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# Time to Listen More and Talk Less

Barbara G. Bokhour  
*Boston University*

Sarah L. Cutrona  
*University of Massachusetts Medical School*

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## EDITORIAL AND COMMENT

## Time to Listen More and Talk Less

Barbara G. Bokhour, PhD<sup>1,2</sup> and Sarah L. Cutrona, MD, MPH<sup>1,3</sup><sup>1</sup>Center for Healthcare Organization and Implementation Research, Edith Nourse Rogers Veterans Affairs Medical Center, Bedford, MA, USA;<sup>2</sup>Department of Health Law, Policy & Management, Boston University School of Public Health, Boston, MA, USA; <sup>3</sup>Department of Quantitative Health Sciences, University of Massachusetts Medical School, Worcester, MA, USA.

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In 1984, Elliot Mishler published a book called the *Discourse of Medicine*<sup>1</sup> in which he argued that patients and providers bring different stories to a clinical encounter—the former reflecting the world in which the patient manages their health and illness and the latter reflecting the biomedical definitions of disease and treatment. He showed that providers far too often interrupt the patient stories in favor of a more biomedical version of the person in front of them. It was the beginning of reflections on the need to bridge these two stories in order to foster better communication and patient-centered care.

Since Mishler's publication, the recognition of the need for patient-centered provider-patient communication has grown, resulting in the development of many effective communication trainings<sup>2</sup> and the advent of the patient-centered medical home. A critical component of patient-centered communication is addressing what is most important to the patient in the clinical encounter, and often this is achieved by jointly setting an agenda for the encounter. Yet, according to the findings of Singh Opsina et al.<sup>3</sup> in this issue of *JGIM*, we have not come very far in improving that communication. They found that relatively few providers in their study elicited patients' agendas and when they did, they quickly interrupted the patient, with an average time to interruption of 11 seconds. Notably, this is 7 seconds sooner, on average, than documented in prior studies. With this type of interruption, it becomes impossible for the provider to listen and truly hear the patient, to learn and collaborate with the patient on determining the best course of care and treatment.

But it is unlikely that this pattern is due to the poor intentions of providers. Frankel's study of providers demonstrates that providers gain the most pleasure when they can build relationships, connect and converse with their patients.<sup>4</sup> So why are we seeing such a disconnect between the goals of patient-centered care, the goals of providers and patients, and actual communication in clinical encounters? There are likely several contributing factors.

A central part of a provider's work in a clinical encounter is engaging in differential diagnosis (when required) and providing evidence-based care. This requires providers to focus on the signs and symptoms presented by the patient, the clinical knowledge needed to diagnose the problem, and the evidence supporting treatment. This approach assumes that acquisition of this data and application of the necessary knowledge will yield appropriate care for all patients with a given diagnosis. Yet, there remains a tension between providing standardized, evidence-based care and providing patient-centered care that is tailored to the individual patient. And it is this tension that may lead providers to attend more to the biomedical agenda and less to the patients' agenda, interrupting to gather more information early in the conversation.

Singh Opsina et al. further add to the literature on agenda setting and interruptions by examining these patterns among specialists as well as primary care providers. They found even less agenda setting and quicker interruptions among the specialists. This may be due to the nature of the visit, which the authors did not specify in this study. Primary care physicians often see same day/sick visits for which opening questions eliciting the reason for the patients' visit may be more common. Specialists often receive referral requests detailing reasons for a consultation and, for established patients, may adhere to more disease-focused agendas; they may therefore believe they know what's critical to address in the visit. But this may not be what matters most to the patient for his or her health.

There are several system level factors that may also explain why providers limit elicitation of patients' agendas and why they interrupt. These include increasing time pressures during the encounter, increasingly complex aging patient populations, electronic health records (EHRs) that compete for attention, and misaligned incentive systems.

As provider practices focus on increasing access and maximizing the number of patients seen each day, providers are pressured to address each patient's primary concern in the shortest amount of time possible. A 2002 study of primary care encounters in six countries found an average visit length of 10.7 minutes (6.7 SD).<sup>5</sup> Providers are also being asked to accomplish more in their visits. Providers would need to spend an estimated 7.4 hours per working day just to provide all the required preventive services for a panel of patients.<sup>6</sup>

Moreover, an aging population with multiple co-morbidities and complex illnesses may require even more time, with the

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need to address medical, psychological and social issues. A 2015 study found that almost a quarter of US PCPs said their practices were not equipped to manage patients with multiple chronic conditions.<sup>7</sup> In fact, Ostbye et al. estimated that it would take 6.7 hours per day just to manage the most common chronic illnesses of a panel of patients.<sup>8</sup> Faced with these patients, providers may feel the need to address one problem at a time, interrupting to quickly parse out the individual conditions facing the patient. Separating out individual conditions for focus may incompletely recognize that there is a whole person who is experiencing all these ills concurrently. Moreover, taking the time to allow patients to set the agenda without interruption may mitigate the well-known, “hand-on-the-doorknob” phenomenon where patients raise the problem of greatest concern as the provider prepares to walk out the door.

The inclusion of the computer in the clinical encounter also draws visual and cognitive attention away from the patient.<sup>9</sup> The provider must contend with an overload of information from the EHR, clicking through to look at prior visits, diagnoses, and medications and navigating prompts to screen, provide evidence-based care, and complete documentation. When providers are more engaged with the computer, active patient participation decreases.<sup>10</sup> This further limits the opportunity to focus on what is most important to the patient, leading to missed opportunities to foster patient engagement in health management.

Finally, organizational and financial incentives are misaligned with patient-centered care. As a provider once told me, “I feel more like a clerk now, checking boxes, and not like a doctor at all.” Providers are encouraged to provide “cookie-cutter care”—to do exactly the same for every patient with specified diagnoses or risk factors, regardless of the needs, preferences, and goals of the individual person. As they seek to follow evidence-based practice guidelines, providers must constantly battle information overload. Providers may have a hard time sorting out what is most important clinically, much less what is important to the patient.

This type of care is further reinforced through financial incentives which focus on pre-specified clinical tasks and screenings. Although CMS now includes patient experience as one of the metrics for pay-for-performance, other incentives may remain more powerful. When we incentivize providers to check the boxes, attend to the rules and expectations of the medical care system in which they practice, it is no wonder they interrupt patients’ stories.

So what if the system allowed for more time and promoted listening to patients alongside adhering to universal guidelines? Could this help providers interrupt less? And if they did, what would be the impact on the care of patients? Although Singh Ospina et al. found that eliciting the patients’ agenda did increase the length of the encounter, others have argued that setting the agenda with the patient and allowing the patient to tell her story could help patient and provider get to the heart of the matter sooner and more efficiently.<sup>11</sup>

Patient-centered communication seeks first to understand that which matters most to a patient, and then to incorporate

these preferences into shared decisions on subsequent care. When done well, this communication strategy strengthens the doctor-patient relationship; ultimately, these conversations can enhance adherence to recommendations and lead to improved outcomes of care. We need, and many of us want to do a better job allowing patients’ stories to enter into the clinical encounter; only through hearing these stories can we hope to understand the context in which our patients manage their health and illness. It is time for the healthcare system to honor this ideal, and to restructure the organization of care and provider incentives to support patient-centered communication. Finding a way to shift the system of constant distraction and pressure may lead to greater mindful practice and attention to what really matters to patients. It is time to listen more, and talk less.

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**Corresponding Author:** Barbara G. Bokhour, PhD; Center for Healthcare Organization and Implementation Research Edith Nourse Rogers Veterans Affairs Medical Center, Bedford, MA, USA (e-mail: Barbara.Bokhour@va.gov).

#### Compliance with Ethical Standards:

**Conflict of Interest:** The authors declare that they do not have a conflict of interest.

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## REFERENCES

1. **Mishler EG.** The Discourse of Medicine: Dialectics of Medical Interviews. Norwood: Ablex Publishing; 1984.
2. **Levinson W, Lesser CS, Epstein RM.** Developing physician communication skills for patient-centered care. *Health Affairs* 2010;29(7):1310–1318.
3. Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, et al. Eliciting the Patient’s Agenda- Secondary Analysis of Recorded Clinical Encounters. *J Gen Intern Med* 2018. <https://doi.org/10.1007/s11606-018-4540-5>
4. **Horowitz CR, Suchman AL, Branch WT Jr, Frankel RM.** What do doctors find meaningful about their work? *Ann Intern Med* 2003;138(9):772–775.
5. **Deveugele M, Derese A, van den Brink-Muinen A, Bensing J, De Maeseneer J.** Consultation length in general practice: cross sectional study in six European countries. *BMJ* 2002;325(7362):472.
6. **Yarnall KS, Pollak KI, Ostbye T, Krause KM, Michener JL.** Primary care: is there enough time for prevention? *Am J Public Health* 2003;93(4):635–641.
7. **Osborn R, Moulds D, Schneider EC, Doty MM, Squires D, Sarnak DO.** Primary Care Physicians In Ten Countries Report Challenges Caring For Patients With Complex Health Needs. *Health Aff (Millwood)* 2015;34(12):2104–2112.
8. **Ostbye T, Yarnall KS, Krause KM, Pollak KI, Gradison M, Michener JL.** Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med* 2005;3(3):209–214.
9. **Frankel R, Altschuler A, George S, et al.** Effects of Exam-Room Computing on Clinician-Patient Communication: A Longitudinal Qualitative Study. *J Gen Intern Med* 2005;20(8):677–682.
10. **Street RL Jr, Liu L, Farber NJ, et al.** Keystrokes, Mouse Clicks, and Gazing at the Computer: How Physician Interaction with the EHR Affects Patient Participation. *J Gen Intern Med* 2018;33(4):423–428.
11. **Haidet P, Paterniti DA.** “Building” a history rather than “taking” one: a perspective on information sharing during the medical interview. *Arch Intern Med* 2003;163(10):1134–1140.