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TEAMWORK AND COMMUNICATION

Optimizing Hospitalist-Patient Communication: An Observation Study of Medical Encounter Quality

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Background: Optimizing patient-hospitalist interactions heightens patient satisfaction, improves patient health outcomes, and improves hospitalist job satisfaction. A study was conducted to recognize hospitalist communication that enhance encounters, identify hospitalist behaviors for improvement interventions, and explore the association of time and gender with communication quality.

Methods: Researchers observed encounters between 36 hospitalists and 206 adult patients. All but 1 of the hospitalists was observed at a 410-bed, general medical and surgical facility in the Midwest.

Results: On the adapted Kalamazoo Essential Elements of Communication Checklist (KEECC), hospitalists scored highest on the Builds a Relationship, Shares Information, and Gathers Information dimensions. Participants were seen using multiple, effective verbal and nonverbal techniques to show care and concern, as well as create relational rapport, often while successfully sharing and obtaining clinical information. Hospitalists scored lowest on the Understands the Patient Perspective and Reaches Agreement dimensions. Hospitalists were observed infrequently and inconsistently empathizing with patients and rarely attempting to gain shared understanding and agreement from patients. Significant difference was found in sharing information (t [194] = 2.47; p = 0.01), with male hospitalists (mean [M] = 4.14; standard deviation [SD] = 1.01) more highly rated than female hospitalists (M = 3.78; SD = 0.90). Hospitalist and patient gender match revealed significant difference in sharing information (F [3,192] = 2.60; p = 0.05). Male hospitalists were rated higher interacting with female patients than female hospitalists interacting with male patients.

Conclusion: Results identify specific hospitalist communication techniques that may ultimately contribute to better-quality medical encounters. Communication interventions are recommended.

Hospital quality has long been the focus of national interest in the United States, as represented in consumers', patients', and government and business leaders' increasing concern about the need to improve safety, efficacy, and efficiency—and to reduce costs. The 2010 Patient Protection and Affordable Care Act heightened attention on the quality of the hospitalized patient experience as a major indicator for the caliber of hospital and clinician performance.[1] Hospitalists play central roles in the inpatient experience, providing direct care and communicating in myriad ways to ensure that hospital care delivery is smooth and seamless.[2,3] Hospitalist discursive responsibilities include, but are not limited to, updating patients and families about procedures, tests, and consultations; coordinating patient care between multiple clinicians; and educating patients about health status and next steps in care.[2,3] Such activities, which focus on the patient's values, abilities, concerns, culture, and goals, are enhanced by hospitalist communication proficiency.[4,5]

Decades of physician-patient communication research literature in medicine, health studies, health communication, and related disciplines demonstrates that physician communication competence is essential to high-quality care.[6–8] Patient-centered communication (PCC), characterized by Epstein and Street in terms of the following themes, figures prominently in this literature[9(p.2)]:

- Eliciting, understanding, and validating the patient's perspective (e.g., concerns, feelings, expectations)
- Understanding the patient within his or her own psychological and social context
- Reaching a shared understanding of the patient's problem and its treatment
- Helping a patient share power by offering him or her meaningful involvement in choices relating to his or her health

The research literature generally suggests that PCC contributes to better-quality physician-patient interpersonal relationships and heightens proximal outcomes—patient satisfaction, trust, feeling understood, and motivation to change. These proximal outcomes contribute to adherence and self-care, often resulting in improved patient health.[10,11]

Studies specific to hospitalists also show that when hospitalists develop positive relationships with patients on the basis of PCC, patients tend to be satisfied with care,[5,12] which has been associated with lower readmission rates, higher patient compliance, and greater patient self-management.[13–15] Good patient-centered relationships also lessen hospitalist

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burnout, which can undermine the quality of care.[16] Unfortunately, hospitalists routinely experience workplace challenges that minimize or prevent them from consistently and/or fully displaying desirable patient communication.[17] First, the short-term nature of hospitalist-patient relationships makes it difficult to develop trust and understanding.[18] Second, hospitalists see a large number of patients during a single shift, sometimes exceeding US hospital benchmark recommendations of 10 to 15 patients daily.[19] More patients translates to less time at the bedside, and in such circumstances hospitalists need to prioritize brevity and directness to deliver care to all patients. Third, hospitalist time with patients is routinely truncated by non–direct care activities. One study shows hospitalists spend just 15% of their work time talking with patients.[20]

We conducted an observational study to (1) identify hospitalist communication that optimizes the quality of medical encounters, (2) identify hospitalist behaviors for targeted interventions improvement, and (3) explore the relationship between medical encounter time and hospitalist communication quality.

METHODS

Study Design

In 2016 we conducted 206 observations (126 hours) of hospitalist-patient interactions and assessed hospitalist communication qualitatively and quantitatively in terms of the adapted Kalamazoo Essential Elements of Communication Checklist (KEECC).[21] The KEECC is a measure of general physician communication competence; its seven dimensions—(a) Builds a Relationship, (b) Opens the Discussion, (c) Gathers Information, (d) Understands the Patient's Perspective, (e) Shares Information, (f) Reaches Agreement, and (g) Provides Closure (Sidebar 1)—are drawn from five prominent models of physician-patient communication that are consistent with PCC.[22] The ratings are made on a five-point scale (1 = poor to 5 = excellent). Multiple studies in varied clinical contexts with physicians of differing professional experience have shown that this tool is a reliable measure of desirable physician communication.[23–25] This study received approval from the Institutional Review Boards of the research team's university (Western Michigan University, Kalamazoo, Michigan) and the study hospital (Bronson Healthcare Group, Kalamazoo).

Sidebar 1. Kalamazoo Essential Elements Communication Checklist–Adapted Dimensions and Items

Builds a Relationship
Greets and shows interest in patient as a person
Uses words that show care and concern throughout the interview
Uses tone, pace, eye contact, and posture that show care and concern
Opens the Discussion
Allows patient to complete opening statement without interruption
Asks questions (e.g., "Can you tell me about why you are here?") to elicit full set of concerns
Explains and/or negotiates an agenda for the visit (e.g., "I'm concerned about. . .")
Gathers Information
Begins with patient's story using open-ended questions (e.g., "Tell me about. . .")
Clarifies details as necessary with more specific "yes/no" questions
Summarizes and gives patient opportunity to correct or add information
Transitions effectively to additional questions
Understands the Patient's Perspective
Asks about life events, circumstances, other people that might affect health
Elicits patient's beliefs, concerns, and expectations about illness and treatment (e.g., "Tell me more. . .")
Responds explicitly to patient's statements about ideas and feelings
Conveys empathy
Shows sensitivity to patient's cultural background (e.g., race/ethnicity, gender, age) and adapts accordingly
Shares Information
Assesses patient's understanding of problem and desire for more information
Explains using words the patient can understand
Checks for mutual understanding of diagnostic and/or treatment plans
Asks if patient has any question
Reaches Agreement
Includes patient in choices and plan of care
Asks about patient's ability to follow diagnostic and/or treatment plans
Identifies additional resources as ppropriate
Provides Closure
Asks if patient has questions, concerns, or other issues
Summarizes/asks patient to summarize plans until next visit
Clarifies follow-up or contact arrangements
Acknowledges patient and closes interview

Research Team and Observations

The research team consisted of two communication professors [J.A., K.H.], two communication master's students [M.B., S.S.], and a hospitalist study hospital leader [S.V.]. The communication professors and students, who performed all of the observations, completed several pre-observation training sessions to avoid rater bias. These meetings consisted of watching videos of physician-patient interactions supplied by the study hospital and sources (for example, major teaching hospitals, medical schools) as a team and independently coding the interactions using the KEECC. The research team members discussed scoring to achieve consensus, and discrepancies were resolved through discussion.

The observations occurred from January through June 2016, with each hospitalist observed one time during his or her service rotation (hospitalists rotate on and off service at the study site). The observation days and times were chosen on the basis of mutual agreement of the researcher and hospitalist rather than the timing of hospitalists in their rotation (first day, middle day, last day) or the timing within