs in the treatment group improved their communication skills compared to the control group and over time. Treatment group CNAs increased their use of positive statements, time spent talking, use of specific one-step instructions, and they used fewer multi-step instructions. No differences were found in the use of biographical statements or time spent in care giving. Residents were more independent in self-care at 2-month follow-up as assessed by the FIM.

CONCLUSIONS: Communication skills training, along with a staff motivational system, improved CNAs ability to communicate effectively with nursing home residents without increasing the time delivering daily care.

*Bylund CL & Makoul G. (2005). Examining empathy in medical encounters: An observational study using the empathic communication coding system. *Health Communication*, 18(2), 123-140.

Educators, researchers, clinicians, and patients often advocate empathy in the physician-patient relationship. However, little research has systematically examined how patients present opportunities for physicians to communicate empathically and how physicians respond to such opportunities. The Empathic Communication Coding System was used to investigate empathic opportunity-response sequences during initial visits in a general internal medicine clinic. This study focuses on 100 visits during which patients created at least 1 explicit empathic opportunity. Overall, patients presented 249 empathic opportunities in these 100 visits; physicians most often responded by acknowledging, pursuing, or confirming the patient's statement. The mean length of empathic opportunity-response sequences was 25.8 sec;

sequences tended to be longer in duration when the physician used a more empathic response. Positively valenced empathic opportunities generated a more empathic response than did negatively valenced empathic opportunities. However, there was no relation between the emotional intensity of empathic opportunities and the level of empathy in subsequent physician responses. Further research should examine patient preferences and outcomes associated with varying levels of empathic responses.

*Calvin AO, Frazier L & Cohen MZ. (2007). Examining older adults' perceptions of health care providers: identifying important aspects of older adults' relationships with physicians and nurses. Older adults want to feel cared for, respected, and informed. *Journal of Gerontological Nursing*, 33(5):6-12.

This article describes older adults' conversations about their relationships with health care providers. Focus group participants (N = 23) were from three ethnic groups (Black, White, and Hispanic) and ages 53 to 92. All but three of the participants were women. Content analysis revealed an overarching theme of genuine caring and three sub-themes: interest in patients' well-being, respectful dialogue, and sharing of information. Older adults' perceptions of genuine caring by physicians and nurses did not differ by ethnicity. Older adults want to engage in a caring, respectful, and educational relationship with their health care providers, which is consistent with fundamental professional values.

*Caris-Verhallen WM, Kerkstra A, Bensing JM & Grypdonck MH. (2000). **Effects of video interaction analysis training on nurse-patient communication in the care of the elderly.** *Patient Education & Counseling*, 39(1): 91-103.

Describes an empirical evaluation of communication skills training for nurses in elderly care. The training program was based on Video Interaction Analysis and aimed to improve nurses' communication skills such that they pay attention to patients' physical, social, and emotional needs and support self-care in elderly people. The effects of the training course were measured in an experimental and control group. Independent observers rated them, by comparing videotapes of nursing encounters before and after training. 40 nurses participated in 316 videotaped nursing encounters. Multilevel analysis was used to take into account similarity among same nurse encounters. It was found that nurses who followed the training program provided the patients with more information about nursing and health topics. They also used more open-ended questions. In addition, they were rated as more involved, warmer, and less patronizing. Due to limitations in the study design, it could not be demonstrated that these findings can entirely be ascribed to the training course. Further research, incorporating a randomized controlled design and larger sample sizes, is recommended to determine whether the results can be attributed to this specific type of training.

OBJECTIVE: To determine the effects of Video Interaction Analysis communication training on the communicative behavior of nurses and patients in elderly care.

DESIGN: Quasi-experimental, Pre-test/ Post-test, Treatment group/ Control group design. Groups were not randomly assigned but there were no significant differences between groups on background variables.

SETTING: A home care organization and a nursing home.

SUBJECTS: Treatment group: n=24 nurses; Control group: n=23 nurses (who received training later). Nurses recruited patients subjects for videotaped encounters, patient n=241.

INTERVENTION: Nurses participated in a series of communication skills trainings. Training focused on developing nurses' awareness of the physical, social, and emotional needs of the elderly, verbal communication techniques (i.e. "structuring" and "exploring patients' ideas and opinions"), using active listening skills (paraphrasing, "mhm") to enhance patients' feelings of competence, asking open ended questions, and nonverbal behaviors (eye contact, leaning forward, smiling, head nodding, touch). They spent 2 days learning about communication theory, communication with the elderly, Video Interaction Analysis, and role-playing nurse-patient interactions with trained actors. Pairs of nurses then spent 6 Video Interaction Analysis sessions watching videotape of their own behavior during care giving and discussed their behaviors with the trainer. Learning took place in 3 ways: the participants' review of their own performance,

feedback from the trainer, and peer comments. Video Interaction Analysis was meant to improve nurses' communication skills so that they would pay more attention to patients' physical and social needs, facilitate self-care in elderly patients, and support patients in finding their own solutions to problems. During the 6-week periods between sessions, participants practiced their new skills and recorded a new caring interaction, which they analyzed on their own before the next session. At the end of course, the participants held a group discussion about their experiences and evaluated the course structure, process, and their personal results.

DATA COLLECTION: Before commencing training, participants videotaped care giving encounters to provide pre-test data (treatment group = 87 encounters, control group = 69 encounters). Encounters had a mean duration of 18 minutes. Post-test data included 87 videotaped encounters for the treatment group and 73 for the control group. Two independent observers who were blinded to the experimental condition measured nurse-patient communication. They used the CAMERA computer system to code behavioral interactions. Verbal communication was coded using Roter's Interaction Analysis System. Clusters of behavior included social communication, affective communication, communication that structures the encounter, communication about nursing and health, and communication about lifestyle and feelings. Proportion of the time spent engaging in nonverbal behaviors--eye contact, affirmative nodding, smiling, leaning forward, and affective and instrumental touch-- were also coded. General affective impression was coded on 6-point scales rating irritation, nervousness, assertiveness, interest, warmth, patronizing, and involvement.

DATA ANALYSIS: Proportion of care giving time spent in verbal and nonverbal communicative behaviors was compared pre- and post-intervention within the treatment and control groups. Hierarchical linear modeling was used to analyze the data.

FINDINGS: In the treatment group, significant differences were found for verbal disagreement (decreased), information provision (increased), and counseling and advice (decreased), and open-ended questions (increased) when comparing the pre-test to the post-test. In post-test, nurses in the treatment group smiled less often and leaned forward less often than at pre-test. At post-test, nurses in the treatment group expressed more positive affect, including more interest, warmth, and involvement and less patronizing. Nurses in the treatment group improved more in showing interest and warmth than the control group, but did not significantly improve in the other nonverbal behaviors, affect, or verbal communication compared to the control group. Patients interacting with the treatment group nurses showed less disagreement, gave more information, and produced their own solutions more often at post-test. In general, results were more significant in the home care setting than in the nursing home setting, although there was increased use of structuring communication skills among treatment group nurses in the nursing home setting. No significant differences were found between the treatment and control groups when mean differences between pre- and post-test results were compared.

CONCLUSIONS: Nurses in the treatment group, especially those in home care, showed significant improvement in communication skills after receiving the intervention. Though not significant, changes in the positive direction also occurred in the control group, indicating cross-contamination or bias introduced by virtue of participation in the study. Weaknesses in the study design limit the ability to draw conclusions that Video Interaction Analysis improved nurse communication skills, though the results suggest that this method is helpful for training nurses in communication skills.

*Clever SL, Jin L, Levinson W, & Meltzer DO. (2008). Does doctor-patient communication affect patient satisfaction with hospital care? Results of an analysis with a novel instrumental variable. *Health Services Research*, 43:5, Part I (Oct 2008): 1505-1519.

OBJECTIVE: To determine the relationship between physicians' communication behaviors and patients' overall satisfaction with hospital care using a novel instrumental variable to address possible confounding of this association by patient attributes.

DATA SOURCES/STUDY SETTING: Administrative records and postdischarge survey data were obtained from patients discharged from the General Medicine service at an urban tertiary-care academic hospital between July 1, 1997 and June 30, 2000. Administrative data included comorbidities, demographic data, and payer status. In the discharge survey, patients rated their

attending physician on four communication behaviors, other aspects of their hospital stay, and their overall hospital care.

STUDY DESIGN: The primary outcome was patients' ratings of their overall satisfaction with hospital care, and the primary independent variable was patients' ratings of their physicians' communication behaviors. To remove possible confounding of the association between patient ratings of physician communication and overall satisfaction by other patient-specific attributes, we created an instrumental variable (IV) in a two-stage linear regression. The IV was the mean of the communication ratings given to each physician by the other patients cared for by that physician.

PRINCIPLE FINDINGS/CONCLUSIONS: Three thousand one hundred and twenty-three patients were included in the analysis. In the ordinary least squares regression, there was a significant positive relationship between overall satisfaction and overall ratings of attendings' communication behaviors, with an increase in overall satisfaction of 0.58 points on a 5-point scale for each 1-point increase in overall attendings' communication behaviors, $p < 0.001$. This relationship was maintained but attenuated in the IV regression, with a coefficient of 0.40, $p = 0.046$. Although we find that the relationship between patient communication ratings and overall patient satisfaction may be confounded by patient-level factors, we nevertheless continue to find evidence of a statistically significant and sizable relationship between physicians' communication behaviors and overall patient satisfaction after controlling for such factors.

*Corbett G & McGuigan T. (2008). Patient satisfaction: Gillian Corbett and Tricia McGuigan report the results of a survey of patients' responses to the care they receive from minor/major injury/illness nurse treatment service nurses. *Emergency Nurse*, 16(3):26-35.

Authors report the results of a survey of patients' responses to the care they receive from minor/major injury/illness nurse treatment service nurses. The survey results indicate an improvement in patient satisfaction over several components of care, including patient information, since the Picker Institute surveys were conducted in 2005. When asked about receiving information on condition and treatment in 2005, 46 per cent of patients indicated that they had been given enough information. When asked the same question for the see-and-treat survey in 2007, 85 per cent of patients expressed this opinion. The survey revealed that patients' satisfaction with the see-and-treat services was high and independent of waiting times. When compared with middle grade and consultant doctors, nurses performed well and, according to patients, were knowledgeable and competent, and generally had good communication skills. While nurses achieved high scores on all subscales of the questionnaire, results suggest that lack of professional confidence is an issue worth addressing.

*Coulehan JL, Platt FW, Egner B, Frankel R, Lin CT, Lown B, et al. (2001). **"Let me see if I have this right...": Words that help build empathy.** *Annals of Internal Medicine*, 135(3) 221-227.

Emphasized the importance of the choice of words and sentences in the facilitation of empathy in the medical encounter. Difference between empathy and sympathy; Components of empathic communication; Potential empathic opportunities; Guidelines for clinical empathy in the cross-cultural setting.

*DeLemos D, Chen M, Romer A, Brydon K, Kastner K, Anthony B & Hoehn KS. (2010). **Building trust through communication in the intensive care unit: HICCC.** *Pediatric Critical Care Medicine*. 11 (3): 378-384.

OBJECTIVE: The goal of this study was to explore the role of communication in building trust between intensivists and parents in the pediatric intensive care unit.

METHODS: Semistructured qualitative interviews were administered to English-speaking parents of children who were admitted to the pediatric intensive care unit for at least 48 hrs. Parents were asked about the factors impacting trust and communication in the pediatric intensive care unit. Qualitative data were managed with NVIVO software (QSR International, Southport, UK) and analyzed for themes.

RESULTS: Participants were 122 parents (41% black, 40% white). Most parents articulated that communication is integral to building trust. Specifically, parents described that they wanted healthcare workers to communicate in ways that were Honest, Inclusive, Compassionate, Clear and Comprehensive, and Coordinated, which can be summarized using the acronym, HICCC. In addition, nonwhite parents were more likely than white parents to report instances when they felt doctors did not listen to them ($p = 0.0083$). Parents from minority groups reported instances of self-experienced or observed discrimination in healthcare with greater frequency than white parents. When asked to identify their pediatric intensive care unit doctor, 46% of parents were either unable to do so or named doctors from other hospital departments.

CONCLUSIONS: Communication is vital to building trust in the pediatric intensive care unit. Developed from parents' own observations and perspectives, HICCC is an accessible framework that can help doctors to remember what parents value in communication in the acute care setting. In addition, pediatric intensivists would benefit from targeted cultural competency training to reduce physician bias.

Derksen F, Bensing J, Lagro-Janssen A (2013). **Effectiveness of empathy in general practice: a systematic review.** *Br J Gen Pract.* 2013 Jan;63(606):e76-84. doi: 10.3399/bjgp13X660814. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3529296/> [Accessed 9-26-2016]

BACKGROUND: Empathy as a characteristic of patient–physician communication in both general practice and clinical care is considered to be the backbone of the patient–physician relationship. Although the value of empathy is seldom debated, its effectiveness is little discussed in general practice. This literature review explores the effectiveness of empathy in general practice. Effects that are discussed are: patient satisfaction and adherence, feelings of anxiety and stress, patient enablement, diagnostics related to information exchange, and clinical outcomes.

AIM: To review the existing literature concerning all studies published in the last 15 years on the effectiveness of physician empathy in general practice.

DESIGN AND SETTING: Systematic literature search. Method: Searches of PubMed, EMBASE, and PsychINFO databases were undertaken, with citation searches of key studies and papers. Original studies published in English between July 1995 and July 2011, containing empirical data about patient experience of GPs' empathy, were included. Qualitative assessment was applied using Giacomini and Cook's criteria.

RESULTS: After screening the literature using specified selection criteria, 964 original studies were selected; of these, seven were included in this review after applying quality assessment. There is a good correlation between physician empathy and patient satisfaction and a direct positive relationship with strengthening patient enablement. Empathy lowers patients' anxiety and distress and delivers significantly better clinical outcomes.

*Elder R, Neal C, Davis BA, Almes E, Whitley L & Littlepage N. (2004). **Patient satisfaction with triage nursing in a rural hospital emergency department.** *Journal of Nursing Care Quality.* 19(3):263-268.

This study examined what relationships or differences exist between patient and nurse characteristics, satisfaction with triage nurse caring behaviors, general satisfaction with the triage nurse, and intent to return to a rural hospital emergency department (ED). The ED, located at a 401-bed teaching hospital in a small southern city, averages 28,000 visits annually. Samples of ED nurses ($N = 11$) and ED patients ($N = 65$) were asked to respond to demographic forms and the Consumer Emergency Care Satisfaction Scale (CECSS) Adapted. Findings indicated that the nurse's acuity rating and the patient's perception of condition had a positive relationship. The patient's perception of condition, patient satisfaction, and caring satisfaction were predictors of intent to return. When patients perceived themselves as seriously ill or injured, they expressed less intent to return to that ED.

*Epstein N, Brendel T, Hege I, Ouellette D, Schmidmaier R, Kiesewetter J. (2016). **The power of the pen: how to make physicians more friendly and patients more attractive.** *Medical Education* 50(12):1214-1218.

Studies have shown that patients' subjective perceptions of physicians' competence and friendliness are relevant aspects of a successful treatment, influencing patients' well-being and trust in the physician. Psychological research has repeatedly shown that unconsciously contracting muscles that are usually used to smile can intensify and even elicit positive feelings (known as facial feedback). Empirical evidence also suggests that a smiling person is favourably judged by others with respect to attractiveness and trustworthiness.

*Flickinger TE, Saha S, Roter D, Korthius PT, Sharp V, Cohn J, Moore RD, Ingersoll KS, Beach, MC. (2015). **Respecting patients is associated with more patient-centered communication behaviors in clinical encounters.** *Patient Educ Couns*, pii: S0738-3991(15)30057-4. doi: 10.1016/j.pec.2015.08.020.

OBJECTIVE: Attitudes towards patients may influence how clinicians interact. We investigated whether respect for patients was associated with communication behaviors during HIV care encounters.

METHODS: We analyzed audio-recordings of visits between 413 adult HIV-infected patients and 45 primary HIV care providers. The independent variable was clinician-reported respect for the patient and outcomes were clinician and patient communication behaviors assessed by the Roter Interaction Analysis System (RIAS). We performed negative binomial regressions for counts outcomes and linear regressions for global outcomes.

RESULTS: When clinicians had higher respect for a patient, they engaged in more rapport-building, social chitchat, and positive talk. Patients of clinicians with higher respect for them engaged in more rapport-building, social chitchat, positive talk, and gave more psychosocial information. Encounters between patients and clinicians with higher respect for them had more positive clinician emotional tone [regression coefficient 2.97 (1.92-4.59)], more positive patient emotional tone [2.71 (1.75-4.21)], less clinician verbal dominance [0.81 (0.68-0.96)] and more patient-centeredness [1.28 (1.09-1.51)].

CONCLUSIONS: Respect is associated with positive and patient-centered communication behaviors during encounters.

PRACTICE IMPLICATIONS: Clinicians should be mindful of their respectful attitudes and work to foster positive regard for patients. Educators should consider methods to enhance trainees' respect in communication skills training.

*Frellick M. **Most physicians, nurses say empowered patients are helpful.** *Medscape*, Aug 09, 2017.

*Ford WS, & Snyder OJ (2000). Customer service in dental offices: analyses of service orientations and waiting time in telephone interactions with a potential new customer. *Health Communication*, 12(2): 149-172.

Examined service practices engaged by dental office staff interacting over the telephone with a potential new customer. The goals of the study were to determine whether the staff displayed customer-oriented and control-oriented service communication behaviors and to examine the relation between these service behaviors and waiting time required of customers. Structured observational data were collected in phone encounters with staff in 84 dental offices.

Approximately 40% of the staff engaged in the customer-oriented behavior of inviting the customer to share questions or concerns, and 31% exhibited the control-oriented behavior of reciting promotional pitches on behalf of the dental office. Six other communication behaviors were observed with less frequency. Staff who made customers wait on the line longer were more likely to use promotional pitches. The telephone script is appended.

OBJECTIVE: To determine the extent to which dental office staff engages in communication behaviors with customer orientation / control orientation during initial telephone interactions with potential new customers, and to determine the relationship between staff communication orientation and customer waiting time.

DESIGN: cross-sectional; the researchers called the dental offices and used a script to engage in a

conversation about dental services.

SETTING: 84 dental offices in a medium metropolitan area in the Midwest.

SUBJECTS: 84 dental office staff.

DATA COLLECTION: Calls were recorded and timed. Communication behaviors were coded for 4 types of customer oriented communication behaviors: chit chat, laughter, invitations to speak, and listening responses (reflecting/paraphrase and following (mhm, okay), for 4 types of control oriented communication behaviors: promotional pitches, commitment prompts, talkovers, and cutoffs, and for 2 types of waiting while on the phone (extra rings, being on hold).

DATA ANALYSIS: Communication behavior frequencies were calculated using descriptive statistics.

FINDINGS: 40.5% of the office staff invited customers to speak, a form of customer-oriented communication. Some used laughter (22.6%). Few used chitchat (3.6%) or listening responses (8.3%). Control-oriented behaviors were more frequently used than customer-oriented behaviors: promotional pitches (31%), commitment prompts (10.7%), talkovers (7.1%), and cutoffs (8.3%). Though there were no significant inter-item correlations between any of the two types of behaviors, 27.4% of the staff used both control- and customer-oriented communication behaviors. However, another 27.4% of the staff did not display any of the behaviors at all. Most waiting time occurred during extra rings, though the phone never rang more than 3 times. Only 10.4% of staff put the caller on hold. There was no association between waiting through extra rings and being placed on hold. Only promotional pitches were significantly, positively associated with waiting time.

CONCLUSIONS: Dental office staff seemed to rely on a communication routine, rather than on customer-oriented communication behaviors, when speaking with potential new patients on the phone. The authors recommended that receptionist staff in healthcare organizations use more personalized communication behaviors such as asking customers to ask questions or indicating that they are listening by saying "mhm" in order to let customers know they are being paid attention.

Fox S & Rainie L. (2008). **The engaged e-patient population** Washington, DC. Pew Internet and American life project. Available at: http://www.pewinternet.org/pdfs/PIP_Health_Aug08.pdf

This latest Pew Internet Project survey confirms that information gathering has become a habit for many Americans, particularly those in the 55% of households with broadband connections. Home broadband has now joined educational attainment, household income and age as the strongest predictors of Internet activity. For example, 78% of home broadband users look online for health information, compared with 70% of home dial-up users. Home broadband users are twice as likely as home dial-up users to do health research on a typical day—12% vs. 6%. High-speed, always-on connections enable frequent and in-depth information searches, which is particularly attractive if something important is at stake.

*Glickman SW, Boulding W, Manary M, Staelin R, Roe MT, Wolosin RJ, Ohman EM, Peterson ED, Schulman KA. (2010). **Patient satisfaction and its relationship with clinical quality and inpatient mortality in acute myocardial infarction.** *Cir Cardiovasc Qual Outcomes.* 3(2): 188-95

BACKGROUND: Hospitals use patient satisfaction surveys to assess their quality of care. A key question is whether these data provide valid information about the medically related quality of hospital care. The objective of this study was to determine whether patient satisfaction is associated with adherence to practice guidelines and outcomes for acute myocardial infarction and to identify the key drivers of patient satisfaction.

METHODS AND RESULTS: We examined clinical data on 6467 patients with acute myocardial infarction treated at 25 US hospitals participating in the CRUSADE initiative from 2001 to 2006. Press Ganey patient satisfaction surveys for cardiac admissions were also available from 3562 patients treated at these same 25 centers over this period. Patient satisfaction was positively correlated with 13 of 14 acute myocardial infarction performance measures. After controlling for a hospital's overall guideline adherence score, higher patient satisfaction scores were associated with lower risk-adjusted inpatient mortality (P=0.025). One-quartile changes in both patient satisfaction and guideline adherence scores produced similar changes in predicted

survival. For example, a 1-quartile change (75th to 100th) in either the patient satisfaction score or the guideline adherence score yielded the same change in predicted survival (odds ratio, 1.24; 95% CI, 1.02 to 1.49; and odds ratio, 1.24; 95% CI, 1.08 to 1.41, respectively). Satisfaction with nursing care was the most important determinant of overall patient satisfaction ($P < 0.001$).
CONCLUSIONS: Higher patient satisfaction is associated with improved guideline adherence and lower inpatient mortality rates, suggesting that patients are good discriminators of the type of care they receive. Thus, patients' satisfaction with their care provides important incremental information on the quality of acute myocardial infarction care.

Groopman J. (2007). **How doctors think**. Houghton Mifflin Company: N.Y.

On average, a physician will interrupt a patient describing her symptoms within eighteen seconds. In that short time, many doctors decide on the likely diagnosis and best treatment. Often, decisions made this way are correct, but at crucial moments they can also be wrong -- with catastrophic consequences. In this myth-shattering book, Jerome Groopman pinpoints the forces and thought processes behind the decisions doctors make. Groopman explores why doctors err and shows when and how they can - avoid snap judgments, emee uncertainty, communicate effectively, and deploy other skills that can profoundly impact our health. This book is the first to describe in detail the warning signs of erroneous medical thinking and reveal how new technologies may actually hinder accurate diagnoses. *How Doctors Think* offers direct, intelligent questions patients can ask their doctors to help them get back on track. Groopman draws on a wealth of research, extensive interviews with some of the country's best doctors, and his own experiences as a doctor and as a patient. He has learned many of the lessons in this book the hard way, from his own mistakes and from errors his doctors made in treating his own debilitating medical problems. *How Doctors Think* reveals a profound new view of twenty-first-century medical practice, giving doctors and patients the vital information they need to make better judgments together.

*Hojat M, Louis DZ, Markham FW, Wender R, Rabinowitz C, Gonnella JS (2011). **Physicians' Empathy and Clinical Outcomes for Diabetic Patients**. *Acad Med* 86(3): 359-364.
http://journals.lww.com/academicmedicine/Fulltext/2011/03000/Physicians__Empathy_and_Clinical_Outcomes_for.26.aspx [Accessed 3-13-2017]

PURPOSE: To test the hypothesis that physicians' empathy is associated with positive clinical outcomes for diabetic patients.
METHOD: A correlational study design was used in a university-affiliated outpatient setting. Participants were 891 diabetic patients, treated between July 2006 and June 2009, by 29 family physicians. Results of the most recent hemoglobin A1c and LDL-C tests were extracted from the patients' electronic records. The results of hemoglobin A1c tests were categorized into good control ($< 7.0\%$) and poor control ($> 9.0\%$). Similarly, the results of the LDL-C tests were grouped into good control (< 100) and poor control (> 130). The physicians, who scorers. Associations between physicians' level of empathy scores and patient outcomes were examined.
RESULTS: Patients of physicians with high empathy scores were significantly more likely to have good control of hemoglobin A1c (56%) than were patients of physicians with low empathy scores (40%, $P < .001$). Similarly, the proportion of patients with good LDL-C control was significantly higher for physicians with high empathy scores (59%) than physicians with low scores (44%, $P < .001$). Logistic regression analyses indicated that physicians' empathy had a unique contribution to the prediction of optimal clinical outcomes after controlling for physicians' and patients' gender and age, and patients' health insurance.
CONCLUSIONS: The hypothesis of a positive relationship between physicians' empathy and patients' clinical outcomes was confirmed, suggesting that physicians' empathy is an important factor associated with clinical competence and patient outcomes.

*Homma M, Ishikawa H, Kiuchi T. (2018). Illness perceptions and negative responses from medical professionals in patients with fibromyalgia: Association with patient satisfaction and number of hospital visits. *Patient Education and Counseling*, 100(3):532-540.

OBJECTIVE: To examine whether illness perceptions among patients with fibromyalgia and negative responses from medical professionals correlate with their satisfaction with their physicians or with their number of hospital visits.

METHODS: Questionnaires were sent by post to members of the Japan Fibromyalgia Support Association. Measures collected included, as independent variables, the Brief Illness Perception Questionnaire and the Illness Invalidation Inventory; and as outcomes, the Patient Satisfaction Consultation Questionnaire and the number of hospital visits.

RESULTS: We analyzed data from 304 patients. Multiple logistic regressions showed that perception of poor treatment control and the experience of being discounted and misunderstood by medical professionals were strongly correlated with dissatisfaction with attending physicians. Patients who perceived poor treatment control visited the hospital fewer times, while patients who reported being discounted by medical professionals visited more times. Patients' negative emotions correlated neither with patient satisfaction nor with the number of hospital visits.

CONCLUSION: Treatment effectiveness and the respect accorded to patients were the key factors significantly correlated both with patient satisfaction and the number of hospital visits.

PRACTICE IMPLICATIONS: Physicians should not emphasize only patients' negative psychological status but also should convey a respectful attitude and help patients understand their current treatment is useful.

* Institute of Medicine, Committee on Quality of Health Care in America, (2001). **Crossing the Quality Chasm: A New Health System for the 21st Century**. Washington DC: National Academy Press. ISBN 0-309-07280-8. <http://nap.edu/10027> [Accessed 6-2-2016]

The committee proposes six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should. Health care should be: Safe—avoiding injuries to patients from the care that is intended to help them. • Effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively). Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. Timely—reducing waits and sometimes harmful delays for both those who receive and those who give care. Efficient—avoiding waste, including waste of equipment, supplies, ideas, and energy. Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. A health care system that achieved major gains in these six dimensions would be far better at meeting patient needs. Patients would experience care that was safer, more reliable, more responsive, more integrated, and more available. Patients could count on receiving the full array of preventive, acute, and chronic services from which they are likely to benefit. Such a system would also be better for clinicians and others who would experience the satisfaction of providing care that was more reliable, more responsive to patients, and more coordinated than is the case today.

*Jordan A, Wood F, Edwards A, Shepherd V, Joseph-Williams N. (2018). What adolescents living with long-term conditions say about being involved in decision-making about their healthcare: A systematic review and narrative synthesis of preferences and experiences, *Patient Education and Counseling* 101(10): 1725-1735.

HIGHLIGHTS: Adolescents with long-term conditions want to “have a say” about their treatment. Involvement preferences between and within individuals can vary substantially. Adolescents often feel that treatment options do not exist. Preferences not being met can be harmful to adolescent well-being and self-efficacy.

OBJECTIVE: To understand the preferences and experiences of adolescents (age 10–19) with

long-term conditions (LTCs) towards involvement in discussions and decisions regarding management of their condition.

METHODS: A systematic review and narrative synthesis of mixed-methods, quantitative and qualitative and research was performed. Six databases were searched from inception to March 2017. The quality of the articles was assessed, and relevant data were extracted and coded thematically.

RESULTS: The search yielded 27 articles which met the inclusion criteria. Decision-making involvement preferences and experiences were reported from the adolescents' perspectives. Adolescents often report that they do not have any choice of treatment options. Variability in preferences and experiences were found within and between individuals. Mismatches between preferences and experiences are common, and often with negative emotional consequences.

DISCUSSION: Adolescent preferences for involvement in the decision-making process are situational and individualistic. Healthcare professionals can encourage involvement by ensuring that adolescents are informed of treatment options, and aware of the value of their contribution. Future research should explore adolescent perceived barriers and facilitators to SDM.

PRACTICAL IMPLICATIONS: Interventions are needed to effectively train HCPs in the delivery of shared decision-making, and to support the participation of adolescents with LTCs in shared decision-making.

*Kahn MW. (2008). **Etiquette-based medicine.** *New England Journal of Medicine*, 358(19): 1988-1989.

This editorial advocates training for an "etiquette-based" approach to patient care that would complement efforts to train clinicians to be more humane and the development of checklists of clinician etiquette for the clinician-patient encounter which might include: (1) asking permission to enter the room and waiting for an answer; (2) introducing yourself; (3) shaking hands (wear gloves if needed); (4) sitting down and smiling if appropriate; (5) explaining your role on the team; and (6) asking the patient how he or she is feeling about being in hospital.

Keating NL, Green DC, Kao AC, Gazmararian JA, Wu VY & Cleary PD. (2002). **How are patients' specific ambulatory care experiences related to trust, satisfaction, and considering changing physicians?** *Journal of General Internal Medicine*, 17: 29-39.

Telephone survey of 2000+ patients of a large national health insurer (58% response rate) to assess relationships between outpatient problem experiences and patients' trust in their physicians, and consideration of changing physicians. Classified as problem experiences if the patient reported that the physician did not 1) give them enough time to explain the reason for their visit 2) give answers to questions that were understandable 3) take enough time to answer questions 4) ask about how their family or living situation affects their health 5) give as much medical information as they want 5) involve them in decisions as much as they want.

CONCLUSIONS: Problem experiences in ambulatory settings strongly related to lowered trust.

*Gillespie H, Kelly M, Duggan S, Dorman T. (2017). How do patients experience caring? Scoping review. *Patient Education and Counseling*, 100(9):1622-1633.

Summarizes empirical research into patients' experiences of caring in order to promote this as a core condition for the work of health professionals.

METHODS: A review team: carried out a scoping review with a phenomenological orientation that did not privilege any profession or context of care; comprehensively searched six databases from inception to the present, including all English language articles that report patients' lived experiences of caring; and identified and contrasted uncaring experiences.

RESULTS: 43 articles straddled nursing, medicine, and physiotherapy, and a wide range of care settings. Patients experienced caring when competent professionals displayed positive attitudes, communicated effectively, formed relationships, helped them navigate clinical services, and engaged emotionally.

CONCLUSION: This research provides a rich description of caring, which was derived from patients', rather than professionals' experiences.

PRACTICE IMPLICATION: Whilst publications and basic professional curricula are dominated by

the perspectives of single professions, this research describes patients' experiences that can prepare all health professionals to be caring in collaborative, interprofessional practice.

*Kerfoot KM. (2008). **Hospital and service: Leading real change.** *Nursing Economics*, (26): 191-193.

A patient's decision to recommend a health care organization and the patient's loyalty scores are largely determined by the interaction patients and their families have had with the nurses. Hospitality is now the delivery of that product makes the person feel and is a dialogue that requires the server to be "on the guest's side" throughout the experience. The challenge for health care is to help our patients and their families transcend the usual routine care of our health care world and to experience an emotional connection that provides that sense of affiliation and emotional kinship with the organization and the staff. Moving from the service mindset in health care to the hospitality mindset that engages people positively and emotionally is what healing is all about.

Kettunen T, Poskiparta M, et al. (2000). **Communicator styles of hospital patients during nurse-patient counseling.** *Patient Education & Counseling*, 41(2): 161-180.

This article describes nurse-patient communication during counseling sessions. It focuses on the patient as a participant in a discussion and aims at a description of patients' communicator styles, which were observed on videotape based on 38 counseling sessions transcribed word by word. Interviews of the participating nurses and patients were used for partial support of the interpretations. The analytic method chosen was typology, used for achieving a multifaceted qualitative description of patient communication. The research material yielded 7 types of communicator styles: Quietly Assenting, Emotionally Expressive, Storyteller, Stoic Observer, Inquisitive of Detail, Dominant, and Critical Self-observer. The communicator styles were indicative of the multitude of ways in which patients participate in counseling discussions; use of the typology of styles makes it possible to describe the varying expressions of patient communication. This article presents new background information on patient communication. The outcome may prove to be useful for developing health counseling.

OBJECTIVE: To examine and describe patient communication styles.

SETTING: Finnish hospital

SUBJECTS: Nurses (n=19), patients (n=38)

DATA COLLECTION: Nurses videotaped 38 patient counseling sessions, which lasted 5 to 45 minutes, and involved topics such as discharge planning, education about an illness, admittance interviews, and other topics. Videotaped sessions were transcribed. Nurses and patients were interviewed.

DATA ANALYSIS: The typological analysis involved 8 stages: transcription, viewing tapes & reading transcripts, isolating central themes for each tape (showing initiative, self-disclosing, asking, etc.), describing how themes were manifested in verbal communication behaviors, seeking differences and comparing patients' speech & reading background literature on communication styles, defining type dimensions & grouping patients, constructing communicator style types, and relating the type descriptions to the literature on communication.

FINDINGS: Seven patient communicator types were identified: quietly assenting, emotionally expressive, storyteller, stoic observer, inquisitive of detail, dominant, and critical self-observer. Communication behaviors for each type were described for the following features of communication: nonverbal, speech, manner of participation, topics, feedback, assertiveness, and contributing to the discussion. For quietly assenting patients (n=14), the norms for the discussion depended largely upon the practices of the hospital and the actions of the nurse. These patients are quiet and respond to nurses' questions, without bringing up other topics or expanding much on their answers. Emotionally expressive patients (7 women) discuss their feelings, talk for long periods of time, take initiative in making comments and expressing opinions, and seem to want to create a relationship with the nurse. Storytellers (5 men) used anecdotes and humor to discuss past experiences, and replied to nurses' questions in depth. Stoic observers (n=4) expressed themselves little and showed few emotions. Sometimes, the patients gave short responses despite long pauses between nurse's questions. At other times,

patients who were giving longer responses or asking questions were interrupted or ignored by the nurse and then gave only short responses thereafter. Three patients were classified as inquisitive of detail. These patients were highly attentive and asked the nurse more questions than the nurse asked them. Dominant patients (n=3) were assertive, self-assured, and often critical or corrective of the nurses' comments. These patients also sidetracked the conversation into a peripheral topic and often controlled the conversation by using "I" statements and making their own judgments, predictions, and decisions. Critical self-observers (2 women) controlled the conversation by assessing their own actions critically, and by displaying their knowledge, skills, attitudes and behaviors regarding the health topic. They also discussed the pragmatic issues involved in carrying out health behavior instructions.

CONCLUSIONS: Nurses in the study showed a strong tendency to direct the conversation in a routine, scripted manner and to restrict the speech of the patient. Many nurses gave patients the opportunity to ask questions only at the end of the counseling session, at which point some patients were discouraged from speaking and many patients were unable to participate fully in the health education experience. Familiarity with patient communicator styles is helpful for nurses and other health care providers for providing adequate, participatory health counseling and for understanding how to respond to patient concerns.

*Kim SS, Kaplowitz S, Johnston MV (2004). **The effects of physician empathy on patient satisfaction and compliance.** *Evaluation & the Health Professions*, 27(3): 237-251. DOI:10.1177/0163278704267037. <http://ehp.sagepub.com/content/27/3/237.abstract> [Accessed 10-4-2016]

The present study attempted to develop new scales of patient-perceived, empathy-related constructs and to test a model of the relationships of physician empathy and related constructs to patient satisfaction and compliance. Five hundred fifty outpatients at a large university hospital in Korea were interviewed with the questionnaire. The data were analyzed using structural equation modeling. Patient-perceived physician empathy significantly influenced patient satisfaction and compliance via the mediating factors of information exchange, perceived expertise, interpersonal trust, and partnership. Improving physician empathic communication skills should increase patient satisfaction and compliance. Health providers who wish to improve patient satisfaction and compliance should first identify components of their empathic communication needing improvement and then try to refine their skills to better serve patients.

*Kraus, M. (2017). **Voice-only communication enhances empathic accuracy.** *American Psychologist*, 72(7): 644-654.

This research tests the prediction that voice-only communication increases empathic accuracy over communication across senses. We theorized that people often intentionally communicate their feelings and internal states through the voice, and as such, voice-only communication allows perceivers to focus their attention on the channel of communication most active and accurate in conveying emotions to others. We used 5 experiments to test this hypothesis (N = 1,772), finding that voice-only communication elicits higher rates of empathic accuracy relative to vision-only and multisense communication both while engaging in interactions and perceiving emotions in recorded interactions of strangers. Experiments 4 and 5 reveal that voice-only communication is particularly likely to enhance empathic accuracy through increasing focused attention on the linguistic and paralinguistic vocal cues that accompany speech. Overall, the studies question the primary role of the face in communication of emotion, and offer new insights for improving emotion recognition accuracy in social interactions.

*Krznicaric R. (2015). **Empathy: Why It Matters, and How to Get It.** Penguin Random House.

<https://www.romankrznaric.com/empathy-a-handbook-for-revolution> [Accessed 3-13-2017]

*Langewitz W, Denz M, Keller A, et al. (2002). **Spontaneous talking time at start of consultation in outpatient clinic: Cohort study.** *British Medical Journal.* 325:682-683.

Examined how long it would take outpatients at a tertiary referral centre to indicate they had completed their story if uninterrupted by their doctors. A sequential cohort of patients from the outpatient clinic of a university hospital participated (n=406; mean age 42.9 yrs). Doctors surreptitiously activated a stopwatch at the start of the communication, and pressed it again when the patient indicated they wanted the doctor to take the lead. Mean spontaneous talking time was 92 seconds, and 78% of patients had finished their initial statement in 2 minutes. Seven patients talked for longer than 5 minutes. In all cases doctors felt that the patients were giving important information and should not be interrupted. Implications for patient treatment and doctor-patient communication are discussed.

Larson EB & Yao X. (2005). **Clinical empathy as emotional labor in the patient-physician relationship.** *Journal of American Medical Association,* 293(9), 100-1106.

Empathy should characterize all health care professions. Despite advancement in medical technology, the healing relationship between physicians and patients remains essential to quality care. We propose that physicians consider empathy as emotional labor (i.e., management of experienced and displayed emotions to present a certain image). Since the publication of Hochschild's *The Managed Heart* in 1983, researchers in management and organization behavior have been studying emotional labor by service workers, such as flight attendants and bill collectors. In this article, we focus on physicians as professionals who are expected to be empathic caregivers. They engage in such emotional labor through deep acting (i.e., generating empathy-consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the method-acting tradition used by some stage and screen actors), surface acting (i.e., forging empathic behaviors toward the patient, absent of consistent emotional and cognitive reactions), or both. Although deep acting is preferred, physicians may rely on surface acting when immediate emotional and cognitive understanding of patients is impossible. Overall, we contend that physicians are more effective healers—and enjoy more professional satisfaction—when they engage in the process of empathy. We urge physicians first to recognize that their work has an element of emotional labor and, second, to consciously practice deep and surface acting to empathize with their patients. Medical students and residents can benefit from long-term regular training that includes conscious efforts to develop their empathic abilities. This will be valuable for both physicians and patients facing the increasingly fragmented and technological world of modern medicine.

*Leland J. (2008). **In 'sweetie' and 'dear,' a hurt for the elderly.** *New York Times, October 7, 2008.*

Professionals call it elderspeak, the sweetly belittling form of address that has always rankled older people: the doctor who talks to their child rather than to them about their health; the store clerk who assumes that an older person does not know how to work a computer, or needs to be addressed slowly or in a loud voice. Then there are those who address any elderly person as "dear." Now studies are finding that the insults can have health consequences, especially if people mutely accept the attitudes behind them, said Becca Levy, an associate professor of epidemiology and psychology at [Yale University](#), who studies the health effects of such messages on elderly people. See also Williams et al., 2009,

*Levinson W, Gorawara-Bhat R & Lamb J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *JAMA,* 284(8) 1021-1027.

OBJECTIVE: To explore the nature and frequency of patient clues during medical encounter and physician response among primary care physicians and surgeons.

DESIGN: Descriptive study of audio-taped office visits (data set was part of a larger research project that examined the relationship between physician-patient communication and medical malpractice).

SETTING: Community-based practices of primary care physicians and surgeons in Oregon and Colorado.

SUBJECTS: 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons (94% male, 91% Caucasian, 67% group practice). Ten patients per physician were selected sequentially from the waiting rooms (54% female, 88% Caucasian, 71% married, average age=54).

INTERVENTION: None.

MEASURES: Audio-taped interactions and transcripts were reviewed to identify and describe segments of the interview in which there were clues about patients' emotional or social concerns. Clues that were initiated by the patient were coded for type and timing and nature of physician response. In addition, physician questions that encouraged patient to discuss a personal topic were also coded as physician-initiated clues. Length of visit was also recorded.

RESULTS: Clues occurred in 52% of the primary care visits (mean number of clues =2.6) and in 53% of the surgical visits (mean number of clues = 1.9). Patients initiated approximately 70% of those clues and physicians initiated approximately 30%. Of the patient led clues in primary care visits, 76% were emotional and 60% in the surgical setting. Physicians missed the opportunity to respond to patient led clues 79% of the time in primary care and 62% in the surgical setting. In 50% of those interviews where the physician missed the opportunity to respond to the patient-led clue, the patient brought up the same issue (clue) a second or third time. In addition, in primary care, visits were longer when there was a missed opportunity to respond by the physician compared with visits where the physician responded with a positive response (mean time, 20.1 min vs. 17.6 min).

CONCLUSIONS/RECOMMENDATIONS: Patients offer clues to physicians that provide rich opportunities for empathy and a greater understanding of patients' lives. In primary care and surgery settings, physicians tend to miss these clues and thus overlooking opportunities to strengthen the doctor-patient relationship. Two aspects of the medical encounter uncovered in this study, patient clues and physician responses, should be recognized as being interdependent and necessary in building a trusting relationship between physician and patients and impacting health outcome.

*Levinson W, Kao A, Kuby A, & Thisted R. (2005). **Not all patients want to participate in decision-making: a national study of public preferences.** *Journal of General Internal Medicine*, 20(6):531-535.

BACKGROUND: The Institute of Medicine calls for physicians to engage patients in making clinical decisions, but not every patient may want the same level of participation.

OBJECTIVES: 1) To assess public preferences for participation in decision making in a representative sample of the U.S. population. 2) To understand how demographic variables and health status influence people's preferences for participation in decision-making.

DESIGN AND PARTICIPANTS: A population-based survey of a fully representative sample of English-speaking adults was conducted in concert with the 2002 General Social Survey (N= 2,765). Respondents expressed preferences ranging from patient-directed to physician-directed styles on each of 3 aspects of decision making (seeking information, discussing options, making the final decision). Logistic regression was used to assess the relationships of demographic variables and health status to preferences.

MAIN RESULTS: Nearly all respondents (96%) preferred to be offered choices and to be asked their opinions. In contrast, half of the respondents (52%) preferred to leave final decisions to their physicians and 44% preferred to rely on physicians for medical knowledge rather than seeking out information themselves. Women, more educated, and healthier people were more likely to prefer an active role in decision making. African-American and Hispanic respondents were more likely to prefer that physicians make the decisions. Preferences for an active role increased with age up to 45 years, but then declined.

CONCLUSION: This population-based study demonstrates that people vary substantially in their preferences for participation in decision-making. Physicians and health care organizations should not assume that patients wish to participate in clinical decision-making, but must assess individual patient preferences and tailor care accordingly.

*Lown BA, Roy E, Gorman P, Sasson JP. (2009). **Women's and residents' experiences of communication in the diagnostic mammography suite.** *Patient Educ Couns*, 77(3): 328-37.

To gain understanding of radiology residents' and women's experiences, concerns, information needs, coping strategies and perspectives about optimal communication during diagnostic mammography.

METHODS: Qualitative analysis of focus groups of radiology residents and women who had undergone diagnostic mammograms.

RESULTS: Five categories of themes emerged from our analysis: information needs, perspectives and ideals, emotional experiences and observations, working together, individual experiences, and others' roles. Women preferred continuous orientation, clear explanations and emotional support by physicians and radiology technologists throughout diagnostic processes.

Communication about diagnostic mammogram results evoked the threat of breast cancer and was experienced as "bad news" by women, but not necessarily by all radiology residents. Lack of collaboration among radiologists, technologists and other healthcare professionals engendered confusion and anxiety in patients. Radiology residents felt inadequately prepared to meet the communication challenges of providing information and emotional support tailored to women's needs in this context.

CONCLUSION: Women's experiences are influenced by the extent to which they receive clear information and support, and perceive collaboration among professionals involved in the diagnostic mammography process.

PRACTICE IMPLICATIONS: Radiology education must address communication with patients and among healthcare professionals involved in the care of patients undergoing diagnostic procedures and interventions.

*Lown BA, Rosen J, Marttila J. (2011). An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. *Health Aff*, 30(9):1772-8.

As the US health care system undergoes restructuring and pressure to reduce costs intensifies, patients worry that they will receive less compassionate care. So do health care providers. Our survey of 800 recently hospitalized patients and 510 physicians found broad agreement that compassionate care is "very important" to successful medical treatment. However, only 53 percent of patients and 58 percent of physicians said that the health care system generally provides compassionate care. Given strong evidence that such care improves health outcomes and patients' care experiences, we recommend that national quality standards include measures of compassionate care; that such care be a priority for comparative effectiveness research to determine which aspects have the most influence on patients' care experiences, health outcomes, and perceptions of health-related quality of life; and that payers reward the provision of such care. We also recommend the development of systematic approaches to help health care professionals improve the skills required for compassionate care.

*Maisels M, Jeffrey MB, & Kring EA. (2005). **A simple approach to improving patient satisfaction.** *Clinical Pediatrics*. 44(9):797-800.

Improved communication with families may significantly increase their satisfaction with the care of their hospitalized child. The families of children admitted to a general pediatric service were randomly assigned to receive a daily visit from a communicator/facilitator whose purpose was to respond to any questions the family might have and, if necessary, to explain results of laboratory tests. Control families received routine care. At the time of discharge (study 1) or following discharge (study 2), the families were asked to complete a brief questionnaire regarding the quality of nursing care and physician care (both attending and resident physician). Responses were received from 76/83 (91.6%) in the study group and 75/83 (90.4%) in the control group. There was a highly significant improvement in parent satisfaction with all of the care delivered-nursing, attending physician, and resident care ($p < .005$ in all categories of care). The simple act of offering a sympathetic and understanding ear, and answering questions, many of which were unrelated to the medical problem at hand, had a salutary effect on overall

patient and family satisfaction with both nursing and medical care. In the current era of intense competition to fill available beds and the important emphasis on quality of care, this approach deserves further evaluation by department managers and hospital administrators.

*Makoul G, Zick A & Green M. (2007). **An evidence-based perspective on greetings in medical encounters.** *Arch Intern Med*, 11;167(11):1172-6.

BACKGROUND: Widely used models for teaching and assessing communication skills highlight the importance of greeting patients appropriately, but there is little evidence regarding what constitutes an appropriate greeting.

METHODS: To obtain data on patient expectations for greetings, we asked closed-ended questions about preferences for shaking hands, use of patient names, and use of physician names in a computer-assisted telephone survey of adults in the 48 contiguous United States. We also analyzed an existing sample of 123 videotaped new patient visits to characterize patterns of greeting behavior in everyday clinical practice.

RESULTS: Most (78.1%) of the 415 survey respondents reported that they want the physician to shake their hand, 50.4% want their first name to be used when physicians greet them, and 56.4% want physicians to introduce themselves using their first and last names; these expectations vary somewhat with patient sex, age, and race. Videotapes revealed that physicians and patients shook hands in 82.9% of visits. In 50.4% of the initial encounters, physicians did not mention the patient's name at all. Physicians tended to use their first and last names when introducing themselves.

CONCLUSIONS: Physicians should be encouraged to shake hands with patients but remain sensitive to nonverbal cues that might indicate whether patients are open to this behavior. Given the diversity of opinion regarding the use of names, coupled with national patient safety recommendations concerning patient identification, we suggest that physicians initially use patients' first and last names and introduce themselves using their own first and last names.

*Mazzi AM, Rimondini M, Boerma WGW, Zimmerman C, Bensing JM. (2015). **How patients would like to improve medical consultations: Insights from a multicultural European study.** *Patient Educ Couns*, pii: S0738-3991(15)30047-1. doi: 10.1016/j.pec.2015.08.009.

OBJECTIVE: In a previous qualitative study (GULiVer-I), a series of lay-people derived recommendations ('tips') was listed for doctor and patient on 'How to make medical consultation more effective from the patient's perspective'. This work (GULiVer-II) aims to find evidence whether these tips can be generally applied, by using a quantitative approach, which is grounded in the previous qualitative study.

METHODS: The study design is based on a sequential mixed method approach. 798 patients, representing United Kingdom, Italy, Belgium and the Netherlands, were invited to assess on four point Likert scales the importance of the GULiVer-I tips listed in the 'Patient Consultation Values questionnaire'.

RESULTS: All tips for the doctor and the patient were considered as (very) important by the majority of the participants. Doctors' and patients' contributions to communicate honestly, treatment and time management were considered as equally important (65, 71 and 58% respectively); whereas the contribution of doctors to the course and content of the consultation was seen as more important than that of patients.

CONCLUSIONS: The relevance of GULiVer-I tips is confirmed, but tips for doctors were assessed as more important than those for patients.

PRACTICE IMPLICATIONS: Doctors and patients should pay attention to these "tips" in order to have an effective medical consultation.

*Mazzi AM, Rimondini M, van der Zee E, Boerma W, Zimmerman C, Bensing J. (2018). **Which patient and doctor behaviours make a medical consultation more effective from a patient point of view.** Results from a European multicentre study in 31 countries. *Patient Educ Couns*, <https://doi.org/10.1016/j.pec.2018.05.019>

OBJECTIVE: To assess European patients' preferences regarding seven aspects of doctor-patient communication.

METHODS: 6049 patients from 31 European countries evaluated 21 doctor and 12 patient behaviours, through a patient-generated questionnaire (PCVq). Multilevel models explored the effects of patient characteristics, contextual and cultural dimensions on preferences.

RESULTS: Patients attributed more responsibility to doctors, by giving greater importance to doctor than to patient factors, in particular to Treating the patient as a partner and as a person and Continuity of care. Gender, age, education, the presence of chronic illness and two of Hofstede's cultural dimensions, Individualism and Indulgence, showed differential evaluations among patients. Women gave greater importance to all seven communication aspects, older patients to being prepared for the consultation, lower educated patients to Treating patient as a person and Thoughtful planning. Patients from countries with an indulgent background rated all seven communication aspects of greater importance. A more individualistic orientation was related to lower importance regarding the four doctor's factors and the patient factor Open and Honest.

CONCLUSIONS: Treating the patient as a person and providing continuity of care emerged as universal values.

*Montague E, Chen P, Xu J, Chewning B & Barrett B. (2013). Nonverbal interpersonal interactions in clinical encounters and patient perceptions of empathy. *J Participat Med.*, 5

OBJECTIVE: The relationship between nonverbal behaviors and patient perceptions of clinicians has been underexplored. The aim of this study was to understand the relationship between nonverbal communication behaviors (eye contact and social touch) to patient assessments of clinician (empathy, connectedness, and liking).

METHODS: Hypotheses were tested including clinician and patient nonverbal behaviors (eye contact, social touch) were coded temporally in 110 videotaped clinical encounters. Patient participants completed questionnaires to measure their perception of clinician empathy, connectedness with clinician, and how much they liked their clinician.

RESULTS: Length of visit and eye contact between clinician and patient were positively related to the patient's assessment of the clinician's empathy. Eye contact was significantly related to patient perceptions of clinician attributes, such as connectedness and liking.

CONCLUSION: Eye contact and social touch were significantly related to patient perceptions of clinician empathy. Future research in this area is warranted, particular with regards to health information technology and clinical system design.

PRACTICE IMPLICATIONS: Clinical environments designed for patient and clinician interaction should be designed to facilitate positive nonverbal interactions such as eye contact and social touch. Specifically, health information technology should not restrict clinicians' ability to make eye contact with their patients.

Muntlin A, Gunningberg L, & Carlsson M. (2006). Patients' perceptions of quality of care at an emergency department and identification of areas for quality improvement. *Journal of Clinical Nursing*. 15(8):1045-1056.

AIMS: This paper reports a study to identify patient's perceptions of quality of care at an emergency department and areas for quality improvement.

BACKGROUND: Patients are not always satisfied with the care received at emergency departments. More attention needs to be paid to the specific needs and expectations of the non-urgent group of patients, who make up the majority of attenders at many emergency departments. Nurses' and physicians' perceptions about good quality of care do not always agree with patients' perceptions. Instruments measuring patient satisfaction have often been focused on inpatient treatment.

METHOD: A prospective, descriptive survey design was adopted and the study took place in one

emergency department at a Swedish university hospital in 2002. The participants were 99 women and 101 men, with an average age of 51 years. The emergency department version of the questionnaire Quality from the Patient's Perspective was used for data collection.

RESULTS: Patients estimated quality of care at the emergency department as fairly good, but there were areas in need of improvement. A high percent of inadequate quality was related to the environment in the emergency department. About 20% of patients reported that they did not receive effective pain relief. More than 20% estimated that nurses did not show an interest in their life situation and patients did not receive useful information on self-care and about which physician was responsible for their medical care.

CONCLUSIONS: The use of a research-based instrument gave valuable information for quality improvement in clinical practice. Many of the identified areas for quality improvement are related to nursing care. Therefore, the importance of nursing care in the emergency department should be highlighted to nurses and physicians and they also need to be more attentive to the need of the individual patient.

RELEVANCE TO CLINICAL PRACTICE: Identifying areas for quality improvements are important, to know where to take action. These findings may facilitate the work with changing attitudes and working routines, which are needed to deliver effective care and to improve patients' perceptions of quality of care at emergency departments.

Nerney M, Chin M, Jin L, Karrison TG, Walter J, Mulliken R, Miller A, Hayley D & Friedmann P. (2001). **Factors associated with older patients' satisfaction with care in an inner-city emergency department.** *Annals of Emergency Medicine.* 38(2):140-145.

STUDY OBJECTIVES: We sought to assess older patients' satisfaction with care in the emergency department and to identify factors associated with global satisfaction with care.

METHODS: We performed a prospective cohort study of 778 patients 65 years of age and older presenting to an urban academic ED between 1995 and 1996, of whom 79% were black and 63% were female. A baseline survey at presentation to the ED asked for demographic information, medical history, and health-related quality of life information. A follow-up satisfaction survey asked patients to rate the care they received in the ED on a 5-point Likert scale (1=excellent, 5=poor). Overall satisfaction with care, dichotomized into responses of "excellent" versus all others, was the primary dependent variable in our bivariate analyses.

RESULTS: Of respondents, 40% rated their ED care as "excellent." Variables significantly correlated with high satisfaction include having the perception of time spent in the ED as not "too long," having the emergency physicians and nurses clearly answer patients' questions, having a relationship of trust with an ED staff member, being told why tests were done, feeling involved in decisions about care as much as they wanted, having pain addressed fully, having a perception of greater health status, and having fewer comorbid conditions at the time of the ED visit. Results may be applicable only to urban academic EDs and may be limited by time elapsed between ED visits and follow-up surveys.

CONCLUSION: To improve quality of care for older adults in the ED, physicians should be more attentive to older patients' concerns and questions, recognize and aggressively treat pain, and reduce the patients' perception of a long waiting time.

*Newcomb P, Wilson M, Baine R, McCarthy T, Penny N, Nixon C, Orren J. (2017). **Influences on patient satisfaction among patients who use emergency departments frequently for pain-related complaints.** *Journal of Emergency Nursing,* 43(6):553-559.

The primary purpose of this study was to assess relationships between opioid prescribing practices, patient and ED attributes, and patient satisfaction ratings of nursing and physician care among patients with high utilization of the emergency department for pain relief.

METHODS: A retrospective cohort study was conducted to examine 305 individual patient satisfaction surveys from users with high ED utilization for pain complaints. Responses were compared with an age-matched control group (n =305) of nonfrequent ED users. Patient satisfaction survey responses and electronic medical records were used to model relationships between patient satisfaction and predictor variables.

RESULTS: ED frequent users with pain complaints were 75% less likely to return a satisfaction survey

compared with other patients (odds ratio = 0.2488; $P < .0001$). Patient satisfaction with physician behavior was largely accounted for by ED cleanliness, pain control, wait time for the physician, satisfaction with nursing, and feelings that ED staff cared about the patient personally. On the other hand, patient satisfaction with nursing care was largely accounted for by perceptions that nursing care was compassionate, feelings that the patient mattered personally, perceptions of safety precautions, and wait times. Receipt of prescriptions for scheduled drugs did not significantly influence patient satisfaction with physician or nursing behaviors.

DISCUSSION: Emergency nurses can influence patient satisfaction scores by promoting clean, caring environments and prioritizing patient flow and pain management. ED providers can withhold opioids when appropriate without fear of a significant impact on patient satisfaction.

*Norfolk T, Birdi K, Walsh D (2007). **The role of empathy in establishing rapport in the consultation: a new model.** *Medical Education* 2007; 41: 690–697.
<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2007.02789.x/abstract> [Accessed 10-4-2016]

Considerable research has been conducted recently into the notion of patient-centred consulting. The primary goal of this approach is to establish a clear understanding of the patient's perspective on his or her problem, and to allow this understanding to inform both the explanation and planning stages of the consultation. The quality of this understanding is largely determined by the empathic accuracy achieved by the doctor; the primary benefit is a therapeutic rapport between doctor and patient.

METHODS: To highlight the role of empathy and communication skills in establishing rapport, we initially developed a model which seeks to draw the various motivational and skill elements identified in separate research papers into a comprehensive model of the journey towards shared understanding between doctor and patient. We then conducted an initial validation of the model via qualitative analysis involving general practitioners (GPs) and clinical psychologists.

RESULTS: The validation offered encouraging support for the principal elements of the model.

Specific suggestions for clarification and extension were then incorporated in a revised model.

CONCLUSIONS: The model appears to capture the dynamic process of establishing a therapeutic relationship (rapport) between doctor and patient, defined by the quality of the doctor's understanding of the patient's perspective on his or her problem. Arguably, the most important contribution of the model is to highlight the fact that 'empathy' and consequent 'rapport' are not mystical or exclusive concepts but, rather, involve the use of specific skills accessible at some level by all.

*O'Connor MB, Nolan DP, O'Dwyer M, O'Shea S & Phelan MJ. (2011). **Doctor-patient introductions: getting it right.** *Irish Journal of Medical Science*, 180(4):935–936.

The first interaction a doctor has with a patient can often be the foundation on which the doctor-patient relationship blossoms or perishes. Those first few seconds in a medical encounter are pivotal in creating the rapport, making the patient feel comfortable, and setting the tone for a medical consultation. Historically, physicians and medical students are encouraged to shake hands with the patient, address the patient by name, and introduce themselves. This communication process is an important part of a medical consultation and can affect patient satisfaction. Such is the importance of this communication process that it is now recognized as a core clinical skill when practicing in a medical setting. It also needs to be highlighted that non-verbal communication is extremely important and a doctor's attire is to the fore in this area. From this study, we can conclude that patients, from this cohort, prefer doctors to address them in a friendly personal manner with the use of only first names being very acceptable. This is in direct comparison with how patients prefer doctors to introduce and present themselves, with the use of using of title, full name and formal attire being viewed most appropriate, with the traditional handshake now less acceptable.

*Ofri D. (2017). *What Patients Say, What Doctors Hear*. Beacon Press.

Despite modern medicine's infatuation with high-tech gadgetry, the single most powerful diagnostic tool is the doctor-patient conversation, which can uncover the lion's share of illnesses. However, what patients say and what doctors hear are often two vastly different things. Patients, anxious to convey their symptoms, feel an urgency to "make their case" to their doctors. Doctors, under pressure to be efficient, multitask while patients speak and often miss the key elements. Add in stereotypes, unconscious bias, conflicting agendas, and fear of lawsuits and the risk of misdiagnosis and medical errors multiplies dangerously. Though the gulf between what patients say and what doctors hear is often wide, Dr. Danielle Ofri proves that it doesn't have to be. Through the powerfully resonant human stories that Dr. Ofri's writing is renowned for, she explores the high-stakes world of doctor-patient communication that we all must navigate. Reporting on the latest research studies and interviewing scholars, doctors, and patients, Dr. Ofri reveals how better communication can lead to better health for all of us.

* Östlunda A, Wadensten B, Häggström E, Lindqvist H, Kristofferzon M. (2016). Primary care nurses' communication and its influence on patient talk during motivational **interviewing**. *Journal of Advanced Nursing*, 72(11), 2844-2856,

The aim of this study was to describe what verbal behaviours/kinds of talk occur during recorded motivational interviewing sessions between nurses in primary care and their patients. The aim was also to examine what kinds of nurse talk predict patient change talk, neutral talk and/or sustain talk.

*Pollak KI, Alexander SC, Tulsy JA, Lyna P, Coffman CJ, Dolor RJ, Gulbrandsen P, Østbye T (2011). **Physician Empathy and Listening: Associations with Patient Satisfaction and Autonomy**. *J Am Board Fam Med*, 24(6): 665-67.

http://selfdeterminationtheory.org/SDT/documents/2011_Pollaketal_physicianMI_JABFM.pdf
[Accessed 9-26-2016]

PURPOSE: Motivational Interviewing (MI) is used to help patients change their behaviors. We sought to determine if physician use of specific MI techniques increases patient satisfaction with the physician and perceived autonomy.

METHODS: We audio-recorded preventive and chronic care encounters between 40 primary care physicians and 320 of their overweight or obese patients. We coded use of MI techniques (e.g., empathy, reflective listening). We assessed patient satisfaction and how much the patient felt the physician supported him or her to change. Generalized estimating equation models with logit links were used to examine associations between MI techniques and patient perceived autonomy and satisfaction.

RESULTS: Patients whose physicians were rated as more empathic had higher rates of high satisfaction than patients whose physicians were less empathic (29% vs. 11%; P .004). Patients whose physicians made any reflective statements had higher rates of high autonomy support than those whose physicians did not (46% vs. 30%; P .006).

CONCLUSIONS: When physicians used reflective statements, patients were more likely to perceive high autonomy support. When physicians were empathic, patients were more likely to report high satisfaction with the physician. These results suggest that physician training in MI techniques could potentially improve patient perceptions and outcomes.

Post S. (2011). Compassionate touch: Benefits & effects of long term care. *PsycEXTRA Dataset*, 1(4).

This review of outcome studies demonstrates that compassionate care benefits patients with regard to elected treatment adherence, wound healing, satisfaction and well-being; it benefits physicians with regard to lowered depression rates, elevated meaning, lower burnout, and more diligent technical care; it benefits healthcare systems that establish reputational gains at no greater use of time or resources; it benefits medical students with regard to their diminished complaints of abusive clinical environments and maladaptive team interactions. There is no doubt that compassionate care has many dimensions of beneficial impact.

Quill TE, Arnold RM & Platt F. (2001). "I wish things were different": Expressing wishes in response to loss, futility, and unrealistic hopes. *Annals of Internal Medicine*, 135(7) 551-555.

Physicians who care for patients encounter many powerful and painful emotions, including anger, sadness, fear, grief, loss, hopelessness, and blame. Many studies suggest that physicians should express empathy in response to emotion-laden patient statements to ensure that patients feel listened to and understood. These physician responses usually consist of efforts to comprehend how things feel to the patient and to express that understanding back to the patient. Situations that evoke loss, guilt, or hopelessness are particularly hard for physicians to respond to empathically. Physicians who think that they have failed a dying patient and who fear depriving the patient of hope may respond by avoiding the topic entirely, by overcompensating with overtreatment, or by apologizing for not "saving" the patient. When a patient expresses overwhelming anger or disappointment with limitations in medicine, physicians may be afraid that any explicit response to the patient's emotion may be construed as evidence of their failure, mistake, or inadequacy. In these challenging situations, we have observed that many physicians attempt to respond empathically by stating, "I'm sorry." This well-intentioned response, although frequently appropriate, may be misinterpreted and misdirected. We have found that saying, "I wish...(things were different)" to the patient and family is a more effective initial response. We explicate some of the challenges of saying "I'm sorry" and explore the potential benefits of joining with patients and families and saying, "I wish..." in specific, difficult clinical scenarios.

Rabinowitz I, Tamir R, & Reis A. (2004). Length of patient's monologue, rate of completion, and relation to other components of the clinical encounter. *British Medical Journal*, 328: 501-502.

The patient's opening statement in a consultation (the patient's monologue) is an important part of history taking, and doctors are encouraged not to interrupt the patient--but they often do, probably because they think that the patient's monologue is time consuming. When uninterrupted, patients conclude their monologue in less than 30 seconds in primary care and about 90 seconds in consultant settings. The researchers assessed encounters in primary care that included a new clinical problem, recording the length and rate of completion of patients' monologues before and after instructing doctors not to interrupt.

*Rhodes KV, Vieth T, He T, Miller A, Howes DS, Bailey O, Walter J, Frankel R & Levinson W. (2004). **Resuscitating the physician-patient relationship: Emergency department communication in an academic medical center.** *Annals of Emergency Medicine*. 44(3):262-267.

STUDY OBJECTIVE: We characterize communication in an urban, academic medical center emergency department (ED) with regard to the timing and nature of the medical history survey and physical examination and discharge instructions.

METHODS: Audiotaping and coding of 93 ED encounters (62 medical history surveys and physical examinations, 31 discharges) with a convenience sample of 24 emergency medicine residents, 8 nurses, and 93 nonemergency adult patients.

RESULTS: Patients were 68% women and 84% black, with a mean age of 45 years. Emergency medicine providers were 70% men and 80% white. Of 62 medical history surveys and physical examinations, time spent on the introduction and medical history survey and physical examination averaged 7 minutes 31 seconds (range 1 to 20 minutes). Emergency medicine residents introduced themselves in only two thirds of encounters, rarely (8%) indicating their training status. Despite physician tendency (63%) to start with an open-ended question, only 20% of patients completed their presenting complaint without interruption. Average time to interruption (usually a closed question) was 12 seconds. Discharge instructions averaged 76 seconds (range 7 to 202 seconds). Information on diagnosis, expected course of illness, self-care, use of medications, time-specified follow-up, and symptoms that should prompt return to the ED were each discussed less than 65% of the time. Only 16% of patients were asked whether they had questions, and there were no instances in which the provider confirmed patient understanding of the information.

CONCLUSION: Academic EDs present unique challenges to effective communication. In our

study, the physician-patient encounter was brief and lacking in important health information. Provision of patient-centered care in academic EDs will require more provider education and significant system support.

*Riess H & Kraft-Todd G. (2014). E.M.P.A.T.H.Y.: a tool to enhance nonverbal communication between clinicians and their patients. *Academic Medicine*, 89(8): 1108-12

There is a gap in the medical education literature on teaching nonverbal detection and expression of empathy. Many articles do not address nonverbal interactions, instead focusing on "what to say" rather than "how to be." This focus on verbal communication overlooks the essential role nonverbal signals play in the communication of emotions, which has significant effects on patient satisfaction, health outcomes, and malpractice claims. This gap is addressed with a novel teaching tool for assessing nonverbal behavior using the acronym E.M.P.A.T.H.Y.-E: eye contact; M: muscles of facial expression; P: posture; A: affect; T: tone of voice; H: hearing the whole patient; Y: your response. This acronym was the cornerstone of a randomized controlled trial of empathy training at Massachusetts General Hospital, 2010-2012. Used as an easy-to-remember checklist, the acronym orients medical professionals to key aspects of perceiving and responding to nonverbal emotional cues. An urgent need exists to teach nonverbal aspects of communication as medical practices must be reoriented to the increasing cultural diversity represented by patients presenting for care. Where language proficiency may be limited, nonverbal communication becomes more crucial for understanding patients' communications. Furthermore, even in the absence of cultural differences, many patients are reluctant to disagree with their clinicians, and subtle nonverbal cues may be the critical entry point for discussions leading to shared medical decisions. A detailed description of the E.M.P.A.T.H.Y. acronym and a brief summary of the literature that supports each component of the teaching tool are provided.

Rowland-Morin PA & Carroll JG. (1990). **Verbal communication skills and patient satisfaction: A study of doctor-patient interviews.** *Eval Health Prof*, 13(2):168-85

This research attempted to quantify specific behaviors in the physician's initial interviewing style and relate them to patients' perception of satisfaction. Five physicians were tape recorded during their initial interviews with 52 adult patients. The patients were asked to complete the Medical Interview Satisfaction Scale, a 29-item instrument with a 7-point response scale. These interviews were transcribed, timed, coded, and analyzed with the use of the Computerized Language Analysis System. Selected variables of the language dimensions were entered as the predictor variables in a multiple regression, along with satisfaction scores as the dependent variables. Twenty-seven percent of the variance (p less than .01) in the satisfaction scores of initial interviews were explained by three aspects of a physician's language style: (a) use of silence or reaction time latency between speakers in an interview, (b) whether there was language reciprocity as determined through the reciprocal use of word-lists, and (c) the reflective use of interruptions within an interview. Considering the complexity of human communication, the fact that three variables were identified, which accounted for 27% of the variance in patients' satisfaction, is considered a substantial finding.

Ryan EB, Hamilton JM, et al. (1994). **Patronizing the old: how do younger and older adults respond to baby talk in the nursing home?** *International Journal of Aging & Human Development*, 39(1): 21-32.

To test the Communication Accommodation Theory for intergenerational talk to dependent older persons, eighty young adults and seventy-one older adults evaluated speakers in a brief taped conversation. Specifically, the study was conducted to determine whether the apparent nurturant quality of the baby talk tone of voice and parental style would compensate for the lack of respect associated with this type of patronizing talk to elders. The talk was either secondary baby talk or a neutral variant addressed to an elderly resident in the home by either a nurse or a volunteer. The caregivers who used baby talk were rated as significantly less respectful and competent than their peers in the neutral condition, but no differences were observed for nurturance of the caregiver. The recipients of baby talk were perceived to be less satisfied with

the interaction. Findings were true for both caregiver roles and both respondent age groups. OBJECTIVE: To examine young adults' and older adults' evaluation of nurses' and volunteers' respectfulness, competence, and nurturance and nursing home residents' competence and satisfaction with care, based on audiotaped conversations in which caregivers used either "baby talk" (high pitch, exaggerated intonation) or neutral speech when interacting with a cognitively alert nursing home resident.

DESIGN: Survey

SETTING: University

SUBJECTS: 80 university undergraduates, 71 older adults.

INTERVENTION: Study participants listened to one of two audio-taped conversations, in which a caregiver tried to persuade a nursing home resident to come to dinner. Participants were provided with a written script describing the caregiver as either an experienced nurse or a new volunteer and the 85-year-old nursing home resident as cognitively alert.

DATA COLLECTION: Participants answered several 7-point Likert-type scale questions on a survey instrument. Items included evaluations of caregivers' nurturance (cold, supportive, distant, caring), competence (intelligent, incompetent), benevolence (helpful, trustworthy, unfriendly) and respectfulness (patronizing, respectful, polite, presumptuous) and of the nursing home residents' satisfaction with care (angry, satisfied, happy, frustrated) and competence (capable, healthy, active, alert, childlike). Speech was also rated on understandability, slowness, high pitch, exaggerated intonation, hesitance, softness, and shrillness.

DATA ANALYSIS: Multiple analysis of variance was used to assess the relationships between speech style, care provider role, and participant age group.

FINDINGS: Baby speech style was perceived as less respectful and less competent than neutral speech. Participant age and care provider role made no difference. Baby speech and neutral speech were perceived as equally nurturing. In the baby talk scenario, satisfaction with care was rated lower, while nursing home residents were not perceived as less competent. The nurse was rated more respectful and more competent than the volunteer, and was perceived as using less baby talk in both speech scenarios.

CONCLUSIONS: In general, nurses were rated more competent and respectful than volunteers, even when using baby talk. However, the use of baby talk was perceived as disrespectful and as a sign of caregiver incompetence. These negative assessments of baby talk were not counterbalanced by higher perceived nurturance or benevolence. Caregivers' use of baby talk did not influence the perception of nursing home residents' intelligence or capability, although it did reduce perceived satisfaction with care. This study indicates that caregivers should speak to nursing home residents as they would to any other adult. The authors recommend that caregivers become more aware of their use of baby talk and reduce their use of this patronizing, controlling speech style, in order to improve patient care and satisfaction.

Schattner A, Rudin D & Jellin D. (2004). **Good physicians from the perspective of their patients.** *BMC Health Services Research*, Retrieved on Nov 21, 2005, from <http://www.pubmedcentral.gov/picrender.fcgi?tool=pmcentrez&blobtype=pdf&artid=520754>

BACKGROUND: It is not currently known what is the patient's viewpoint of a "good" physician. We set out to define patient's priorities regarding different physician's attributes in 3 domains important in medical care.

METHODS: Patients hospitalized or attending clinics at a large teaching hospital selected the 4 attributes that they considered most important out of 21 listed arbitrarily in a questionnaire. The questionnaire included 7 items each in the domains of patient autonomy, professional expertise and humanism.

RESULTS: Participating patients (n = 445, mean age 57.5 ± 16 years) selected professional expertise (50%), physician's patience and attentiveness (38% and 30%, respectively), and informing the patient, representing the patient's interests, being truthful and respecting patient's preferences (25–36% each) as the most essential attributes. Patient's selections were not significantly influenced by different demographic or clinical background. Selections of attributes in the domain of patient's autonomy were significantly more frequent and this was the

preferred domain for 31% and as important as another domain for 16% – significantly more than the domain of professional expertise. ($P = 0.008$), and much more than the domain of humanism and support ($P < 0.0005$).

CONCLUSIONS: Patients studied want their physicians to be highly professional and expert clinicians and show humaneness and support, but their first priority is for the physician to respect their autonomy.

*Schnitzler L, Smith S, Shepherd H, Shaw, J, Dong D, Carpenter DM, Nguyen F, Dhillon HM (2017). Communication during radiation therapy education sessions: The role of medical jargon and emotional support in clarifying patient confusion. *Patient Education and Counseling*, 100 (1): 112-120.

Radiation oncology consultations involve explanation of complex technical concepts using medical jargon. This study aimed to: analyze types and frequency of medical jargon that radiation therapists (RTs) use during education sessions; identify how patients seek clarification from RTs; and, explore RTs communication strategies.

METHODS: Education sessions were audio-recorded and transcribed. Medical jargon was analyzed using MaxDictio (a vocabulary analysis programme). A distinction was made between specialized (specialized terms used in RT or cancer) and contextual jargon (common everyday words with a different meaning in RT). Qualitative data were analyzed using Framework analysis.

RESULTS: Fifty-eight patients and 10 RTs participated. Contextual treatment jargon were the most frequently used jargon (32.2%) along with general medical terms (34.6%). Patients appeared uncertain about the number of treatments, side effects, and the risks of radiation. Patients sought clarification by asking RTs to explain or repeat information. RTs replaced jargon with a simpler word, used everyday analogies, and diagrams.

CONCLUSION: Use of medical jargon is common in RT education sessions. RTs used different but contextual jargon dominated.

PRACTICE IMPLICATIONS: Training RTs how to tailor information to enhance patients' understanding would be beneficial. Future research exploring medical jargon used in other (non-) oncology settings is required.

*Shaw C, Williams K, Assassa PR & Jackson C (2000). **Patient satisfaction with urodynamics: A qualitative study.** *Journal of Advanced Nursing*, 32(6): 1356-1363.

OBJECTIVE: To identify the factors that influence patient satisfaction and the ways in which care delivery can be improved in the context of the urodynamic investigation.

SETTING: Patients were recruited from outpatient clinics where urodynamics investigations were carried out by a nurse and hospital clinics where the investigation was carried out by a doctor. Interviews were conducted in patients' homes.

SUBJECTS: $n=21$ (17 female, 4 male).

DESIGN: In-depth interviews.

DATA COLLECTION: Four trained interviewers conducted in-depth, hour-long interviews with the participants. Interviews were audiotaped and transcribed.

DATA ANALYSIS: The text was coded according to categories, including structure and process of care, views of illness, health care, views of the caregiver, feelings, individual characteristics, and caregivers' communication and interpersonal skills. Frequency of occurrence, relationships among the categories, and shared meaning and overlap between categories were used to develop a hierarchical coding frame.

FINDINGS: Patient feelings, including anxiety, embarrassment, and fear of the unknown were a major category. Health care providers' interpersonal skills, communication and information giving, maintenance of privacy, and technical skills reduced patients' anxiety and embarrassment.

CONCLUSIONS: Health care providers who acted friendly, relaxed, and informal helped establish a feeling of equality and relaxation among patients, particularly when the care provider and patient had established a trusting relationship at a prior visit or over the telephone. Care providers' communication skills, particularly active listening and the provision of adequate

information, were essential for patient satisfaction. Information provision that utilized visual aids, such as brochures or posters, as well as verbal explanations helped patients understand the procedure and feel more comfortable. It was also important for health care providers to use appropriate language, neither too technical nor too patronizingly simple. Patient satisfaction was also improved when health care providers appeared unhurried and when they provided feedback regarding the procedure (i.e. what the procedure measured and how the patients' results compared to the standards). Maintenance of patient privacy also improved patient satisfaction, including being in a small room and having curtains that screened the examination area. Patient satisfaction was also influenced by patients' perception of the care providers' competence, which was indicated by caregivers' confidence, efficiency, taking a full history, and willingness to answer questions.

*Sikveland R, Stokoea E, Symonds J (2016). **Patient burden during appointment-making telephone calls to GP practices.** *Patient Education and Counseling* 99: 1310–1318.
<http://www.ncbi.nlm.nih.gov/pubmed/27055769> [Accessed 8-9-2016]

OBJECTIVE: This study addresses, for the first time, the effectiveness of receptionists handling incoming calls from patients to access General Practice services.

METHODS: It is a large-scale qualitative study of three services in the UK. Using conversation analysis, we identified the issue of 'patient burden', which we defined based on the trouble patients display pursuing service. We quantified instances of 'patient burden' using a coding scheme.

RESULTS: We demonstrate how 'patient burden' unfolds in two phases of the telephone calls: (i) following an initial rejection of a patient's request; and (ii) following a receptionist's initiation of call closing. Our quantitative analysis shows that the three GP services differ in the frequency of 'patient burden' and reveals a correlation between the proportion of 'patient burden' and independent national satisfaction scores for these surgeries.

CONCLUSION: Unlike post-hoc surveys, our analysis of live calls identifies the communicative practices which may constitute patient (dis)satisfaction. Practice implications: Through establishing what receptionists handle well or less well in encounters with patients, we propose ways of improving such encounters through training or other forms of intervention.

*Sinclair S, Beamer K, Hack TF, McClement S, Bouchal SR, Chochinov HM, Hagen NA (2016). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliat Med* August 17, 2016 026921631666349.
<http://pmj.sagepub.com/content/early/2016/08/17/0269216316663499.1.abstract> [Accessed 8-18-2016]

BACKGROUND: Compassion is considered an essential element in quality patient care. One of the conceptual challenges in healthcare literature is that compassion is often confused with sympathy and empathy. Studies comparing and contrasting patients' perspectives of sympathy, empathy, and compassion are largely absent.

AIM: The aim of this study was to investigate advanced cancer patients' understandings, experiences, and preferences of "sympathy," "empathy," and "compassion" in order to develop conceptual clarity for future research and to inform clinical practice.

DESIGN: Data were collected via semi-structured interviews and then independently analyzed by the research team using the three stages and principles of Straussian grounded theory.

Setting/participants: Data were collected from 53 advanced cancer inpatients in a large urban hospital.

RESULTS: Constructs of sympathy, empathy, and compassion contain distinct themes and sub-themes. Sympathy was described as an unwanted, pity-based response to a distressing situation, characterized by a lack of understanding and self-preservation of the observer. Empathy was experienced as an affective response that acknowledges and attempts to understand individual's suffering through emotional resonance. Compassion enhanced the key facets of empathy while adding distinct features of being motivated by love, the altruistic role of the responder, action, and small, supererogatory acts of kindness. Patients reported that unlike sympathy, empathy and compassion were beneficial, with compassion being the most preferred and impactful.

CONCLUSION: Although sympathy, empathy, and compassion are used interchangeably and frequently conflated in healthcare literature, patients distinguish and experience them uniquely. Understanding patients' perspectives is important and can guide practice, policy reform, and future research.

*Singh Ospina N, Phillips K, Rodriguez-Gutierrez R, Castaneda-Guarderas A, Gionfriddo, M, Branda M, Montori V. (2018). **Eliciting the patient's agenda- secondary analysis of recorded clinical encounters.** *Journal of Internal Medicine*, (<https://doi.org/10.1007/s11606-018-4540-5>)

Eliciting patient concerns and listening carefully to them contributes to patient-centered care. Yet, clinicians often fail to elicit the patient's agenda and, when they do, they interrupt the patient's discourse.

OBJECTIVE: We aimed to describe the extent to which patients' concerns are elicited across different clinical settings and how shared decision-making tools impact agenda elicitation.

DESIGN AND PARTICIPANTS: We performed a secondary analysis of a random sample of 112 clinical encounters recorded during trials testing the efficacy of shared decision-making tools.

MAIN MEASURES: Two reviewers, working independently, characterized the elicitation of the patient agenda and the time to interruption or to complete statement; we analyzed the distribution of agenda elicitation according to setting and use of shared decision-making tools.

KEY RESULTS: Clinicians elicited the patient's agenda in 40 of 112 (36%) encounters. Agendas were elicited more often in primary care (30/61 encounters, 49%) than in specialty care (10/51 encounters, 20%); $p = .058$. Shared decision-making tools did not affect the likelihood of eliciting the patient's agenda (34 vs. 37% in encounters with and without these tools; $p = .09$). In 27 of the 40 (67%) encounters in which clinicians elicited patient concerns, the clinician interrupted the patient after a median of 11 seconds (interquartile range 7–22; range 3 to 234 s). Uninterrupted patients took a median of 6 s (interquartile range 3–19; range 2 to 108 s) to state their concern.

CONCLUSIONS: Clinicians seldom elicit the patient's agenda; when they do, they interrupt patients sooner than previously reported. Physicians in specialty care elicited the patient's agenda less often compared to physicians in primary care. Failure to elicit the patient's agenda reduces the chance that clinicians will orient the priorities of a clinical encounter toward specific aspects that matter to each patient.

Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW & Jordan J. (2000). **The impact of patient-centered care on outcomes.** *The Journal of Family Practice*, 49(9):796-804.

OBJECTIVE: To assess the association between patient-centered communication in primary care visits and subsequent health and medical care utilization.

DESIGN: Observational cohort study.

SETTING: Family Practices in London, Ontario, Canada and surrounding area.

SUBJECTS: 39 randomly selected family physicians (71.8% male, mean year of graduation was 1975); 315 patients (54% female, 60.3% married).

MEASURES: Outcomes measured included: 1) Patient's health, assessed by a visual analogue scale (VAS) on symptom discomfort and concern. 2) Self-report of health, using the Medical Outcomes Study Short Form-36 (multi-dimensional assessment). 3) Medical care utilization variables of diagnostic tests, referrals, and visits to the family physician, assessed by chart review. Office visits of the medical encounters were audio taped and scored for patient-centered communication (score based on 3 of the 6 components of the model of patient-centered medicine). In addition, patients were asked for their perceptions of the patient-centeredness of the visit (series of 14 times were used to assess patients' post-encounter perceptions of how patient centered the interaction had been).

RESULTS: Patient-centered communication scores were significantly correlated with the patients' perceptions of finding common ground. The total score of patients' perceptions that the visit was patient-centered was associated with positive health outcomes. Patients who perceived that their visit had been patient centered received fewer diagnostic tests and referrals in the subsequent two months.

CONCLUSIONS/RECOMMENDATIONS: Patient-centered communication influences patients'

health through perceptions that their visit was patient centered, and especially through perceptions that common ground was achieved with the physician. Patient-centered practice was associated with improved health status (less discomfort, less concern, and better mental health) and increased efficiency of care (fewer diagnostic tests and referrals). This finding is a concern for medical education and health care policy in that the patients' experience of being a participating member in the discussion of the problem and treatment process may translate into the patients' reduced need for further investigation or referral.

*Tamblyn R, Abrahamowicz M, Dauphinee D, Wenghofer E, Jacques A, Klass D, Smees S, Egale T, Winslade N, Girard N, Bartman I, Buckeridge DL, Hanley JA (2010). **Influence of physicians' management and communication ability on patients' persistence with antihypertensive medication.** *Arch Intern Med* 170(12): 1064-1072.
<http://archinte.jamanetwork.com/article.aspx?articleid=416089> [Accessed 8-24-2016]

BACKGROUND: Less than 75% of people prescribed antihypertensive medication are still using treatment after 6 months. Physicians determine treatment, educate patients, manage side effects, and influence patient knowledge and motivation. Although physician communication ability likely influences persistence, little is known about the importance of medical management skills, even though these abilities can be enhanced through educational and practice interventions. The purpose of this study was to determine whether a physician's medical management and communication ability influence persistence with antihypertensive treatment.

METHODS: This was a population-based study of 13 205 hypertensive patients who started antihypertensive medication prescribed by a cohort of 645 physicians entering practice in Quebec, Canada, between 1993 and 2007. Medical Council of Canada licensing examination scores were used to assess medical management and communication ability. Population-based prescription and medical services databases were used to assess starting therapy, treatment changes, comorbidity, and persistence with antihypertensive treatment in the first 6 months.

RESULTS: Within 6 months after starting treatment, 2926 patients (22.2%) had discontinued all antihypertensive medication. The risk of nonpersistence was reduced for patients who were treated by physicians with better medical management (odds ratio per 2-SD increase in score, 0.74; 95% confidence interval, 0.63-0.87) and communication (0.88; 0.78-1.00) ability and with early therapy changes (odds ratio, 0.45; 95% confidence interval, 0.37-0.54), more follow-up visits, and nondiuretics as the initial choice of therapy. Medical management ability was responsible for preventing 15.8% (95% confidence interval, 7.5%-23.3%) of nonpersistence.
CONCLUSION: Better clinical decision-making and data collection skills and early modifications in therapy improve persistence with antihypertensive therapy.

Thompson DA, Yarnold PR, Williams DR & Adams SL. (1996). Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the emergency department. *Annals of Emergency Medicine*, 28(6): 657-665.

OBJECTIVE: To determine the effects of actual waiting time, perception of waiting time, information delivery, and expressive quality on patient satisfaction.

METHODS: During a 12-month study period, a questionnaire was administered by telephone to a random sample of patients who had presented to a suburban community hospital emergency department during the preceding 2 to 4 weeks. Respondents were asked several questions concerning waiting times (i.e., time from triage until examination by the emergency physician and time from triage until discharge from the ED), information delivery (e.g., explanations of procedures and delays), expressive quality (e.g., courteousness, friendliness), and overall patient satisfaction.

RESULTS: There were 1,631 respondents. The perception that waiting times were less than expected was associated with a positive overall satisfaction rating for the ED encounter ($P < .001$). Satisfaction with information delivery and with ED staff expressive quality were also positively associated with overall satisfaction during the ED encounter ($P < .001$). Actual waiting times were not predictive of overall patient satisfaction ($P = NS$).

CONCLUSION: Perceptions regarding waiting time, information delivery, and expressive quality

predict overall patient satisfaction, but actual waiting times do not. Providing information, projecting expressive quality, and managing waiting time perceptions and expectations may be a more effective strategy to achieve improved patient satisfaction the ED than decreasing actual waiting time.

University of British Columbia (UBC) Health Services and Policy Research, Watson DE, Peterson S, Black C. **In pursuit of quality: opportunities to improve patient experiences in British Columbian emergency departments.** January 2009. Accessed online August 26, 2009 at <http://www.chspr.ubc.ca/research/patterns/emerg>.

In order to identify factors that drive positive or negative patient ratings of the overall quality of care in emergency departments, we used results of a province-wide survey completed by more than 16,800 patients who visited one of 110 facilities in BC in 2007 findings contain the following important lessons for ensuring that most patients in BC continue to report positive experiences and fewer patients report negative experiences: the factors that underlie patient ratings of both positive and negative reports of the overall quality of care in emergency departments are remarkably similar; the degree to which staff are considered to be courteous is the most important factor influencing patient ratings of quality; when health care professionals do well on factors that underlie these ratings, then patients offer high ratings of overall quality of care; and when health care professionals do poorly in those areas, patients are very likely to offer negative ratings of overall quality of the care they receive in emergency. Teamwork, comprehensive services, wait times to see a doctor, views on the reasonableness of that wait and availability of nurses matter also but not as much as the courteousness of staff.

*van der Smagt-Duijnste ME, Hamers JPH, et al. (2001). **Relatives of hospitalized stroke patients: Their needs for information, counseling and accessibility.** *Journal of Advanced Nursing*, 33(3): 307-315.

OBJECTIVE: To identify needs of relatives of hospitalized stroke patients & factors that influence those needs.

SETTING: 17 general hospitals and 2 university medical centers in the Netherlands.

SUBJECTS: 163 stroke patients' relatives (106 responded).

DESIGN: Cross-sectional questionnaire.

DATA COLLECTION: Questionnaires were used to collect participant characteristics and demographic data, degree of need for information, communication, support, and accessibility, and their satisfaction with the degree that the needs had been met by health care professionals. Three-point Likert-type scales were used for each question.

DATA ANALYSIS: Reliability and validity were calculated. Communication and support were condensed into one category, counseling. Descriptive and multivariate analyses were conducted.

FINDINGS: The need for information was very high among the respondents. However, 50% of respondents did not receive the information they needed about their relatives' condition. Counseling needs were slightly less important than information needs, and the respondents were generally satisfied with the provision of support and communication. As far as accessibility, 98% of the relatives found it very important that health professionals take the time to answer their questions and that they should have access to their relatives' neurologist. However, 84% of the relatives were satisfied with their access. Female relatives attached greater importance to their need for information than did male relatives. The need for counseling was influenced by relatives' education level; those with higher education reported less need for counseling. However, those who had previously experienced a relative having a stroke reported greater need for counseling and accessibility. Patient spouses/partners younger than 61 expressed greater need for accessibility to health care providers than other groups. In general, relatives of patients who spent 8-30 days in the hospital or who had other illnesses received more information than relatives of otherwise healthy patients or patients who stayed less than 8 days.

CONCLUSIONS: The most important need for stroke patients' relatives was the need for health professionals to answer their questions honestly. Information needs were rated most highly, although only half of these needs were adequately met. The authors suggest that nurses learn to

be more aware of the needs of patients' relatives and to develop strategies and/or practice guidelines to meet these needs.

Ward J & McMurray R. (2011). **The unspoken work of general practitioner receptionists: A re-examination of emotion management in primary care.** *Social Science & Medicine*, 72(10): 1583-1587

Suggests that GP receptionists perform complex forms of emotion management pursuant to facilitating efficacious care. Identifies two new emotion management techniques: emotional neutrality and emotion switching. Calls for emotion management research to move beyond core occupations to reconsider the complexity of ancillary work. This research article was reviewed and summarized in the New York Times on July 5, 2011 by Pauline W. Chen.

*Werner A, Malterud K (2005). **“The pain isn’t as disabling as it used to be”:** **How can the patient experience empowerment instead of vulnerability in the consultation?** *Scandinavian Journal of Public Health*, 33(Suppl 66): 41–46. http://sjp.sagepub.com/content/33/66_suppl/41 [Accessed 9-6-2016]

AIM: This study explores how doctors can help patients transform vulnerability into strength, instead of increasing a feeling of disempowerment.

METHODS: The authors analyzed their findings from four previously written articles based on qualitative interviews with 10 women with chronic pain, comparing the reported negative consultation experiences with the beneficial effects of good treatment experiences, in order to identify potentials for change.

RESULTS: Altering the way in which the women are encountered may empower and help them deal with a painful life. Doctors can challenge stereotyped macrostructures of women’s “unexplained” pain as hysteria by admitting the shortcomings of medical knowledge. The blame is then put on the medical discipline instead of the individual patient who presents bodily symptoms or reveals help-seeking behaviour that does not fit with biomedical expectations of what illness is and how it should be performed. Thus, the vulnerable position described by the patients can be converted or transformed into strength or resources in spaces that promote empowerment through recognition.

CONCLUSION: Although doctors may feel helpless or puzzled in the consultation, they must take the responsibility for turning the consultation into a space for empowerment of the patient.

*Williams K, Herman, R, Gajewski, B, & Wilson, K. (2009). **Elderspeak communication: Impact on dementia care.** *American Journal of Alzheimer's Disease and Other Dementias*, 24, 11- 20.

To study the effects of elderspeak on people with mild to moderate dementia, Dr. K. Williams and a team of researchers videotaped interactions in a nursing home between 20 residents and staff members. They found that when nurses used phrases like “good girl” or “How are we feeling?” patients were more aggressive and less cooperative or receptive to care. If addressed as infants, some showed their irritation by grimacing, screaming or refusing to do what staff members asked of them.

*Wilson SE, Prescott J, Becket G (2012). **Empathy levels in first- and third-year students in health and non-health disciplines.** *Am J Pharm Educ*, 76(2): 24. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3305933/> [Accessed 8-9-2016]

OBJECTIVE: To compare empathy scores between health professions students (pharmacy and nursing) and non-health professions (law) students and between first- and third-year students. METHODS: The Jefferson Scale of Physician Empathy-Student Version was completed by 282 students.

RESULTS: Nursing and pharmacy students had significantly more empathy than did law students. Third year pharmacy students scored higher on empathy than did first-year pharmacy students, whereas the converse was true for nurses. There was no significant difference in

empathy between first- and third-year law students. Across the study years, empathy increased among pharmacy students, decreased among nurses, and remained the same among law students. Women scored higher on empathy than did males.

CONCLUSIONS: Empathy scores among university students vary depending on discipline and year of study.

iman E & Wikblad K. (2004). **Caring and uncaring encounters in nursing in an emergency department.** *Journal of Clinical Nursing.* 13(4):422-429.

BACKGROUND: Caring is a core characteristic of nursing. Nurses' caring behaviour has been explored in several studies. When caring for trauma patients, the most important caring behaviour must be the procedures associated with lifesaving. However, it is important not to forget the patient's psychological needs.

AIM: The aim of this study was to highlight encounters between injured patients and nurses in the trauma team and to explore whether the theory of caring and uncaring encounters in nursing and health care is applicable in emergency care. Data collection and analysis: Data were collected by videotaping caring episodes between slightly injured patients and nurses in the trauma team. Five episodes involving 10 nurses were studied. The analysis was carried out in four steps. First the videotapes were studied several times and then transcribed into narratives, which were reduced into courses of events. These were subsequently classified according to aspects of caring and uncaring.

RESULTS: The nurses' verbal and non-verbal communication was poor, and they adopted a wait-and-see policy. A new uncaring aspect, instrumental behaviour, emerged from this poor communication. One of the caring aspects, being dedicated and having courage to be appropriately involved, could not be identified. Most encounters included several aspects of caring and uncaring, but the uncaring aspects predominated. The dominance of uncaring aspects indicates a lack of affective caring behavior.

CONCLUSION: The result showed that the theory is partly applicable in emergency care. A new aspect, instrumental behavior emerged. The nurses' behavior in the five episodes was labeled as uncaring. Authentic nurse-patient encounters are essential in nursing.

RELEVANCE TO CLINICAL PRACTICE: The importance of meeting patients' psychological needs and nurses' affective caring behavior should be emphasized in trauma care, trauma courses and nursing education. It is necessary to measure the caring behavior of trauma nurses.

*Wolff, J. (2018). Consumer perspectives on patient experience. The Beryl Institute.

The overall purpose of this study was to determine how consumers perceive patient experience (PX) and how this fits into their broader set of expectations around health and healthcare delivery. The Beryl Institute, SMG Catalyst, and Studer Group collaborated on this first-of-its-kind research initiative. Study grounded in the voices of consumer, framed by initial focus group: 2,000 individuals in 5 countries, spanning demographic and economic levels. Online survey process: Approximately 30 questions. Survey period: February 9-14, 2018.

Wolff JL & Roter DL. (2008). Hidden in plain sight: Medical visit companions as a resource for vulnerable older Adults. *Arch Intern Med*, 168(13):1409-1415

BACKGROUND: Sicker patients are less satisfied with the quality of health care they receive than their healthier counterparts.

METHODS: A sample of 12 018 community-dwelling Medicare beneficiaries 65 years or older from the 2004 Medicare Current Beneficiary Survey was studied. Multivariate regression was used to describe whether beneficiaries' self-reported satisfaction with their usual-care physician was related to the presence or functions assumed by visit companions.

RESULTS: Overall, 38.6% of beneficiaries reported being typically accompanied to routine medical visits. Accompanied beneficiaries were older, less educated, and in worse health than their unaccompanied counterparts. More than 60% of companions facilitated visit communication by recording physician instructions (44.1%), providing information regarding patients' medical conditions or needs (41.6%), asking questions (41.1%), or explaining physicians' instructions (29.7%). After controlling for sociodemographic and health differences,

accompanied beneficiaries were more highly satisfied with their physician's technical skills (odds ratio [OR], 1.15; 95% confidence interval [CI], 1.02-1.30), information giving (OR, 1.19; 95% CI, 1.05-1.35), and interpersonal skills (OR, 1.18; 95% CI, 1.03-1.35) than unaccompanied beneficiaries. Accompanied beneficiaries whose visit companions were more actively engaged in communication rated physician information giving (OR, 1.42; 95% CI, 1.14-1.77) and interpersonal skills (OR, 1.29; 95% CI, 1.05-1.59) more favorably. This relationship was strongest among beneficiaries with the worst self-rated health.

CONCLUSIONS: Visit companions are commonly present in older adults' routine medical encounters, actively engaged in care processes, and influential to patients' satisfaction with physician care. More systematic recognition and integration of visit companions in health care processes may benefit quality of care for a particularly vulnerable patient population.