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Exam Room Culture

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Abstract

If the minds of patients could be read, one would likely discover thoughts related to the culture of the clinical environment. "Do I belong here?" "Will I be judged?" "Is it safe to be honest?" We consider what physicians can do to create a culture in the exam room that corresponds to features found in the cultures of successful organizations. These characteristics include an emphasis on psychological safety for patients, a willingness to be vulnerable on the part of the physician, and a sincere focus on the patient's purpose. Our conclusion is that by prioritizing such elements, the clinical encounter may be more satisfying and productive for the patient and physician alike.

Keywords

patient–physician relationship, patient engagement, culture, chronic disease management

> I have an appointment with my doctor today. I can think of lots of things I'd rather be doing. To be honest, I always worry that my doctor might find something terribly wrong with me. My "white coat hypertension" exposes that fear. I have been having some pain in my knee. I wonder if I should bring that up today.

The Patient Experience

Even in a routine follow-up appointment, whether in-person or virtual, perceptual systems are on alert with much activity occurring deep in the patient's brain. What does the patient perceive from the physician? Warmth? Acceptance? Connection? Threat? Judgment? Rejection? Many brain structures have a role in threat detection, including the amygdalae, ventromedial prefrontal cortex, anterior cingulate cortex, and the periaqueductal gray, among others. Using the amygdalae as a simple representation of these highly complex structures and processes (1), the intensity and valence of the amygdalae response in the clinical setting have important implications for the current appointment, the patient–physician relationship, and health outcomes.

In addition to the well-known role of the amygdalae in the instantaneous perception of physical threat, they also serve as radar for social cues (1,2). From an evolutionary perspective, the human species can be threatened by social discord or hostility, whereas social connection and belonging are assets for survival. Since activity in the amygdalae and other brain regions involved in social and threat perception impacts physiological response and attentional processes, the individual is primed to respond to threat or positive social engagement (3). On top of this, the confirmation bias, a propensity to seek information consistent with one's beliefs, reinforces the defensive or prosocial stance (4).

> How will I be treated today? What might be diagnosed? I know the doctor wants me to exercise more but I can't afford a gym membership. I doubt if the doctor can really understand what it's like to live paycheck to paycheck. Sometimes doctors talk to me like I'm a child . . . like I'm not very smart. Is all that information about me in the computer really secure?

Patients tend to be vigilant about their experience, and are on high alert for the presence of threatening and/or welcoming cues. Physicians establish the tone for the culture of the medical encounter. Patients, family members, learners, and other members of the health care team all look to physicians for these "cultural" cues.

Interfering with physician-intended positive cultural cues may be rudeness at check-in, a long wait, and a confusing myriad of quality-focused processes completed by the

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clinical staff, all functioning as social threat cues. There may be manifestations of implicit or explicit biases that are known to affect the clinical care provided, particularly to marginalized populations (5,6). Potential threat cues in a telehealth visit include uncertainty about internet security or privacy, about the absence of a physical examination, or about unknown distractors that could diminish the physician's attention. Doctors may appear preoccupied and pressured with the clock or finding the right "dot phrase" to use in the electronic health record (EHR). The patient's amygdalae have numerous potential threats to monitor and any perceived indicators of rejection or threat can trump healthy belonging cues (7). Threat perceptions function as stressors, prompting narrowed attention and focus on the potential risk, compromising a patient's ability to think, reason, and retain new information from their physician (8). This can undermine attempts by the physician to interact collaboratively.

> Is it safe to be honest with my doctor? Will I get a lecture if I say I really don't like to exercise, or admit that sometimes I drink too much? I sure hope I don't have to take more medication . . . I can hardly afford what I'm already on. I'm not a "bad patient" but it's hard to do everything doctors want you to do!

Productive patient–physician collaboration is largely dependent on patient honesty. It is concerning that the majority of patients report withholding medically relevant information from their clinicians, and the primary reason for the nondisclosure is not wanting to be judged or lectured about their behavior (9). Because effective chronic disease management is mainly determined by patient engagement with a treatment plan, motivating patients is one of the chief challenges and opportunities facing physicians (10). The quality of the patient–physician relationship clearly affects patient motivation. It is noteworthy that the foundational building block for motivational interviewing, an efficacious approach to promoting behavior change, is interpersonal engagement (10–13).

Many managerial and electronic demands in today's health care environment potentially detract from building a supportive relationship with the patient. Patient perception of cues indicative of a lack of caring may begin the cascade of automatic central nervous system responses described above. While many physicians would correctly argue that they have little control over the prevailing culture of the health care industry today, they do remain the architects and builders of the exam room culture.

Establishing a Supportive Exam Room Culture

In his recent book, *The Culture Code*, author Daniel Coyle describes central features of the culture of groups that are exceptionally successful (14). Leaders of such groups prioritize psychological safety, express vulnerability, and emphasize purpose. The physician–patient dyad is a small group that aims to function successfully, and the culture of the examination room is where this success is truly determined.

> Wow! My doctor remembered that I'm a football fan. I was asked what I wanted to accomplish in the appointment, and what other concerns I had. I didn't get a lecture when I said I really don't like to exercise. The doctor didn't even go to the computer until after we talked for a bit! Even though the doctor wasn't with me very long, I felt like a person and not just the next patient.

Psychological Safety

An environment replete with belonging cues is essential for psychological safety. A member of a psychologically safe culture is confident that "I matter." "I am cared about." "We have a future together." Nurturing the development of a "culture of well-being" for the entire team in one's practice can contribute to psychological safety for the patient, even before getting to the exam room (15). Examples of belonging cues are eye contact, active listening, a welcoming posture, and validation of expressed patient concerns. On the other hand, preoccupation with the EHR, not interacting at eye level, or giving directives/education without eliciting the patient's perspective function as threatening cues for patients. The patient's experience of discordance in the physician–patient dyad is commonly a result of patient dissatisfaction with the quality of physician listening (16). The expression of belonging cues is ongoing in successful groups, in part because an amygdala locking onto a negative social cue quickly obviates numerous positive cues. A physician who capitalizes on opportunities to affirm the patient or otherwise express support is more likely to have a patient who experiences psychological safety in the exam room and is therefore engaged. Importantly, belonging cues increase motivation, a critical element in patient responsibility for chronic disease management.

> After I described the pain in my knee, the doctor asked what most concerned me about the pain . . . and what I thought might be wrong. When we discussed my physical activity, the doctor said that I'm the expert about what will or won't fit into my lifestyle. This doctor certainly didn't seem like a know-it-all! And the doctor said it's difficult to do all the things that are good for your health, even when you've been to medical school.

Vulnerability

At first glance, the expression of vulnerability may seem inconsistent with portraying oneself as a competent medical professional. However, the physician certainly doesn't know everything about the patient. Acknowledging this is a way to invite shared vulnerability, and prompts the patient to be open and honest. Physicians should be encouraged to "consult the expert in the room"—the patient—on what is

most concerning and most meaningful to the patient. Humility is a valuable characteristic for leaders, in part because it makes that individual more approachable (17). Vulnerability is a building block for trust. Patient satisfaction tends to be related to the perceived trustworthiness of the physician (18). Expressing vulnerability includes inviting and listening to the patient's ideas about what may be wrong and/or what the patient wants to do. It can include statements such as, "Your perspective on this is very important for me to understand." Interventions/recommendations will only be effective if the patient is engaged and adheres to the plan.

> I wonder why the doctor asked me what I wanted to accomplish in the appointment. Most doctors say "what brings you in today" but they already seem to have their own idea about what needs to be done. But with the doctor today, it was like I was the one in charge of my own health, and the doctor wanted to support and encourage me with my goals.

Purpose

The unique purpose for the individual physician-dyad in a given appointment is to serve the patient's priorities. What is the patient's "why?" What does the patient care about? What functional goals does the patient have? How does the patient's health impact what the patient values and/or wants to do? The patient's "why" is a much stronger ingredient for patient engagement and motivation than is the physician's "why." What is the current status of the patient, and how does this differ from where the patient wants to be? This discrepancy can become a focal point of reference regarding motivation for behavior change. In most cases, it is possible to find common ground between the patient's priorities and functional goals, and what the physician identifies to be important for the patient's health.

> Maybe this is why the brochure for this medical practice says it is a "patient-centered medical home." Actually I did feel cared about, and that my concerns mattered. It didn't seem like it was all about clicking boxes in a computer.

Most physicians currently practice in a health care marketplace in which reimbursement still favors metrics that emphasize volume over value (19,20). While patient-centeredness may be espoused as a priority for a given health system, achieving patient-centered recognition frequently is determined more by EHR-centered process implementation than by health outcomes. Physicians are prompted to make more clicks in the EHR than to maintain eye contact with the patient. True patient-centered care is known to contribute to better health status (21). A reason for this is that when patient-centered communication and engagement are emphasized by the clinician, patients are found to take more responsibility for their health leading to better outcomes and lower costs (22–24).

Physician Well-Being

Regarding the problem of burnout, physicians' amygdalae find many aspects of this larger health care culture to be threatening, with attention being directed toward the threats and away from the patient who needs to experience "belonging cues." Importantly, meaningful engagement and experiencing a sense of efficacy with patients are important elements of physician well-being, so that patient-centeredness becomes a win-win for the patient and physician (25–27). Even within a complicated health care system, physicians can also enjoy psychological safety, meaningful vulnerability, and maintain a sense of purpose in their daily work with patients by taking charge of the exam room culture.

Next Steps

In spite of the constraints that challenge physicians, it is possible to affect exam room culture. Physicians are taught, or can learn, efficient but effective patient engagement skills (28). Sitting down and warmly greeting the patient, prior to engaging with the EHR, are important "belonging cues," as is the use of reflective listening to ensure understanding of the patient's perspective. Capitalizing on opportunities to affirm the patient serves to build the relationship (29). Eliciting the patient's concerns and prioritizing them (30), and readily asking for the patient's help in coming up with the "plan" are both expressions of vulnerability and of collaboration to find shared purpose.

Training programs at the undergraduate, graduate, and continuing medical education levels can include emphasis on exam room culture. Characteristics of psychological safety may be elicited from students or providers through reflection on their own experience as patients. Physician humility and vulnerability can be highlighted as a component of educational activities that emphasize patient-centeredness. Relevant verbal and nonverbal skills may be accentuated as part of training in the traditional medical interview and in motivational interviewing. Role plays, simulated patient encounters, and objective structured clinical examinations represent opportunities where feedback can be provided. There are many measures of medical interviewing skills that are available for assessment and include elements relevant to building psychological safety, engaging with patients in a humble manner, and prioritizing patient goals (31). Promoting exam room cultures marked by amygdala-friendly physician behaviors can enhance patient and physician experience, patient engagement, and ultimately health outcomes.

Authors' Note

This manuscript expresses a perspective on patient experience, and does not report any human or animal research. Therefore no IRB approval was obtained. No patients were interviewed for this article. The "patient quotations" at several places in the article

were created by the authors to represent what patients may be thinking.

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