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Patient-Provider Communication and Interactions

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Introduction

In a letter to his new primary care physician John Steinbeck reflected, “What do I want in a doctor? Perhaps more than anything else—a friend with special knowledge” [1]. Steinbeck alluded not only to the importance of the relationships that develop between healthcare providers and their patients, but also to the key role that the communication of medical knowledge plays in fostering those relationships and facilitating care over time. Communication between healthcare providers and their patients, particularly during chronic illness, shapes a patient’s healthcare experience. It influences information that is gathered from patients, informs an understanding and conceptualization of their illness, and provides a foundation for the collaborative work that patients and providers will engage in around disease management.

The Institute of Medicine highlighted six aims for improving healthcare in *Crossing the Quality Chasm* report, including the need for care to be patient-centered, responsive to individual patient preferences, needs, and values, to ensure that patient values guide clinical decisions [2]. The report further highlighted the essential role that patient-provider communication plays in achieving this aim, recommending that care be based on continuous healing relationships, that knowledge and information flow freely between providers and patients [2].

There is a substantial body of evidence that supports these recommendations, demonstrating an association between effective patient-provider communication and important health outcomes [3–6]. In addition, quality communication between patients and providers has been linked to patient satisfaction, which is important not for better health, an outcome in a value-based care environment [3, 4, 7]. Healthcare providers may also find greater professional satisfaction through care that involves effective communication, a quadruple aim that includes a patient-centered experience, quality improvement, reducing costs, and improving the work life of healthcare providers [8]. One plausible pathway that described the relationship of effective communication and health outcomes is the association of defined communication elements, such as emotional response and relationship building, as mediators of outcomes, such as disease resolution, survival, emotional well-being, and functionality [9]. Effective communication also impacts proximal patient-centered outcomes, such as satisfaction, trust, motivation, and clinician-patient rapport and agreement [9].

This chapter provides an overview of patient-provider communication in healthcare. The first section focuses on components, processes, and communication techniques in the provider-patient dyad, encounters that have historically been central to patient-provider communication. Understanding and developing communication competencies in this setting is key to the successful provision of chronic illness care. Next, communication within chronic illness care models is introduced and described in relation to health services. Team-based models of care, virtual and technology-based initiatives, and group care are representative of these trends. The chapter closes with future directions in patient-provider communications and interactions.

Communication in the Provider-Patient Dyad

Meaningful and effective provider-patient communication increases disease self-management and treatment adherence, promotes patient satisfaction, and improves quality of care and health outcomes [3, 4]. In face-to-face encounters, provider and patient personal identities and communication styles influence the information that is prioritized and shared [5, 6]. To optimize communication, understanding the patient-provider dyad interaction, and specific techniques,

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knowledge, and skills, can facilitate patient health outcomes.

Goals of Patient-Provider Interactions

Patient communication is most effective when there are specific goals, which may be organized along six dimensions: (1) exploring the illness experience; (2) understanding the whole person; (3) finding common ground regarding management; (4) incorporating prevention and health promotion; (5) enhancing the doctor-patient relationship; and (6) being realistic about personal limitations [10]. This approach is informed by a biopsychosocial model, viewing the patient as a person, sharing power and responsibility, building effective relationships, maintaining and conveying positive regard for patients, and remaining aware of the doctor as person [11].

When considering communication approaches, providers should be aware of techniques that can promote goals of care. The patient-centered medical interview is an approach that views the patient as a unique human being with a life story, promoting trust by clarifying and characterizing the patient's symptoms and concerns in ways that may include biological and psychosocial dimensions of illness, and provides a foundation for an ongoing relationship [12]. Another strategy emphasizes establishing both traditional biomedical goals (e.g., blood pressure) and socioemotional goals (e.g., reduced depressive symptoms), using "2 F's" (Find the illness and Fix it) for the former as well as the "4 E's" for the latter (Engage patients via an interpersonal connection; Empathize with patients' illnesses and situation; Educate patients by effectively delivering information; and Enlist patients to actively participate in decision-making and disease management) [13, 14].

Communication Approaches and Techniques

Several organizing principles can orient providers to actionable communication concepts and skills. Seeing health and illness through patients' eyes allows providers to consider a more inclusive worldview [15]. The perspective of exploring the patient illness experience has been independently associated with increased patient trust [7]. This emotional activity is a central aspect of patient-centered communication [15, 16]. Additionally, provider introspection, self-awareness, and mindfulness are important since provider and patient character traits and personal beliefs strongly influence the communication styles, as well as the nature and content of information that is exchanged [3, 6, 7, 17, 18]. Providers may seek ways to reflect and maintain an awareness of their own traits, biases, beliefs, mannerisms, and reactions that influence their interactions. As providers progress in their communication strategies, they may find a deeper understanding of their patients and of themselves [7].

Several techniques and approaches can facilitate patient-centered communication. A curriculum for conducting medical interviews, for example, identifies knowledge, attitudinal, and skill components for patient-centered communication (Table 14.1) [12].

Table 14.1 Components of patient-centered communication

Knowledge	• Recognize different question types (e.g., open-ended, closed-ended, directive but nonbiased, directive and biased) • Understand the stages of an interview (e.g., opening, characterization of present illness and life setting, closing) • Understand interview functions (e.g., interest and commitment to patient, facilitating communication, calibrating and overcoming barriers in communication, surveying patient problems, selecting priorities and limitations, negotiating contract, use of self and helping skills, the avoidance of hindering skills) • Recognize forms of nonverbal behavior and understand communication patterns • Define transference and countertransference and explore how each effects medical relationships
Attitude	• Approach patients respectfully and nonjudgmentally • Respect patient autonomy and individuality • Willingness to see patients as partners by sharing diagnostic and treatment processes and decisions • Openness to work with and learn from patients with diverse backgrounds and personal styles
Skills	• Elicit illness narrative that includes a delineation of symptoms while pursuing contextual setting • Express interest in and commitment to the patient – Verbal behaviors: introduce self; clarify patient's preferred name; attend to physical comfort; elicit patient's view of the problem; clarify extent of commitment; discuss questions – Nonverbal behaviors: touch, get comfortable, eye contact • Facilitate communication – Verbal behaviors: allow patient to narrate illness story; balance open-ended and closed-ended questions; use nonbiased questions; seek clarification of vague or ambiguous data; use empathy where appropriate; reflect back patient's words and affects; convey nonjudgmental, unconditional positive regard; define the patient's strengths; and utilize in the treatment plan – Nonverbal behaviors: arrange space comfortably; nod, show affect, use posture that communicates interest; acknowledge patient's nonverbal behavior; quiet attention • Avoid hindering behavior – Verbal behavior to be avoided: use of technical language, injecting biases, false or premature reassurance, noninteraction, discussion of fees first, frequent interruptions – Nonverbal behavior to be avoided: posture communicates disinterest, not listening; reading chart or writing note during interview; allowing interruption

Table 14.2 Kalamazoo Consensus Statement Elements

Task	Technique
Open the Discussion	• Allow the patient to complete opening statement • Elicit that patient's full set of concerns • Establish/maintain a personal connection
Gather Information	• Use open-ended and closed-ended questions appropriately • Structure, clarify, and summarize information • Actively listen using nonverbal (e.g., eye contact) and verbal (e.g., words of encouragement) techniques
Understand the Patient's Perspective	• Explore contextual factors (e.g., family, culture, gender, age, socioeconomic status, spirituality) • Explore beliefs, concerns, and expectations about health and illness • Acknowledge and respond to the patient's ideas, feelings, and values
Share Information	• Use language the patient can understand • Check for understanding • Encourage questions
Reach Agreement on Problems and Plans	• Encourage the patient to participate in decisions to the extent he or she desires • Check the patient's willingness and ability to follow the plan • Identify and enlist resources and supports
Provide Closure	• Ask whether the patient has other issues or concerns • Summarize and affirm agreement with the plan of action • Discuss follow-up (e.g., next visit, plan for unexpected outcomes)

The Kalamazoo consensus statement has identified a framework and key elements of patient-provider communication. The statement is grounded in the assumption that a therapeutic relationship is the sine qua non of physician-patient communication; building this relationship is the fundamental communication task with which providers are charged [19] (Table 14.2).

Two sets of techniques can help foster effective, efficient relationship building and communication during patient interactions [20]. The first is rapport building and relationship maintenance, which can be accomplished through warm greetings, eye contact (when culturally appropriate), brief non-medical conversation during visits, acknowledging patient cues with empathetic responses, and checking in on important life events [20]. Additionally, providers can facilitate a mindful approach by being present and curious during patient interactions. Maintaining focus on mutually agreed-upon topics and discussing them in an organized fashion across encounters can help to further reinforce consistency and cohesiveness in the provider-patient relationship [20].

The second set of communication techniques involves partnering with patients to problem-solve and can be iterative utilized during follow-up encounters. An intentional, collaborative agenda focuses the work, which enables providers and patients to explore and prioritize the concerns [20]. Once established, patients' perspectives regarding their concerns and medical conditions are explored using open-ended questions and curious listening [20]. Providers and patients can collaborate to create a plan that incorporates patients' goals of care, gauges readiness to change, and clarifies the roles that the provider, patient, and family members or other supports will play [20].

Shared Decision-Making

Shared decision-making is a communication approach in which clinicians disclose information about alternative diagnostic and therapeutic options, and patients describe what matters to them regarding care choices [21, 22]. Patients with chronic illness often face complicated decisions that involve a complex interplay of personal priorities, changing risk/benefit ratios, and the overall impact of their choices on health. Historical communication models were often paternalistic and more contemporary approaches recognize the importance and value of engaging patients in shared decision-making that is meaningfully patient-centered [23, 24]. Effective shared decision-making is associated with improved patient satisfaction, reduced undesired care, and improved patient functioning [22, 24, 25]. In addition, providers prefer this approach since it can encourage patient understanding of risks and benefits of treatment plans [26]. Shared decision-making is often hindered by logistical, emotional, and knowledge barriers [21, 26, 27] and can be mitigated by the use of facilitative decision aids and tools [23, 28, 29].

Patient knowledge and perception of risk regarding medical treatments are more meaningful with decision aids since they report feeling more knowledgeable, better informed, and clearer about their values [29]. Decision aids come in several forms; however, there is limited evidence regarding the effectiveness of a particular aid [29]. Historically, decision aids were printed educational materials that were reviewed by patients prior to, or following, face-to-face visits with their providers; contemporary aids guide providers and patients through discussions [21, 22, 28, 29]. Information technology has a greater role in decision aids with multiple interactive online tools for patients that can gather and communicate patient preferences and concerns to providers via reports and/or electronic medical records [29, 30].

SHARE is a program developed by Agency for Healthcare Research and Quality to promote shared decision-making in clinical practice [31]. The SHARE approach facilitates productive discussions of the pros and cons of proposed interventions in the context of an individual patient's goals and priorities. Table 14.3 displays the SHARE steps and activities.

Table 14.3 SHARE Program Steps and Activities [31]

Step	Tasks and activities
***S**eek patient's participation in decision-making*	Highlight the importance of patient engagement in decisions
	Summarize the health problems to be addressed
***H**elp patient explore and compare treatment options*	Communicate risks and benefits in patient-oriented terms
	Assess patient's pre-existing knowledge
	Use the "teach-back" technique to ensure understanding
***A**ssess patient values and preferences*	Ask open-ended questions
	Demonstrate empathy and interest in how treatments might impact patient's life
	Encourage a discussion of patient's goals and priorities
	Obtain agreement and shared understanding of the aspects of interventions that are most important to the patient
***R**each decisions*	Confirm that patient has had ample time and information to make a decision
***E**valuate decisions and interventions*	Ongoing assessment of barriers to implementation, impact of the decisions on patient's life, and evolving patient priorities
	This is particularly important in chronic care as intervention risks/benefits and patient status may change significantly during the disease process

Acknowledging, Bridging, and Embracing Language, Identity, and Culture

Navigating Language Differences

The US Census Bureau's 2011 American Community Survey Report noted that 21% of the US population spoke a language other than English at home; of these individuals, only 58% spoke English "very well" [32]. Language discordance between patients and providers can adversely impact healthcare communication [33–35]. Providing care and communicating in a shared language is important. The prevalence and diversity of languages other than English create healthcare encounters in which providers and patients must bridge language gaps [33]. In these settings, in-person or telephonic professional interpreters are critical [34–36] and are associated with positive effects on communication, care plan comprehension, health resource utilization, clinical outcomes, mental illness management, and satisfaction with care [34–37]. Patients who receive care with interpreter assistance do not differ significantly from those who meet with language concordant providers in their propensity to rate the care they receive as "excellent" or "very good" but are more likely to have questions about their care after their visits [33].

Some best practices for working with interpreters, as outlined by the National Council on Interpreting in Healthcare, can be found in Table 14.4 [38].

Table 14.4 Best practices for working with interpreters

Introduce yourself to the interpreter	Acknowledge the interpreter as a professional in communication
Speak directly to the patient	
Speak more slowly rather than more loudly	
Speak at an even pace in relatively short segments	Pause so the interpreter can interpret
Assume and insist that everything you say, and everything the patient says, is interpreted	
Do not hold the interpreter responsible for what the patient does or does not say	The interpreter is the medium, not the source of the message. If you feel that you are not getting the type of response that you were expecting, restate the question or consult with the interpreter to better understand if there is a cultural barrier that is interfering with communication
Be aware that concepts you express may have no linguistic or conceptual equivalent in other languages	Conveying what you say may take longer or shorter than your original speech
Give the interpreter time to restructure information and present it in a culturally and linguistically appropriate manner	
Be conscious of asking personal or sensitive information	Explain to the patient that doing so is part of your evaluation and reiterate that information will remain confidential
Avoid highly idiomatic speech	Complicated sentence structure, sentence fragments, changing your idea in the middle of a sentence, and asking multiple questions at a time can also make communication more difficult
Encourage the interpreter to ask questions and alert you about potential cultural misunderstandings	
Avoid patronizing or infantilizing the patient	
Ask the patient to repeat back important information	
Be patient	Recognize that providing effective care and communication across a language barrier takes time
When possible, allow time for a pre-session with the interpreter	This provides an opportunity to be clear about the nature of the upcoming encounter and the information and type of communication it will involve

The National Association for the Deaf's Position Statement on Health Care Access for Deaf patients is consistent with the interpreter principles described above [39]. It also emphasizes the importance of using visual aids when needed to enhance communication and of avoiding lip reading and written communication whenever possible when communicating with patients who speak American Sign Language [39].

Cultural Competence and Humility

Cultural humility and the provision of culturally competent care can promote patient-provider interactions in many ways [18, 40, 41]. The acknowledgment of, and willingness to embrace, health-associated cultural factors is essential to establishing trust and promoting effective communication. Medical cultural competence is the communication of diagnosis and treatment plans in ways that are acceptable to patients from different cultural backgrounds [42, 43]. Cultural humility reflects an interpersonal perspective that is other-oriented rather than self-focused, is characterized by respect and lack of superiority toward another's cultural background, and is positively associated with the establishment of strong working alliances between patients and providers [43].

There are several techniques that enhance culturally competent healthcare interactions and communication [11]. Providers can explore and acknowledge patient beliefs, values, their meaning of illness, preferences, and needs, which helps to bridge cultural differences and build relationships. To build rapport and find common ground with patients, providers need to be mindful of their own biases and assumptions and informed about cultures that are reflective of their patient populations [11]. Such awareness is essential; however, it is important that providers avoid cultural generalizations and communicate with each patient as individuals whose interactions with the healthcare system are shaped by a complex set of personal, cultural, socioeconomic, and situational factors [44].

Acknowledging Structural Racism

Practicing cultural humility and providing culturally competent care involves understanding and acknowledging the legacy of medical systems and structural racism, which has contributed to healthcare disparities among individuals of different races, ethnicities, sexual orientations, and other demographic characteristics [45–48]. There are documented examples of explicit injustice and violence by medical professionals directed at historically marginalized communities, including conversion therapy of LGBTQ+ patients, sterilization abuse of Native American women, and the medical experimentation on Black patients [49–51]. A systematic review of the effects of race and patient-provider racial concordance on physician-patient communication reported that Black patients consistently experienced poorer communication quality, information-giving, patient participation, and participatory decision-making than white patients during clinical encounters [52]. The review emphasized the importance of training physicians and patients to engage in meaningful communication with Black and racially discordant patients by focusing on improving patient-centeredness, information-giving, partnership building, and patient engagement in communication processes [52].

Intersectionality, Positionality, and Implicit Bias

Intersectionality refers to the complex and cumulative way in which multiple forms of discrimination, such as racism and sexism, accumulate and overlap in marginalized individuals or groups [53, 54]. Providers should consider how patients self-identify to inform the communication dynamics in clinical encounters. Positionality is a concept in which people are not defined by fixed identities (e.g., race, socioeconomic status), but by their location within shifting networks of relationships [55]. This concept can be relevant for providers during patient encounters, where there is a complex interplay between the identities, cultural connotations, and power dynamics of physician and patient. The concept of implicit bias is a bias or prejudice that is operative but not consciously recognized, often influencing the communications, perceptions, and interaction that occur during clinical encounters [55]. Patient-provider communication that is informed by an understanding of intersectionality, positionality, history, systemic racism, and implicit bias can promote strategies to mitigate healthcare disparities.

Communication in Chronic Care Models

Providing chronic illness care accounts for the contributions of an interdisciplinary team and is mindful of significant interactions that occur outside the context of a traditional face-to-face encounters. Multiple providers participate in healthcare teams that incorporate shared decision-making practices, group care models, and expanded communication channels via health information technology (HIT), expanding access and complexity to the dynamics of contemporary chronic care communication.

Healthcare Team Communication

Healthcare team communication is essential to providing efficient, comprehensive, chronic care and improves satisfaction for both patients and providers [21–24]. Healthcare teams may include physicians, nurse practitioners, physician assistants, nurses, care managers, dieticians, pharmacists, social workers, office staff, health coaches, and home health aides, who may work in different clinical settings and may be responsible for different aspects of patient care. An Agency for Healthcare Research and Quality (AHRQ) report on creating patient-centered team-based care highlights the centrality of good relationships among provider team members as the foundation for good relationships with patients and lays out several principles of quality team-based care [56].

A cohesive and high-performing team often reflects a larger organizational culture. The AHRQ report points out that traditional care models have been hierarchical with physicians taking the lead role; however, emerging approaches value the knowledge base and skills of each team member [56]. It is essential for all team members to develop and sustain communication tools for information gathering, synthesis, and reporting [56]. Electronic health records (EHRs) can facilitate synchronous and asynchronous communication across care team members. Other communication modes, such as secure text messaging or emails, allow for real-time updates on patient status and can streamline the process by which the care plan is adapted and advanced.

Introducing team members to patients using bio sheets, formal naming of teams, and visual cues facilitate cohesion and continuity [25]. Involving patients in interprofessional rounds has also been advocated [57]. In these settings, eliciting patient preferences on how, where, and when they would prefer to communicate with the team is critical since patients often have preferences on specific team members and the mode of communication [25, 58]. Warm hand-offs between providers, highlighting and reinforcing information from other team members, and signposting the roles of other team members can provide clear and consistent communication between the care team and the patient [25].

Real-time communication can be facilitated by co-locating team members in a proximate clinical space to promote team huddles or informal meetings develop rapport and share insights for care coordination [23, 56, 57]. Developing innovative workspaces for patient care, such as dedicated chronic care clinics with multiple co-located providers and resources, may help to improve patient communication and satisfaction [58]. Setting expectations and parameters for communication, such as modes and expected response time, can enhance team functioning and patient care. For example, verbal or face-to-face communication may be preferred for unclear or emotional content since it allows for more nuanced information exchange, while an email or text communication may be preferential for routine messages or those with a large amount of data to be assimilated [59].

Group Care Models

Group care has promise and adds complexity to healthcare communication. Ideally, group visits provide patient-centered care in a manner that optimizes quality and outcomes while decreasing access barriers for patients [60]. Chronic care group visits can occur as drop-in appointments, in which a small group of patients meet with the help of a provider facilitator, or as part of cooperative and interactive healthcare encounter with multiple providers to manage their chronic illnesses [61]. During group visits, providers should adopt an empathetic, open communication approach comparable to individual visits [62, 63]. Providers should direct patient-generated questions to the group for discussion and feedback, rather than providing answers directly, to leverage the perspectives and experience of group members [63]. Other approaches include using local subject matter experts and evidence-based educational materials and demonstrative learning environments such as cooking classes or grocery store visits, which can potentiate the group visit format [62].

Specific Challenges and Special Situations

Situations may arise during chronic care that require attention to communication dynamics. Early recognition of communication problems, advance planning, and using effective tools and strategies can avoid disruptions to the patient-provider relationships and maintain information flows.

Working with Family Members, Advocates, and Other Proxies

Patients with chronic illness often receive care in settings accompanied by family members, friends, and other advocates. The level of involvement and responsibility that these companions assume can vary depending upon on the decision-making capacity, health and functional status, and social network of the patient. Patient companions/proxies can facilitate communication by assisting the patient in building rapport with providers, advocating for patients, and ensuring accurate and thorough information exchange [64–66]. Companions/proxies can also add important collateral information, such as a contextual understanding of patients' lives, symptoms, and living conditions. Interactions between providers and companions/proxies can be "autonomy enhancing" since they may encourage patients in self-management of their disease and promote personal agency. Companions/proxies can clarify background and presenting medical information, facilitate patient comprehension of treatment recommendations, and activate and prompt discussion of topics.

Although companion/proxies often have a positive impact on patient-provider communication, there may be challenges, including unclear, undisclosed, or competing agendas between patients and companions/proxies, incomplete and inconsistent information, and concerns of privacy and confidentiality, which impede information exchange and rapport building [64]. In addition, there is variation among patients of how involved they would like family members and companions to be in their care. Several autonomy-detracting behaviors, such as companions/proxies who interrupt patients, disclose irrelevant information about their personal health or that of a third party, correct or blame patients in front of providers, attempt to take on an expert role, or answer questions for patients without allowing them to respond, create communication difficulties [65, 66]. Other actions include companions/proxies who engage in inappropriate alliance building, intentionally or unintentionally attempting to persuade patients and/or providers to agree to agendas that are primarily based on the companions' opinions or preferences [65, 66].

Several techniques can maximize the positive contributions of companions/proxies have while mitigating potential pitfalls. The first involves encouraging and welcoming companions/proxies to the healthcare encounter, ascertaining reasons why companions are involved from both patients' and companions' perspectives, and clarifying the roles of patients and companions at the commencement of the visit [23]. Respecting patients' autonomy and preferences and attending to their communication preferences regarding sensitive information is important. A second approach recognizes value-added companion/proxy behaviors and reinforces strategies that companions can use to provide emotional, informational, and logistical support.

The use of communication tools before and during the encounter may foster the patient-companion-provider interactions [23, 67]. A checklist that is given to the patient/companion before the visit can elicit and organize a healthcare agenda and has been found to improve the experiences of patients and their providers [67]. These checklists, pictured below, prompt patients and companions/proxies to independently identify and prioritize medical concerns and prompt patients to designate the role that the companion/proxy is expected to play [67]. The use of a pre-visit checklist and modifying it during the encounter allows providers to leverage the contribution of the companion/proxy [67] (Fig. 14.1).

Giving Bad News

Chronic illness care is interwoven with the lived experience of patients, including moments of joy, sorrow, adjustment, and change. Bad news in healthcare settings is information which adversely affects an individual's view of their future health and well-being [68, 69]. Physicians and other providers sometimes provide clinical information that is disappointing, upsetting, or devastating to patients and their families. The communication of bad news is an area where many providers feel uncomfortable [17]. In addition to the task of informing patients of potentially distressing and life changing information, communicating bad news involves responding to patients' emotional responses, involving them in subsequent decision-making, and being available for concerns that arise as patients and their family members come to terms with the implications of information that has been conveyed [69].

Two sets of factors influence communication around delivering bad news [70]. One involves the provider assessment of the internal dynamics of patients; the attitudes, wishes, and needs that arise when bad news is delivered. Providers should seek a balance between accurately disclosing distressing news and sustaining hope, being mindful that patient and provider emotions play a significant role in the communication dynamics. The second set is external to the patient-provider dyad, such as family relationships, systematic and institutional factors such as the time available for conversations, the clinical settings in which news is delivered, and the cultural and socioeconomic contexts in which patients and their providers are situated. Family relationships are particularly powerful and providers should guide the level of involvement for family and other support system members. Each set of factors should be considered by providers in determining the time, location, and strategies to optimize a compassionate and effective communication of bad news.

The SPIKES algorithm, initially developed to assist oncology providers in delivering upsetting news to patients, and now widely utilized, provides a stepwise framework by which difficult news can be delivered effectively and in an empathetic, patient-centered manner (Table 14.5) [69].

Crucial Conversations and Conflict Management

Crucial conversations are communication events in which stakes are high, emotions are high, and/or opinions among the participants can differ [71]. The ongoing relationships between chronic care providers and their patients, and the emotionally charged situations that arise, set the stage for the crucial conversations during chronic care. Managing visible and unseen conflicts that often undergird these conversations requires specialized, intentional communication skills. Providers should be self-aware of their emotional states and those of their patients during a crucial conversation. Feeling states of anger or fear may manifest in some as physical cues of arousal, louder speech, or clenched muscles. In others, behaviors such as sarcasm, withdrawing from the conversation, and short answers reflect a silent response, while hyperbolic or threatening statements and aggressive posture reflect a violent response [71]. Acknowledging these cues allows providers to step back and meaningfully employ techniques to address arising conflict while managing their own emotions.

Several techniques can diffuse emotionally charged patient-provider conversations and manage arising conflict. Taking time to reflect on the goal of a conversation, and then planning a progression of talking points can facilitate an intentional and emotionally defused dialog [71]. Apologizing,

Common Concerns	Level of Concern			Discuss with Doctor
	Not at All	A Little	A Lot	
Shortness of breath	1	2	3	
Pain	1	2	3	
Falling or fear of falling	1	2	3	
Dizziness or balance	1	2	3	
Hearing or vision	1	2	3	
Trouble with sleep	1	2	3	
Lack of energy	1	2	3	
Incontinence/bladder problems	1	2	3	
Constipation or bowel problems	1	2	3	
Poor appetite or weight loss	1	2	3	
Concerns about driving	1	2	3	
Difficulty bathing, dressing, or walking	1	2	3	
Receiving the help I need	1	2	3	
Getting out to do the things I enjoy	1	2	3	
Regular exercise	1	2	3	
Stress or worry	1	2	3	
Feeling sad or blue	1	2	3	
Trouble concentrating or remembering	1	2	3	
Sexual function or sexuality	1	2	3	
Smoking or alcohol use	1	2	3	
Medication issues side effects	1	2	3	
Results from a lab test or consultation	1	2	3	
Keeping up with appointments	1	2	3	
Other issues/concerns	1	2	3	
	1	2	3	

I would like my companion to (check all that apply)
Listen to what the doctor says.
Take notes (for example, about your diagnosis, medications, diet, or referrals).
Remind me to ask my questions.
Ask the doctor questions directly, on my behalf.
Remind me to tell the doctor about my symptoms.
Provide information about my health to the doctor.
Make sure I understand what the doctor says.
Stay in the waiting room for part of the visit.
Stay in the waiting room for the entire visit so that I may talk to the doctor alone.
List other help you would like from your companion below:

Fig. 14.1 Patient checklists [67]

when appropriate, creates an atmosphere of mutual respect and helps identify a shared purpose that can maintain a safe environment for negotiation and exchange. Specific techniques such as reflecting observed emotions (e.g., "You seem angry to me. Did I misread you?"), paraphrasing what has been said (e.g., "Let me make sure I'm understanding this correctly…"), and actively soliciting others' viewpoints (e.g., "How do you see it? I'd really like to know your opinions

Table 14.5 The SPIKES Algorithm (from reference [69])

Set Up	Focus on encounter location and privacy
	Minimize disturbances or interruptions
	Gather appropriate medical team and family members
	Sit down and establish connection with patient
Perceptions	Ask open-ended questions to elicit what the patient knows
Invitation	Assess how and to what extent patient would like to be informed about the facts at hand
Knowledge	Begin with a “warning shot” that there is distressing information to deliver
	Share the news using nontechnical words
	Provide information in small increments with periodic checks on patient understanding
Emotions	Offer empathetic statements
	Use exploratory and validating responses
	Help patient connect and process thoughts
Summarize and Strategize	Discuss next steps
	Take the information and context elicited in the first five SPIKES steps into consideration

about this.”) are often effective in diffusing and advancing difficult conversations in an open, respectful manner [71].

Communication regarding medical errors and unanticipated poor outcomes often generates crucial conversations with patients and can be difficult to navigate [13, 72, 73]. Patients may have powerful reactions to these situations since a trusting relationship with their medical providers may have been compromised [73]. Fear, loss of trust, and isolation are some of the complex emotions that patients may experience in these situations [73] Direct, clear communication, preparing for and openly acknowledging patients’ emotional reactions, and summarizing an actionable plan are important elements in communicating medical errors to patients [13]. Patients who receive factual information about medical errors are less likely to dismiss their physicians and have greater overall satisfaction [72].

Health Information Technology

Health information technology (HIT) permeates all aspects of chronic care and has permanently altered patient-provider communication in both direct and indirect patient care. Telemedicine and asynchronous electronic communication via patient electronic health record platforms provide multiple portals for patients and providers to engage with one another beyond traditional office visits. In addition, the growth of health education information via websites and apps has introduced new opportunities and challenges to chronic illness care. The wide adoption of electronic health records (EHRs) and other HIT, such mobile devices and tablets examination rooms, has led to concerns about compromising the provider-patient relationship.

One study reported that the adoption of computers and the full implementation of the EHR fostered collaborative physician-patient relationships, contrary to prior expectations and fears [74]. Many physicians reported changing workflows from making unobtrusive entries in paper charts to using the EHR to collaborate with patients in making electronic chart entries and sharing chart information [74]. Physicians were more likely to share electronic health information with patients than with paper records. A systematic review on EHR use and patient-doctor relationships and communication reported no change in patient satisfaction [75]. In addition, several skills can promote patient-centered care including signposting computer use, inviting patients to look at the screen, maintaining eye contact, continuing verbal and nonverbal communication cues aloud, and making computer use less obvious [75] (Table 14.6).

The COVID-19 pandemic has highlighted the capacity and limitations of telehealth to increase healthcare access [80]. The major principles of in-person communication are applicable to telehealth encounters, however there are several considerations. Webside manner is a concept that illustrates a clinician’s ability to transfer relational skills via HIT and telehealth [81]. During the initial phase of the telehealth visit, acknowledging the virtual nature of the interaction, smiling, looking at the camera and not the screen, and gathering names from everyone on camera and inquiring about their relationships with the patient are important behaviors for clinicians [81]. In addition, providers should be mindful of their talking speed, tone, body language, and nonverbal cues. Finally, components from the provider and patient communication environment, such as Internet connectivity, lighting, sound, background disruptions, and privacy impact the quality of the telehealth communication [82].

Patients expect to have access to their health information, be included with their providers in the healthcare decision-making process, and have their care be collaborative, convenient, and accessible [80]. Patient portals have emerged in healthcare and are a secure online platform that gives patients 24-h access to their personal health information [83]. Portals have basic features that enable patients to access information such as recent office visits, medications, immunizations, allergies, and lab results. More advanced features provide capacity for patients to request prescription refills, schedule non-urgent appointments, and exchange secure messaging with their providers [83].

Secure electronic messaging is often utilized by patients and providers to extend and/or augment the communication that occurs during office visits and is considered a key element of providing access [60]. A study in primary care practice reported that patients found the clinical notes relatively easy to understand, and access to these notes could help reduce confusion and enhance understanding of test results as well as the reasons behind tests [84].

Table 14.6 Health information technology strategies to promote patient-centered care [75]

Practice context	Study finding	Recommendation
Outpatient general practice [76]	Patients did not understand computer functions and preferred being able to see the computer screen.	Invite patients to look at the screen. For example, sharing results or imaging.
Outpatient general practice [77]	Clinicians have a difficult time with multi-tasking; for example, using the computer while interviewing the patient. To improve, clinicians can use specific communication skills to manage the visit.	• Consider position of provider, patient, and computer in the space. Explain why the computer is being used. • Face patient when using computer. • Stop typing when the patient speaks.
Veteran Affairs (VA) internal medicine clinic [78]	"Open" office arrangement helped physicians improve physical orientation and eye contact than with the patient. Physicians who accessed the EMR and took breaks to sustain eye contact with patients used more nonverbal cues in communication. High EMR use interviews were associated with patients asking more questions than low EMR use interviews.	• Consider position of provider, patient, and computer in the space. • Take pauses from computer to engage in nonverbal communication such as eye contact and head nodding.
Academic primary care clinics [79]	EMR use interfered with patient-doctor communication. Example includes that the average screen gaze lasted from 25% to 55% of the visit time.	Separate EMR use from time spent communicating with patients: • Read aloud while typing. • Maintain eye contact. • Use body language to show attention and empathy. • Disengage from computer use for important or sensitive topics.

There are privacy, confidentiality, and end-user concerns with HIT, including the complexity of portal designs, the lack of guidance in how to use applications and portal, and the inability to understand the information presented [83]. Older patients are more likely to have trouble using technology than younger patients, a gap that has been described as the digital divide [83]. In addition, children, adolescents, and their parents are less likely to use patient portals for information or communication, compared to adults, due to the inadequate usability [83]. Healthcare providers are facing an increased volume of electronic messages, which can overwhelm clinical workflows [83]. There are currently no standards for proxy access and EHRs are not designed to allow care teams to filter sensitive versus non-sensitive data [80].

Healthcare providers should ideally discuss preferred modes and expectations regarding HIT communication for a shared understanding. Providers may also identify the characteristics that their patients operationalize as good communication. For example, some patients may place value on easy, direct access to providers, frequent communication, and the flexibility provided by asynchronous communication through messaging, while others may prioritize longer face-to-face encounters of greater depth.

Future Directions

Physicians and other healthcare providers are sharing a growing virtual communication space with their patients; however, there are significant gaps and growing disparities that will need to be addressed and mitigated. For example, patients with limited English language proficiency, low health and digital literacy, and residing in rural and inner-city locations with restricted access to high-speed Internet are limited in utilizing health information technology (HIT) [80]. Digital literacy (i.e., comfort with using web-based technology) is reduced among older Americans and those with limited health literacy [85]. HIT and telehealth will need to increase access, which may be achieved through large-scale expansion of broadband Internet and through distribution of secure mobile WiFi hotspots and video-compatible devices. Additionally, community-based telehealth educators can provide individual or group instruction for those with low digital literacy [85].

As health information technology and digital health applications grow, chronic care providers will still need to establish and sustain meaningful relationships with patients and seek to effectively impart the "special knowledge" that Steinbeck highlighted. Providers will face an ever-changing healthcare landscape and will need to optimize interactions and exchange information across several forums, ranging from the intimate conversations of patient-provider dyad to the more complicated choruses that characterize group and team-based care. While the goal and tasks of effective patient-provider communication in this landscape are daunting, it provides the foundation to the patient-provider relationships and enhances the lives of providers and the patients they serve.

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