

ORIGINAL REPORTS

# Competent Patient Care Is Dependent upon Attending to Empathic Opportunities Presented During Interview Sessions

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**OBJECTIVE:** Core competencies in surgical education and clinical care rely on effective patient-physician communication. We aim to develop quantitative and empirical tools for understanding critical communication tasks during patient interviews.

**METHODS:** Residents in surgical training and attending physicians were separately video recorded during stressful, first visit oncology patient interview sessions. Taped sessions (n = 16) were analyzed in detail to identify and label patient-initiated actions (PTAs), or "empathic opportunities," that call for recognition or action from the caregiver. Doctor-responsive actions (DRAs) were labeled as matching to, or missing from, each empathic opportunity. Missed empathic opportunities occurred when a PIA did not have an associated DRA. Pre-session and post-session surveys queried the patient's perception of how well their health-care needs were met.

**RESULTS:** Resident trainees and attending physicians missed 70% of 160 clearly identified empathic opportunities. There was no clear association with the level of physician training. This pilot study did not have enough power to discern differences in patient satisfaction.

**CONCLUSIONS:** Physicians are often not very attentive to empathic opportunities offered by patients. Individual feedback and training regarding empathic opportunities in recorded patient communication encounters may improve resident and physician core competencies. These improvements may affect patient satisfaction related to these encounters. (Curr Surg 61: 313-318. © 2004 by the Association of Program Directors in Surgery.)

**KEY WORDS:** Communication, core competencies, empathy, conversation analysis

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## INTRODUCTION

"The most important instrument that a successful surgeon must learn to use is... the *telephone*," admonishes the Chairman of the Department of Surgery at the University of California at San Diego (UCSD). This is but one way to stress the importance of good, solid communication skills to our surgical trainees. Especially with the stressors of work-hour regulations, diminished resources in clinical medicine, and the increasing complexity of surgical practices, it is imperative that clear and effective communication occurs at all levels.

Clear and effective communication, although critical to the success of all professions, has many subtleties and

nuances. Communication patterns are not always black-and-white. Emotional content, facial gestures, posture, eye gaze patterns, and subtle neuroticisms<sup>1</sup> are all messages that are routinely given yet often missed by medical professionals.<sup>2</sup> Surgeons and trainees should develop assessment tools and skills in these critical communication patterns to more completely train residents, as well as to more effectively manage and treat their patients.

Our surgical societies and organizations have recently adopted 6 "core competencies" to be stressed within our training programs. All of the 6 core competencies rely heavily on effective communication patterns (<http://www.ACGME.org>).

We have initiated pilot studies involving both residents and attending physicians during first visit interview sessions in stressful oncology clinics. Our hypothesis is that established methods of conversation analysis, using video-recorded sessions, can assist in the assessment and grading of surgical core competencies at its most basic level, ie, effective communication. A secondary hypothesis is that patient satisfaction scores correlate with effective communication.

Our eventual goals are to (1) produce useful assessment tools in surgical education; (2) develop an instructional set of interventions using moderated, self-study, or group session methods; and (3) validate the utility of such interventions in the context of graduate medical education.

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## METHODS

Human subjects committee approval was obtained through UCSD for all aspects of this pilot study. Informed consent was obtained separately from patients, residents, and attending physicians prior to participation in recorded sessions. All interviews were obtained during unselected, regularly scheduled new visit sessions in a multidisciplinary outpatient oncology clinic.

Junior-level residents in general surgery training (PGY-2 or -3) and attending physicians in surgical, medical, or radiation oncology practices were chosen as test subjects. Surgical resident sessions immediately preceded attending interviews in every instance. Apart from equipment availability and scheduling convenience, no selection criteria were used, and no solicitation of specific patients was attempted. New patients who were scheduled for visits during available sessions were all approached for inclusion into the study.

Video- and voice-recorded sessions were reviewed, using specific and validated conversation analysis techniques, by members of the School of Communication at San Diego State University.<sup>3-5</sup> This method of analysis is anchored in repeated listenings to recordings in combination with systematic inspections of carefully produced transcriptions.<sup>6-8</sup> It is an explicit feature of this research method that participants continually refine, through an array of interactional practices, detailed understandings of specific conversational circumstances. The overriding goal is to identify patterns of interaction comprising everyday conversational events.

These comprehensive data sessions occurred under the supervision of one author (W.B.). Identified moments were repeatedly examined and characterized as "patient-initiated actions" (PIAs) and "doctor-responsive actions" (DRAB). PIAs represent specific and validated empathic opportunities presented by patients to doctors, essentially asking for empathy, understanding, or support. DRAs represent the physician's response to a specific PIA.

Specific tabulations of "empathic opportunities" (PIAs) and matched responses (DRAs) were recorded. When the PIA was not recognized, attended to, or minimally addressed by the physician, this event was scored as a missed PIA opportunity. These raw scores, with a variable number of PIAs for each interview session, were converted into a percent PIA-met score. At a most basic level, these methods attempt to measure how "well connected" a medical professional is with his/her patient. That well-connecting physicians provide more accurate and complete care for their patients was not tested.

## RESULTS

Completed interview sessions and analyses were obtained for 8 physicians, including 2 residents, 2 attending surgeons, 2 attending medical oncologists, and 2 radiation oncologists. Sixteen patient interviews were recorded. No patient withdrew from participation once taping began. Because of unintended procedural errors, 6 exit surveys were not completed.

### Selected Excerpts

Complete transcriptions of interview sessions were made for each recorded session. Appendix 1 lists a sampling of transcription symbols used in conversation analysis techniques, and Appendix 2 provides a more detailed analysis of 2 transcribed excerpts. The 2 excerpts are from a single interview with a patient who was concerned about

metastases from a previously excised melanoma. Interested readers are invited to examine through these appendices how claims can be made about the interactional organization of oncology interviews.

### **Matched or Missing DRAs**

Overall, there were 160 clearly defined PTAs obviously presented to physicians. Only 48 (30%) of these PTAs were attended to, or met, with a recognizable empathic connection by the professional. Conversely, 70% of empathic opportunities were not met by physicians during these interview sessions.

With the small number and diversity of personnel in this pilot study, no conclusions could be made regarding patients' satisfaction or sense of competency toward their clinicians.

## **DISCUSSION**

It is a clear-yet-axiomatic leap of faith to expect that effective communication improves patient satisfaction or clinical outcomes. Moreover, it is obvious from the wording of the Accreditation Council on Graduate Medical Education's (ACGME'S) core competency curricula that nearly all of our resident education goals and tools are firmly rooted in effective communication skills. Residents who miss verbal and nonverbal communication opportunities are easily characterized as those who "don't get it." These residents are oftentimes those who demonstrate repeated difficulties during residency training experiences. Patients, their families, and allied health care workers—especially nurses—are quick to recognize these deficits in our surgical trainees. The interactional consequences of these moments during actual interviews remain to be systematically investigated.

Moreover, it is obvious that efficient and clear communication skills are the backbone of many professional safety systems, eg, airline safety programs. For example, simple verbal checklists are regularly completed by pilot and copilot before every commercial flight. Other specific communication rituals exist on airline flights. Members of the public who cannot effectively "connect with" or understand the directions of airline personnel are specifically excluded from potentially critical roles, eg, exit row seating. (It seems clear that those who especially want to sit in exit rows benefit from good communication skills!)

Conversation analysis methods allow for close and repeated examinations of the interactional organization of medical interviews. Specific and grounded criteria for identifying PIAs, DRAs, and their relationship to empathic opportunities can be generated using this methodology. In a different clinical setting,

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Jones and Beach have suggested that physicians tend to avoid, discount, or otherwise fail to address patients' attempts to diagnose or comment about their own illness. Our pilot study reveals that a significant number of empathic opportunities are unattended to by physicians and trainees in oncology clinic settings.

It seems likely that refinements in this methodology will improve our abilities to recognize and assess the critical core competencies of surgical trainees and attending physicians. First visit oncology clinic sessions may prove to be fertile testing grounds for developing a listing, or taxonomy, of the types of empathic opportunities that are presented during clinical practices. Application of this methodology to more diverse settings and populations could specifically augment the educational resources of our surgical residency programs.

## **CONCLUSIONS**

Communication analysis methods allow for the objective measurement of "missed" or "met" empathic opportunities (PIAs) that are routinely offered by patients during stressful oncology clinic visits. The percent of missed PIAs during an interview session allows for a critical assessment of how well a trainee or attending physician meets the communication needs of his/her patients. This "connectivity score" may also help to describe critical elements that are operative in interpreting patient satisfaction scores. Further testing in other clinical settings could significantly augment the educational armamentarium of our surgical residency programs.

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## APPENDIX 1

See Table 1.

*Example of a PIA with matching DRA*

DOC:... you were never ((shakes head)) (.) a:h (0.2) started

on any chemo:: or

immunothe[rapy: or anything like that] \_ PAT: =(shakes head no)= DOC: Okay.

PAT: Cause they got it (0.2) early enough. DOC: *Okay*. Good. (1.0)

This short excerpt reveals a patient essentially asking for sup

port for her contention that "they got it early enough." The

**TABLE 1.** Transcription Symbols

Micropause, less than 0.2 seconds

Timed pause, eg, 1.2-second pause Scenic details, eg, averting gaze Questionable transcription or muffled speech Softer tone than surrounding conversation Latching of contiguous speech with no overlap Overlapping conversation

Extended or stretched sound, syllable or word *survival*/Vocal emphasis

Animated tone

Falling vocal pitch ? Rising vocal pitch

Abrupt cut off of sound or word

>< Pace of speech changes-faster than surrounding talk

HOPE Extreme loudness compared with surrounding talk

Hhh. Audible outbreaths, possibly laughter

Adaptated from Pomerantz,<sup>10</sup>

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{1.2}

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resident trainee responds with a simple "Okay, good." Although brief and limited, this response qualifies as a DRA.

*Example of a PIA without an associated DRA*

PAT: So HOPE:fully I caught mine early enough.

DOC: Well that's the thing. If you had a ah seven millimeter=

PAT: =Mm hm=

DOC: =ah (.) melanoma (.) the: (.) survival is much better (.) if yo:u do a resection early on, and I had mentioned to you about the (sentinel) lymph node biopsy.

PAT: Mm hm.

This short excerpt identifies another opportunity for connection, or empathy from the resident trainee. The patient again seeks reassurance that "I caught mine early enough." The physician avoids this issue and instead provides a short description about sentinel lymph node biopsy techniques—a type of medical response that is common among missed empathic opportunities. This pattern of reply has been described in other settings.<sup>10</sup>

## APPENDIX 2. DETAILED ANALYSIS OF TRANSCRIBED EXCERPTS

The two transcribed excerpts below, involving a melanoma patient and a surgical resident, are drawn from initial historytaking and diagnostic (postphysical examination) phases of the same oncology encounter. These moments are drawn from a larger collection of instances, where patients display (verbally and nonverbally) that they are somehow worried, anxious, or fearful about "cancer." We are interested in when and how such concerns are displayed during oncology visits and, in turn, how doctors respond to such behaviors.

Addressed below are a variety of communication activities that might be identified in 2 related, yet also different, moments during a single oncology interview.

The first instance occurred approximately 3 minutes into history-taking:

### 1) SDCL: Oncology#1:5-6: "Cause *they* got it (0.2) early enough"

((In response to doctor's question about whether she was taking any medications, patient had just described being on a "viral suppressant."))

DOC: Okay. (0.2).hh U:m (0.3) pt The:: other thing is u::m (0.5) you were never ((shakes head)) (.) a:h (0.2) started on any chemo:: or immunothe[rapy: or anything like that.] PAT: [ ((shakes head)) ] \_

DOC: Okay.

PAT: 1-Cause they got it (0.2) early enough. DOC:2-'Okay. Good. (1.0)

DOC:3->.hhh How have you been feeling (.) lately. Havehave you had any fevers

(.) or chills or night sweats, loss of appetite, anything likeany constitutional symptoms.

PAT:4-No. (.) I'm tired but I'm the mother of three kids.

DOC:5-Okay. [I understand.]

PAT: 6- [ \$Hhhhh.\$ ] \$Pretty normal.\$ Yeah.=

DOC:5- Mm hm.=

After the patient's description that a "viral suppressant" was the only medication she was taking, the doctor shifts topics by asking patient about prior treatment with "started on any chemo:: or immunotherapy: or anything like that.. " This shift, however, is marked with *dysfluencies*: By pausing 4 times, and with several stretched words (including 2 floor-holding "U: m's"), the doctor searches for what to say next. With his negatively valued "you were never (.) a:h," in unison with a head shake, doctor seeks confirmation of information he assumed was correct about patient's medical history.

But there is more here: Grammatically, he also displays that the issues he is attempting to raise are indeed *delicate matters*, and he approaches them with some hesitancy and uncertainty. These actions display how oncologists may have troubles talking about cancer diagnoses with patients. Specifically, the resident avoids discussing patient's *diagnosis* in favor of *treatment options*. Rather than asking, "You were never.. .diagnosed with cancer," the doctor redesigns and thus reorients his turn to accommodate, "started on any any chemo:: or immunotherapy: or anything like that." It is thus on the very cusp of raising a cancer diagnosis, even a negative one, that the doctor shifts to a listing of treatment options.

In overlap, patient begins to shake her head and continues to do so until the doctor's "Okay." receipt. Immediately, and on her own initiative, patient further elaborates with "Cause they got it (0.2) early enough." (1-->). Several key

features are evident in patient's utterance:

After answering the doctors initial query with "Okay.," the patient initiates this utterance by volunteering what is essentially "good news" about her condition. Bodily, however, her announcement is visibly tenuous and thus contradicts otherwise "good news." The patient's embodied actions - "knowing" smile and grimace, averted gaze, closing of eyes, and anxious "leg kicks" - reveal a communicative display of what might best be characterized as "anxiety" or "fear."

The patient's "it" indirectly references and thereby avoids the word "cancer." Both the doctor and patient have thus constructed alternative ways of *not* referencing "cancer." Following a (0.2) pause, her reference to "early enough" reflects a sensitivity to cancer growth, and a recognition that early detection and treatment might alleviate such concerns. Taken together, patient's "Cause they got it (0.2) early enough." exhibits a delicate orientation to an otherwise "good news" announcement.

It is also interesting that the patient's reference to "they got it" depicts how anonymous medical professionals somehow pursued, captured, and halted the progress of cancer. This raises a basic question: How do patients describe their own diagnosis and treatment procedures?

Patient's verbal and nonverbal behaviors evidence how even a "brush" with a cancer diagnosis can promote noticeable actions: A patient being not only concerned about cancer, but displaying being negatively impacted by the experience.

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definitions of treatment modalities. In (3-'), the patient Seri attend to the patient's exhibited anxiety could not only mitigate

It is important to emphasize that the patient's "Cause they got it (0.2) early enough." *invites* and thereby *solicits* from the doctor an acknowledgment and confirmation that the news just delivered by patient is indeed "good." With "Okay, good." (2-->), the doctor provides this minimal response. However, the patient's display of being negatively impacted, and experiencing an ongoing concern with cancer - the "bad news" contradiction in her behaviors - is not verbally addressed by the doctor. During the following (1.0) pause it appears that the doctor is assessing the patient's demeanor, observations which his next "hhh How have you been feeling (.) lately." (3-p) seem designed to address. However, notice that he quickly moves away from any possibility that the patient will hear his query as asking for psychosocial or emotional implications of his question. Instead, he quickly produces a list of biomedical (constitutional) "symptoms" - and by so doing qualifying what he had designed his earlier "feeling (.) lately." to address.

In response, the patient's "No. (.) I'm tired but I'm the mother of three kids." fails to confirm any symptoms but does nominate an additional symptom - being tired - as well as an explanation rooted in her lifeworld experience: Being a mother of three children. Thus, despite the doctor's moving away from potential psychosocial/emotional issues, the patient brings the discussion back to everyday life events by implicitly offering parenting as a reasonable explanation of her fatigue. With "Okay. I understand" (5--) the doctor both acknowledges and explicitly confirms both the relevance and normality of the patient's dilemma. Through laughter (\$), the patient's "\$Hhhhh.\$ \$Pretty normal.\$ Yeah.=" (6-p) marks the delicacy of her situation (see Haakana, 2001), her resistance to the trouble (Jefferson, 1984), and a recognition that the doctor's prior "Okay. I understand" was attentive to her quandary. Finally, the doctor's "Mm hm." offers yet further assurance that the normality attributed by the patient is, indeed, "normal."

To summarize Excerpt 1 (above), it is clear that any assessment of "core competencies" must not only come to analytic grips with such delicate and often complex moments, but move past thick descriptions and explanations (for their own sake, as basic knowledge) toward *prescriptions* of whether or not - and in what precise ways - such involvements reflect a range of *effective/skilled* - \* *ineffective/unskilled* communication activities. It is also evident that any given set of moments during oncology interviews are fraught with meaningful and often delicate social actions:

From these moments and the actions comprising them, the following "training" issues might arise:

What difficulties exist, for patients and doctors alike, when raising and referring to cancer diagnoses and treatment?

What relationships exist between "good and bad" cancer news?

How might doctors address contradictions in patients' verbal and nonverbal actions (e.g., as with "Cause they got it (0.2) early enough.")?

How do psychosocial/emotional issues get raised and alluded to (directly or indirectly) by both patients and doctors?

How do psychosocial/emotional issues get acknowledged and confirmed rather than avoided and disattended by both patients and doctors?

How do patients go about volunteering life-world experiences (e.g., being tired but a mother of three kids), and how might doctors treat as relevant patients' dilemmas and concerns?

Of course, any discussion of these matters would require the articulation of specific consequences of these collaborative actions for effective, patient-centered care.

Now that a single instance (Excerpt 1, above) has been addressed in some detail we very briefly consider the following excerpt, drawn from the same oncology interview approximately 5 minutes further into the interview:

SDCL: Oncology #1:17: "τ hope::fully I caught mine early enough" This patient had no family history of melanoma, but one melanoma had been identified and removed (0.7 millimeter, 3 years prior) along with several other moles that were not suspicious. Subsequent x-rays and bone scans were negative, though patient did have several swollen lymph nodes identified during physical examination. Below, the doctor had just provided a summary of symptoms, including "forgetting things," that could indicate that melanoma spread somewhere in the body. In response, the patient mentions "To your brain" and initiates the following story.

PAT: (Now we have)- ah a friend of mine- (.) a friend- (.) it wrapped around the stem <of his bra::in.> hhh [ ° Like ] oh my God.°=

DOC: [Mm hm.]

PAT: =It metastasized in his le:g (.) °Ya know.° But he's down at Anderson.=

DOC: =Mm hm.

PAT: 1 -So: τ hope::fully I caught mine early enough.

DOC: 2-Well that's the thing. If you had a ah seven millimeter=

PAT: =Mm hm.=

DOC: 2-ah (.) melanoma (.) the: (.) ah (.) survival is much better (.) if yo:u do a resection early on, and I had mentioned to you about the (sentinel) lymph node biopsy.

PAT:3-Mm hm.

*That the patient even volunteered this story about her friend's diagnosis reveals her preoccupation with forgetting "as a symptom which may be related to brain cancer.*

Following her story, in (1-) patient's "So: τ hope::fully I caught mine early enough." (1-p) achieves several key and related actions: a) She is audibly concerned that her melanoma problems might lead to more serious cancer diagnoses. b) She is "hopeful" that that is not the case. 3) By announcing her concerns in this manner, she is inviting and thus soliciting from the doctor some reassurance that her "hope" is realistic, and that positive healing outcomes will be forthcoming.

What the doctor provides (2-3), however, is a withholding of the reassurance patient was seeking. Instead of acknowledging patient's concern directly and immediately (e.g., by stating "It seems that we have, and your condition is very good."), doctor