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"Won't You Be My Doctor?": Four Keys to a Satisfying Relationship in an Increasingly Virtual World

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Abstract

Despite rapid technological advances in healthcare, medicine is still largely practiced in a doctor's office *one conversation at a time.* This reality is changing rapidly during the COVID-19 pandemic as face-to-face conversations with primary care practitioners are being replaced by virtual visits conducted by phone or video conferencing. Communication challenges in patient-practitioner relationships exist in face-to-face visits and they are accentuated in virtual ones. Absent a physical examination and other sensory data, conversation is the primary means by which safe, satisfying care depends. We present 4 steps to help patients and practitioners work together to obtain optimal results from virtual or face-to-face visits, summarized by the acronym PREP: *P*repare, *R*ehearse, *E*ngage, and *P*ersist. Based on 80 years of combined clinical practice and research, we recommend strategies to help bridge the gap between what patients want and deserve in their medical visits and practitioners' understanding of their patients' concerns.

Keywords

patient/doctor relationship, communication, patient/relationship centered skills, health information technology, patient engagement

Introduction

While technological advances have changed many aspects of healthcare, medicine is still largely practiced in a PCP office *one conversation at a time.* This reality is changing rapidly as face-to-face in-person conversations with PCPs (physicians, MDs, DOs, nurse practitioners, and physician assistants) are being replaced by virtual visits conducted by phone or video conferencing. Unable to do a physical examination, the focus of virtual visits depends more than ever on the organization and quality of communication between the patient and PCP. Recently, Gordon et al interviewed patients to understand their experiences of virtual visits (1). While having significant advantages, patients were concerned that PCPs paid less attention, controlled the flow of conversation making asking questions more difficult, appeared rushed, and did not establish meaningful relationships (2). While not entirely absent in face-to-face visits, these concerns may be accentuated in virtual visits because of the physical separation of the participants and limited access to sensory data such as subtle nonverbal cues and microexpressions.

This paper describes several components of the kind of personalized, evidence-informed care patients want and deserve and PCPs strive to deliver. This is not a "how to" paper in the traditional sense. Rather, it highlights aspects of the patient-PCP partnership that can help create more

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meaningful encounters. By focusing on what is known about effective communication, we highlight tools that patients can use and PCPs can recommend to their patients to enhance the quality and effectiveness of their visits (be they face-to-face or virtual).

What is different about this paper is our emphasis on *shared* responsibility. Our goal is for patients and clinicians to recognize what they can do differently to coproduce more efficient, effective interactions. Coproduction is a concept that has its origins in behavioral economics and has recently found its way into the literature on quality and safety (3). It focuses on the differences between *goods*, for example, buying a car in which one has no role in its production, and *services* like a medical visit, in which the provider and patient cocreate what is consumed (4). Importantly, coproduction reframes the traditional view of patients and practitioners as individual social actors and instead treats them as an irreducible relational unit (5).

There is a rich literature in medical education and practice describing various challenges in patient-practitioner communication (2,6–8). Most studies come down to the fact that in the 20th and 21st centuries, the dominant educational paradigm has been focused on identifying and curing diseases while minimizing or ignoring the concept of illness, defined as social and psychological responses to disease (9).

Historically, the focus on biomedicine makes great sense. The great flu pandemic of 1918 killed an estimated 50 million people worldwide (10). Today (COVID-19 notwithstanding), most major diseases have found cures or at least life-sustaining treatments. Most care seekers today either have chronic disease(s) or do not have an identifiable biomedical condition (11). They may suffer from the stresses of modern life, but according to the definition of health as the absence of disease, they are healthy. The recurring emphasis in medical education on etiology and pathophysiology means that while young PCPs may have great diagnostic tools they may not have the requisite listening and empathic skills to deal with the estimated 1 billion outpatient visits that occur every year (12). This is important since surveys consistently show that patients expect PCPs to be both technically skilled and compassionate and caring (13).

Below, we present 4 steps patients can take to make their visits more effective (be they virtual or face-to-face), and PCPs can consider recommending to their patients as a guide to enhancing quality. Our approach is summarized by the acronym PREP: *P*repare, *R*ehearse, *E*ngage, and *P*ersist. There are many positives to virtual visits including reduced travel and wait times, better scheduling, and the comfort of one's own residence. Even in a postpandemic world, it's clear that virtual visits will become more routine. And, while PCPs can certainly improve their communication in virtual visits, it will be equally important to have skilled and focused patient communicators as well.

Prepare

Many patients come to their visits (virtual or face-to-face) without a clear idea of what they want and how to get it. This can lead to dissatisfaction as many PCPs have been trained to use a questioning style that focuses narrowly on objective information and time lines that are important in making correct diagnoses but may leave out important psychological or contextual details (14). Rapid fire questions such as, "When did you first notice the headaches?" "How long after the chest pain did you take nitroglycerin? "Is the pain better or worse in the morning or evening? may leave patients feeling as though they are being "processed" through the interview with little chance to share all their concerns. The Boy Scout motto is, "Be Prepared," which is good advice when it comes to safety in the home, at work, or visiting a PCP.

Preparation is one way to ensure that all your concerns are heard, prioritized, and discussed. It is always useful to write down what you would like your PCP to know about, prioritizing what's most important to you (15). Many PCPs will assume that the first concern you mention is the most important to cover (16). This may or may not be the case, so clarifying and sharing *your* priorities will ensure that you get the most out of the visit. The average visit will cover an average of 3 concerns, so prioritizing them is especially valuable. For example, you could say, "My priorities for today are to review my test results, let you know my hip pain has increased, and to ask about getting a yearly mammogram." Additional concerns can be handled through the electronic medical record's patient portal or communication with other team members.

Know yours and your PCPs style of agenda-setting. Some people favor listing their concerns, others prefer describing them, and still others prefer storytelling as a communication preference. Our experience is that stories are viewed clinically as inefficient and are often interrupted by PCPs. Limiting storytelling can go a long way to making PCPs less nervous about time and efficiency. Knowing that your chest pain began last Sunday when you were carrying a heavy chest of drawers is likely more important to your PCP than the fact that it was your grandmother's. While we do not advocate abandoning telling stories, judicious use is recommended for optimizing the visit and respecting the PCPs' time.

Review tasks, responsibilities, promises, and unaddressed issues from previous visits. If there are follow-up items like a diet diary, have that information on hand. If you have been unable to follow through on suggested regimens or treatments, be brave and let your PCP know. Shame and embarrassment are often barriers to negotiating new and creative approaches that have a higher likelihood of succeeding (17). If you feel shame or embarrassment, tell your PCP because, left unaddressed, they can lead to feelings of resentment, resistance, and inaction.

Follow through on agreed-upon plans from previous visits. If you disagree with a recommendation, let the PCP know *before* the visit ends so a new plan can be negotiated. Politely agreeing to something that you are unlikely or unwilling to complete for fear that it will hurt the PCPs' feelings is likely to be frustrating for you both. Better to be honest and settle on an alternative plan during the visit. If all else fails, seeking a new PCP may be warranted (18).

Rehearse

Time is precious. The more you can anticipate the flow of the visit, the more likely you and your PCP will benefit. This is especially true for virtual visits where limitations on time are accentuated. For example, PCPs frequently interrupt patients' opening statements of concerns (15). Once interrupted, patients rarely raise additional concerns at the beginning of the visit. More often, interrupted concerns surface at the end when there is little or no time left to evaluate them (19). A useful alternative is to rehearse respectful ways of sharing additional concerns early in the visit (20). This is especially helpful for patients who find it difficult because of cultural background to defer to authority (21). For example, practice saying, "I'd really like to tell you more about my back pain" or "In addition to my shoulder, I'm concerned my vision is getting worse."

Another important area to rehearse is attribution, your perspective on the cause of your symptoms informed by cultural context (22). If you are not asked, offering your ideas about what caused your problem(s) can help the PCP think ahead about the tests or treatment(s) most appropriate for you. For example, if you think your headaches are from a remote parasitic infestation, you and your PCP can explore that possibility. Likewise, if you believe your headaches are related to cancer, your PCP might have a very different conversation. The same "objective condition" is present in both examples; what differs are the patients' attributions about cause. When attributions are left unaddressed, patients often worry that the "real" cause(s) of their problem has been missed. Optimal care occurs when attributions are explicitly discussed and addressed (23).

Since it is difficult to remember everything that is discussed, consider including another person or recording the visit whether it is face-to-face or virtual (24). This is particularly useful for geriatric and low literacy visits (25,26). Rehearsing the request to include another person can be helpful, especially if you are concerned about how your PCP will respond. Bottom line, you should be comfortable asking for anything that improves your capacity to effectively participate in your care.

Finally, having a list makes presenting all your symptoms easier. Like any tightly scripted play, knowing your lines helps as does doing a dress rehearsal with a spouse or friend to practice what you want your PCP to know about. The more you practice asking difficult questions like, "What is your experience in taking care of people with my condition?" "What have your treatment outcomes been?", the more confident you will be. Research shows that patients who ask more questions have better outcomes (27,28), so, rehearse, and speak up for what you need.

Engage

There is a direct association between levels of patient engagement and processes and outcomes of care (29,30). One classic study showed that patients who learned to be more assertive had better outcomes in diabetes, hypertension, and trended toward living longer with cancer (31). Two ways that engagement can be increased are building trust and promoting psychological safety (32). Trust is built by being honest and vulnerable in your relationship. For example, a demeaning statement about your weight or hair loss can reduce trust and damage the relationship. It's better to be direct and give the PCP an opportunity to be trustworthy and repair the relationship than remaining silent and ruminating about it. Subtle signs of distress may be more difficult for your PCP to appreciate in virtual visits making it all the more important to be active and speak up when you are displeased or unhappy with how you are being treated.

Psychological safety is a related concept. Statements from your PCP such as, "I am interested in your point of view; it helps me help you" or "anyone who has gone through what you have would feel this way" or "while we don't see eye to eye on this issue, I respect and will abide by your decision" all invite a feeling of psychological safety. Knowing that you won't be judged for sharing difficult emotions or lifestyle decisions is an important step in feeling psychologically safe (7,33). Likewise, maintaining confidentiality, except where authorities must be alerted, is another dimension of psychological safety. Being asked about having family members join an in-person or virtual visit, or asking a spouse or caretaker to leave the room for a sensitive discussion about domestic violence or sexual matters, may also increase psychological safety.

Persist

It is estimated that patients recall about 50% of the information shared in ambulatory visits (34,35). In high-stress situations, like receiving bad news, the amount of information retained is undoubtedly lower (36). An oft cited fact is that between 40% and 80% of patients who are given a medical recommendation don't follow it (37). This is generally used to suggest that patients are disregarding their PCPs' recommendations. It may well be, however, that they simply don't remember what was said or were afraid to ask for clarification (38).

Airline pilots and nuclear plant operators face a similar situation ensuring that an "order" from air traffic control or the reactor control room is heard as intended and is accurate and complete (39). High-reliability industries use an approach known as a "teach-back," which requires that a

receiver repeat a message to the sender so that she/he can confirm its content and accuracy (40). Teach-backs have been found to be especially useful in low literacy populations where they improve retention of information and can be an effective substitute for the written word (26,40).

In our experience, PCPs rarely use teach-backs for fear it is too time-consuming. We urge *patients to incorporate teach-backs whenever appropriate, but especially at the end of a visit*. For example, you might say, "Here's what I heard you suggest" or, "Let me repeat what I heard you recommend." With that summary, the PCP can address aspects of the plan that were misstated, forgotten, or misunderstood. Reviewing visit recommendations also increases information retention and follow-through. Redundancy is the best memory aid. Once the plan is agreed upon, write it down!

Finally, being persistent about recommendations is effective in reducing disappointment and frustration. The recommendation of an expensive but unaffordable medication is a prescription for nonadherence and feelings of humiliation. Rather than accepting the recommendation knowing you won't follow it, asking about less expensive alternatives paves the way for more practical solutions to be negotiated.

Conclusion

One of the joys of clinical practice is having deep meaningful relationships with patients. Communication lies at the heart of relationship-building and involves promises on both sides of the stethoscope to engage fully and honestly. On the professional side, many advances have been made in embracing the importance of relationships as a gateway to effective, satisfying care (41). The fact that patient and relationship-centered care are now required competencies in medical education and PCPs are being incentivized to improve their patients' experiences is a positive sign of changing expectations and practice patterns.

As the country moves toward more virtual visits, a natural experiment is underway. The patient-PCP relationship has always been at the center of medicine (42). We all have a part to play in the future of medical care created by the novel Corona virus. New relationships will be forged virtually and new opportunities for patients and PCPs to teach each other what it means to be present and engaged with one another will test the limits and possibilities of technologically based care. In this context, it seems sensible to level the playing field and provide patients with many of the same tools that PCPs use to communicate. Doing so holds the potential for transforming the clinical encounter into a genuine meeting between experts and not adversaries (43).

Authors' Note

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Howard Beckman spent his research career attempting to understand and improve communication between healthcare leaders and practitioners, patients and their practitioners, students and teachers, and improving the effectiveness of health care teams. Dr Beckman has been working to reduce the use of low value care.