Satisfying the Patient, But Failing the Test

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ABSTRACT

Communication experts convened in Kalamazoo, Michigan, in 2002 to assess current tools that evaluate physician communication skills. They noted occasional discrepancies between a patient's impression of a physician's skill and the physician's performance as measured by current checklists. The authors explore the reasons for this discrepancy and propose a research agenda to resolve it.

They maintain that the patient's evaluation of physician communication skills depends upon the degree to which the patient's reason for seeking care is satisfied. Since current evaluation tools do not incorporate information to which only the patient has access, they can assess neither the meaning of the interview nor the success of the physician from the patient's point of view.

The authors conclude that physicians' understanding of how well they are meeting patients' needs may require competencies that are unmeasured or only partially measured by current assessment tools, such as "flexibility" or "improvisational skills." These competencies likely reside in the nonverbal domain. The authors suggest that (1) a new tool must be developed that measures the *essence*, or meaning, of the visit from the patient's perspective; (2) this tool must incorporate information derived directly from the patient; and (3) research is needed to define those physician and patient behaviors that facilitate meaningful encounters.

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A medical student is practicing history-taking skills with a standardized new patient encounter. Another student and a faculty preceptor are evaluating the student using a skills checklist supplemented with narrative comments. Both observers note many information-gathering and relationship-building skills being poorly executed. For example, after the patient remarks that "it was pretty scary" when she became septic from an abdominal abscess, the student responds, "But obviously that's better now because you're here." In addition to missing empathic opportunities, the student asks focused or closed ended questions that were begging for more open-ended approaches.

After the interview, the standardized patient (SP) begins her feedback before the observers speak, and says, "I'd certainly come to you if you were done with medical school." The SP remarks that the student had such an empathic look on his face and "demonstrated such caring concern with his tone and his connection." Thus, a dilemma emerges: Should the professional observers defer their judgment of deficient skills, objectified by a validated rating instrument, to the patient's sense that her needs were met?

Communication experts convened in Kalamazoo, Michigan, in 2002 to assess what is known about the ability to evaluate physician communication skills. (For a report on that meeting, see the previous article in this issue, by Duffy et al.) The participants agreed that while theory and research regarding medical communication has become stronger, a physician could perform well on checklists that assess communication skills but still fail to address a patient's central need, and vice versa.

How can this happen? How can we be mindful of addressing both the skills of the interview and the essence of the visit, from the patient's perspective? This article reflects our attempts to capture the larger group's concerns about important limitations of current communication assessment tools.

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For articles on related topics, see pp. 495–507 and 511–520.

Numerous tools to evaluate physician interview skills exist: patient satisfaction and feedback forms, observation of physicians by standardized patients, OSCEs (objective structured clinical examinations), sophisticated behavioral checklists, such as the Calgary-Cambridge and SEGUE scales, and tools that take advantage of advanced computer and audiovisual technologies, like the RIAS (Roter Interaction Analysis System) and videotape feedback. Although these tools consider both communication and interpersonal skills, none convincingly answers the central question: *Did the physician satisfy the essential reason for which the patient sought help?* Each focuses on physician behaviors that have been considered (with some evidence) to be critical to a successful transaction with the patient. The problem is that current tools are potentially reductionist—they measure observable behaviors but not their effect on the patient. Meaning is an emergent property of the medical encounter, a property of neither the patient nor the physician, but of both. Just as the *meaning* of illness (as opposed to its clinical consequences) can be defined only by the patient, the meaning of the clinical encounter can be defined only by its participants. Although the clinical encounter may have meaning for both the doctor and the patient, we are most concerned with *meaning* as defined by the patient when we judge the *quality* of the encounter.

How should we approach defining a meaningful encounter? Many students of the interview have noted that pivotal, "critical,"[1] or "connexional"[2] moments occur in some encounters. In interviews in which they occur, both of the actual participants in the encounter can independently identify the same critical point of the interview on a videotape. And yet experienced observers who were not actually part of the interview are unable to identify those moments.[3]

Which physician qualities promote meeting the needs of the patient? There are certainly behaviors, many of which are components of the assessment instruments named above, that are likely to (1) assist in the identification of the patient's conscious or unconscious clinical needs, (2) promote the emergence of those needs into the interview, and (3) facilitate healing. All these tools incorporate some measure of patient centeredness. Indeed, "understanding the patient's agenda" and "reaching agreement on problems and plans" are two of the seven essential elements of communication as defined by the Kalamazoo Consensus Statement,[4] formulated at an earlier conference in 1999. "Feeling understood" is necessary, but not sufficient, for "healing" to occur. While skill training can lead to measurable skill development, patients may not notice![3] Thus we need to address *task* as well as *skill*.

To do this, higher-order competencies may be necessary, such as the quality of "flexibility," or the ability to improvise in response to unanticipated patient verbal and nonverbal behaviors. Such physician skills may be observable proxies for the "meaningful event" but may reside in the realm of nonverbal behavior, a relatively unexplored and unmeasured domain.

For example, the skill "observing the patient" is not typically included in the commonly evaluated skill "gathering information." Rather than focusing solely on verbal information, we should help students develop their observational skills. They need to practice gathering information with their eyes (How does the patient look? Is there congruence between what the patient says and how she says it? How is the patient responding to the style of questioning? Does he appear to be experiencing the degree of pain he describes?) These information-gathering skills are critical to helping facilitate that harder-to-measure "essence" of the encounter.

Certainly improved nonverbal skills will better enable the interviewer to assess whether the patient feels his needs have been met. It remains to be determined whether, in order to accomplish the interview's goals from the patient's point of view, previously defined clinician skills (such as those addressed by the report from the second Kalamazoo conference) or new skills will be required, or whether consideration of emergent properties of the interview will ultimately require patient skills as well.

From these reflections, we have formulated three recommendations:

1. Having discovered that physicians can gain interview skill proficiency without accomplishing the task of the interview, we must reach consensus about the most effective way to measure the task of understanding the essence of the visit from the patient's perspective. Although the Kalamazoo Consensus Statement identifies the key tasks and subset of skills for effective communication, we suggest that once we know how to identify and measure the skill that could be stated as "understanding the true essence or meaning of the visit," that skill should be added to the list of core skills.
2. Since a meaningful transaction can only be defined from the patient's point of view, future assessments of the quality of medical encounters must incorporate the patient's perspective. The task may be more complicated than simply measuring the discrepancy between what patients say they want and what they receive. A patient may not be able or willing to articulate what it would take to produce the *feeling* that her needs have been met.
3. For a meaningful transaction to occur, there must be observable behaviors that lead to the emergence of that

meaning. A new research agenda lies before us, *to define those physician (and perhaps patient) behaviors that facilitate meaningful encounters*. The critical behaviors may reside within the more difficult-to-categorize and less frequently measured domain of nonverbal behaviors. One possible methodology would be to study videotapes of encounters in which the patient judges that the critical transaction was accomplished, and to compare these to interviews in which it was not. Qualitative research methods that focus on patient observations of physician behavior and patient reflections on their experience of the encounter may point us in the right direction.

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From the Archives

CLINICAL COMPETENCIES OF GRADUATING MEDICAL STUDENTS

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Medical education is usually considered a continuum of several overlapping processes. The first part involves mastery of the academic foundation (the science); the second involves mastery of the mechanics (the skills); and the final process involves the integration of the first two parts and the mastery of the "art" of practicing medicine. Much time and research have been devoted to the first and third portions of medical education; however, an extensive literature search by the authors provided little information on the actual mechanics of practicing medicine in terms of what a graduate should be able to do following four years of medical school.

. . . The problems associated with evaluating clinical skills have been studied and medical educators' expectations for medical students vary, depending upon the level of education of the students. Obviously, a medical student is not expected to be competent in all areas in which competency is expected of residents, and the level of competency of first-year residents is not equal to that of senior residents.

Although medical schools are designed to begin the medical education process, the end product of that process has never been critically defined. Because of the lack of specific information on the skills and competencies of medical school graduates...a list of minimum clinical expectations can serve as a guide for interactions with medical students. In no way should expectations limit the students' education. It should always be possible for the student to exceed the expectations of physicians and schools yet to have a common point from which the student and the teacher can begin to work. Also, the correlation between a student's self-evaluation and his actual competency in clinical areas needs to be established. The difficulty in doing this is due to the absence of any reliable method to test students' competency in performing clinical skills.

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