

Patients, Doctors, and Videotape: A Prescription for Creating Optimal Healing Environments?

RICHARD M. FRANKEL, Ph.D.,^{1,2} SUE HEE SUNG, MPH,³ and
JOHN T. HSU, M.D., M.B.A., M.S.C.E.³

ABSTRACT

Despite repeated calls for greater patient autonomy, shared decision making, and exploration of patient preferences, relatively little is known about how patients actually experience care as a face-to-face interactional process. A selected review of the literature in this area suggests that important asymmetries exist. Key among them is the tendency to report experiences from the point of view of only one member of the doctor-patient dyad. Thus, patients might report on their experiences of the system gone awry or professionals might attempt to understand the root cause(s) of an error by describing the conditions under which it occurred. Either way, information about the experience of care tends to be reported as a “my side” telling.

Optimal healing environments are defined as health care contexts that are based upon mutual respect and build positive, resilient relationships among participants, using the qualities and resources of those relationships to enhance health. Understanding optimal healing environments also requires a knowledge of how doctors and patients share time and space together in the consultation (an etic or outsider perspective) and also a knowledge of the participants’ experience of their time together (an emic or insider perspective).

After reviewing its methodological roots, the IMPACT approach (Interactive Methodology for Preserving and Analyzing Clinical Transactions) using videotaped encounters along with independent commentaries by participants is described and applied in two different types of analyses: one in which the doctor-patient dyad is the unit of measure; the second in which physicians are stratified by having historically high or low satisfaction scores. In the latter approach, doctors’ and patients’ comments are compared across strata.

At the dyadic level, and despite large gaps in income and social status, doctors and patients exhibit a strong tendency to cluster in terms of where they comment, so much so that in a pilot study using the approach, each stopped and commented on the videotapes at the “same” location (within an utterance of one another) 60% of the time. This finding flies in the face of traditional sociological thought, which holds that the greater the social distance between actors (doctors and patients), the more difficult it should be to communicate.

With respect to being stratified by historical satisfaction scores, doctors with high historical satisfaction were found to comment more often, make fewer assumptions, take longer with their patients, and be more vigilant than doctors with historically low satisfaction scores. We conclude that videotape review is a parsimonious way of integrating face-to-face communication with the participants’ lived experience of the care process, a necessary ingredient in creating optimal healing environments.

¹Roudebush Veterans Administration Medical Center, Indianapolis, IN.

²Department of Medicine and Geriatrics, Indiana University School of Medicine, Indianapolis, IN.

³Division of Research, Kaiser Permanente Medical Care Program, Oakland, CA.

This work was supported, in part, by a grant from the Garfield Memorial Fund of Kaiser Permanente.

*We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time . . .*

—T.S. Eliot¹

INTRODUCTION

Caring and compassion for the suffering of patients, respect for patient autonomy, and trust and integrity have repeatedly been identified by medical educators,² policy makers,³ and the public⁴ as core characteristics of a humane health care system. Attention to patients' wants, needs, and preferences, defined by the Institute of Medicine as patient-centered care, have been identified as one of six critical elements in delivering high-quality care.⁵ The patient-centered approach has been associated with improved biomedical and psychological healthcare outcomes.⁶ Relationship-centered care, a relatively new framework, expands the notion of patient-centered care to include dynamic elements of relationship that may act in the service of healing, a key element in creating optimal healing environments. There is evidence that this approach too is associated with positive health outcomes.⁷⁻⁹ Based on the foregoing, we define optimal healing environments as health care contexts that are based upon mutual respect and build positive, resilient relationships among participants, using the qualities and resources of those relationships to enhance health. Furthermore, we assert that the creation of optimal healing environments requires knowledge of how doctors and patients share time and space together in the consultation (an etic or outsider perspective), and also knowledge of the participants' experience of their time together (an emic or insider perspective).

Voices of patients and doctors

Individual patient reports/experiences

Despite policy pronouncements and evidence of positive effects on outcome, surprisingly little direct information is available from patients about their health care experiences and perceptions. Single case studies¹⁰⁻¹² and numerous editorials and essays detailing individual experiences with the health care system have appeared,¹³ but these are largely anecdotal and typically represent "my side" tellings of things gone awry in the medical care system.

Larger-scale reports of patient perceptions of health care have also appeared. These are largely based on public opinion polls¹⁴ and large-scale survey research instruments¹⁵⁻¹⁷ that attempt to measure attitudes and beliefs with respect to what patients want and expect from their doctors. While perhaps representative of the general medical population, large-scale surveys necessarily miss the "narrative thread" of patient experiences and, consequently, the meaning particular events may have for persons seeking health care.

Critical incident reports

Critical incidents are stories of "memorable" moments or events that occur in organizational contexts. Critical incident reporting involves the identification of preventable occurrences (i.e., events that could have led or did lead to an undesirable outcome) reported by those persons directly involved in the process in question at the time of discovery of the event. The goal of critical incident reporting is not to gather epidemiologic data *per se*, but rather to gather qualitative data to better understand the context, circumstances, and root cause(s) that led to an untoward outcome.

The *Critical Incident Technique* was originally developed by Flanagan to examine military aircraft training accidents.¹⁸ It has had a venerable history over the past 6 decades and has been used in a number of educational and business contexts. It has also been used in medical education. For example, Branch et al. used critical incidents told by third-year medical students to identify challenges and opportunities for educators to more deeply understand the key experiences of becoming a doctor.¹⁹

With very few exceptions, critical incident reporting has been used by professionals to understand and reduce sources of variation in practice that lead to errors and other potentially harmful behaviors. Much as the literature on patient perceptions of care depends upon "my side" tellings of patients, critical incidents tend to represent "things gone awry" from the professionals' perspective. One exception is a recent study²⁰ that focused on patient perceptions of medical error. Interestingly, the investigators found that 75% of what patients considered to be medical harms (errors) was psychological in nature and would not qualify as errors from a professional perspective. In summary, critical incident reporting has found very little use in the patient sphere, and, in the few instances where it has been used, there seems to be a lack of concordance between patients' and professionals' points of view.

Interaction analysis

In the late 1960s and early 1970s, researchers in several different fields (education, medicine, aviation) began to study the moment by moment organization of face-to-face interaction and the mutual influence of speakers and hearers on one another.^{11,21,22} In contrast to methods that focused on the actions and perceptions of individuals in isolation, interaction analysis afforded researchers the opportunity to study the details of interaction *between* teachers and students, doctors and patients, or pilots and air-

traffic controllers using audiotape and videotape as a reproducible medium for data capture.²³

In medical education, the use of videotape review was pioneered by Kagan.²⁴ A psychiatrist by training, Kagan's technique, "Interpersonal Process Recall," is based on showing a physician a videotape of her or himself and stopping the tape from time to time to explore the physician's thinking, feeling, and perceptions. In this respect, the audio or videotape is like an auditory or visual "mirror" used to help stimulate reflection. This method can improve the skill of the physician, but it leaves the most essential judge—the patient—out of the picture. If a primary goal of health care is to create an optimal healing environment, direct input from the patient is essential.

During the same period of time in other areas of education, investigators were experimenting with ways of systematically gathering information from multiple perspectives. A pioneer in this effort was Frederick Erickson, who used 16mm film to capture the stream and structure of interaction. An anthropologist by training, Erickson was interested in both observing the interaction and understanding what it meant from the perspectives of the participants. Using principles of ethnographic research, Erickson developed a method where he would invite participants to independently review a film of an encounter and stop it at points of interest commenting on what each one saw going on. By carefully tracking where the film had been stopped, Erickson was able to gather information on similarities and differences in perspectives and the tacit assumptions underlying them.²⁵

A stunning example of the use of this technique was described by Erickson and Schultz²⁵ in college counseling interviews between Caucasian interviewers and African-American students. The students routinely stopped the film at similar points and were highly critical of the counselors for repeating themselves numerous times and treating them as "stupid." Likewise, the counselors routinely stopped the film and complained that the students just didn't seem to "get" what they were recommending. When Erickson and Schultz reviewed the points at which the students and counselors stopped the film, they discovered they were both focused on the same moments in time, but each group had different interpretations of what was going on. As it turned out, the counselors were consistently missing a nonverbal acknowledgment and understanding cue (vertical head nod) that African-American students performed in a much more subtle way than their Caucasian counterparts. The "fix" for this problem was to teach the interviewers to recognize the more subtle form of the vertical head nod. As a result, a safer, more satisfying environment was created for the interview process.

Adapting the technique developed by Erickson and Schultz, Frankel and Beckman²⁶ introduced the IMPACT method in a primary care internal medicine residency program. IMPACT stands for Interactive Methodology for Pre-

serving and Analyzing Clinical Transactions. It consists of independent reviews and reactions of the patient and resident physician to a videotape of their medical encounter. The review and commentaries are captured on audiotape. The audiotaped comments are then edited on to a copy of the original videotaped encounter using stop action (still frame) of the moment the tape was stopped to create a visual scene in which the audio comment can be simultaneously heard. At the conclusion of each commentary, the tape returns to the action that was taking place when the tape was stopped. The completed tape thus contains each of the comments made by the participants superimposed on the videotape at the exact points in the interaction where the comment was made. The synthesis of commentaries captures both the original event and each participant's experience or point of view relative to the event.

As a research tool, the tape can be used to assess the relationship between the commentaries and what was happening in the encounter at the time the tape was stopped. It can also be used to compare and contrast the perspectives of each of the participants individually and relative to one another. Finally, it can be used to compare doctors and patients as a group in terms of the kinds of commentaries each provides. A unique use of the edited tapes is that they can also be shown to the doctor and patient to provide education and feedback about each other's perspectives. In this way, implicit and explicit assumptions made about the other can be tested based on comparing one's own to the other's commentary in "real" video time.

In essence, the IMPACT method represents a democratization of the research process in that it gives the participants equal access to the data of their own performance and invites reactions and responses to those performances using the same review criteria. It is interesting to compare the results of this process with more theory-driven models of the doctor-patient relationship. Parsons,²⁷ for example, is widely credited for modern theorizing about the doctor-patient relationship. In his influential book *The Social System*, Parsons states "The patient has a need for technical services because he doesn't—nor do his lay associated, family members, etc.—know what the matter is or what to do about it." The theory of social action that the doctor-patient relationship is taken to be an instance of holds that the social distance between doctor and patient creates a situation in which there is little shared knowledge or understanding. Notice, however, that the assertion about what patients and doctors do or do not know is asymmetric; that is, it is expressed from a professional perspective. As was argued above, we do not know much about what patients feel or experience during their medical encounters, and thus the assertion that patients and family members do not have ideas about what is the matter and what to do about it is an unsubstantiated stipulative claim.

Using the IMPACT methodology, which elicits independent reactions from both patient and doctor, a small sample of mostly white, middle-class medical residents providing

care to mostly poor African-American patients produced results that actually contradict the Parsonian model. Given an open-ended opportunity for the doctors and patients in the sample to comment on the data of their own performance, we found significant overlap in where the tape was stopped by doctors and patients. The doctors and patients in the sample stopped the tape at the “same” points (“same” being defined as within an utterance of one another) 60% of the time suggesting that, irrespective of social distance, both doctors and patients tend to focus on the same interactional events. Moreover, in terms of content, the commentaries often appeared dialogic as if the doctor and patient were conversing at a metalevel about the events they were witnessing on the tape of their interaction.

Capturing voices using IMPACT: An example

Below is a transcript of a videotaped interaction between a 19-year-old patient and her obstetrician–gynecologist. It is a return visit in which the patient presents with a problem of vaginal itching and discharge. A week after the encounter, the patient and doctor were invited independently to review and comment on the taped encounter.

Segment 1: Opening. [The parentheses in the transcribed text refer to elapsed time in seconds and tenths of seconds. Unfilled parentheses indicate that the transcriptionist was unable to hear what was being said. Parentheses with a dot in them indicate a very brief pause too short to count and // represents material not provided.]

- Dr: Okay, let me ask you a few questions if you don't mind, okay?
 Dr: Okay, you're 19, is that right?
 Pt: Yes, I am.
 Dr: Okay. Ever been pregnant?
 Pt: Nope.
 Dr: Never (1.3) Okay, . . . and your last menstrual period was on the third, third of, uh, November, is that right?
 Pt: Uhm: no.
 Dr: I mean third—third of//uh:
 Pt: January.
 Dr: January (1.0), okay.
 Pt: No, February.
 Dr: February.
 Pt: It was February.
 Dr: February third//okay.
 Pt: Yep.
 Dr: Okay//then.
 Pt: [heh, heh].
 Dr: And what do you do for birth control? (1.4)
 Pt: What do you mean, what do I do//for it.
 Dr: What do you take, pills or—
 Pt: Yeah.
 Dr: You take pills?

Patient's comments:

I had to watch what he was writing down just to see, you know, exactly what he was talking about because he did not talk to me, he was writing down things instead of discussing things with me. Like, you know, with my problem of understanding what he meant by birth control and everything. That shouldn't have been a problem. He should have asked a direct question, right to me, but instead he kept looking down.

Pt: Uhm, Ortho Novum, I believe.

Doctor's comments:

Is it a good idea to write while you're talking to them or—I always wonder. And also if I don't forget.

Dr: What strength (.) Is it seven, seven, seven?

Notice in the first segment the patient and the doctor in their commentaries both focus on the same event, note taking while eliciting the patient's history. What the patient notices is the doctor's lack of eye contact and multitasking (during this portion of the encounter, the doctor is talking and reviewing the patient's chart simultaneously), which results in several reformulations of the date of the patient's last menstrual period. Independently reviewing the same tape, the doctor comments less than 1 second later than the patient had. His comment also focuses on the problem of taking a history and writing simultaneously. From the doctor's point of view, however, the problem is one of accuracy (i.e., if he doesn't write while he talks, he forgets what the patient said). The doctor thus surfaces a dilemma that he faces; one for which he does not have a ready solution.

This segment is of interest because it illustrates the parallel experiences each of the actors had during the same event in the encounter. It is relatively easy to see how one point of view without the other can produce biased or even inaccurate judgments about the motivation and goals of each person. In terms of creating optimal healing environments, the commentaries of each participant state a point of view that is either in or out of alignment. Where there is agreement or alignment, the potential for optimal healing goes up. Likewise, when there is a lack of agreement or alignment, the probability of optimal healing goes down.

Segment 2: Diagnosis and Plan

Dr: Okay [not audible]. I looked at the slide, okay. It showed that you have a—a vaginal infection, okay. I wouldn't worry about it's very m-minor infection called gardinerelle (1.0) what we call bacterial vaginitis, it's—it's a minor infection. Usually it's—most of the time sexually transmitted (0.5). And usually we can give you some pills for that, Flagyl®. Have you ever taken Flagyl?

Patient's comment:

I'm sure he didn't know how it upset me because I've never had anything like that.

Dr: It's a pill that you take twice a day for five days.

Pt: Now wait a minute. This is sexually transmitted.

Dr: It is but it's not like a—(0.5) like gonorrhea or chlamydia or those serious infections. It's a very mild infection. It's like yeast (.) you know sort of (0.8).

Pt: I know that it's not a very serious infection but it—obviously means that //—

Dr: It means that (.) not really.

Pt: My partner got it from // someone else.

Dr: Not really. It doesn't mean it—no.

Pt: Alright.

Dr: Uh uh—It means—But it means also that we really—probably need to treat him at the same time. Would you be able to get in touch with him and take some pills if I give it to him.

Patient's comment:

It's been different. You know there was some distrust and whatever but—like he said he probably could have gotten it any place, but—as it stands now I'm not seeing him anymore. Because I know I didn't get it from anyone else and I'm fairly sure that I wasn't like that with him, but how can I be positive.

Dr: The reason why, because if I don't treat him, then he'll give it to you back and it's—

Doctor's comment:

See, I always have a problem, you know, with those minor infections. They are sexually transmitted, but how could you tell them they're not like the other ones. I really have a hard time delivering that they are sexually transmitted, but also that they're not as the other ones and that it means they had an extra relation. So how would you tell them that?

Dr: It's going to be annoying for you.

The second segment captures the interactions and comments around the doctor's delivery of diagnosis and proposed treatment plan. Again, notice that, taken in isolation, the patient's comments question the doctor's sensitivity and perhaps ability to relate to the emotional impact of the diagnosis and the termination of her relationship with her partner in the aftermath of the news. Setting aside the accuracy of the information provided by the physician (bacterial vaginosis is not considered by most clinicians to be sexually transmitted), it is clear from the doctor's comment that he is not only sensitive to the nature of the information he is conveying, it represents another dilemma for him, how to deliver diagnostic news effectively. Taken together, it is striking how conversationlike

the commentaries are even though they were produced totally independently and without prompting.

In its use as an educational tool, we would often show both the doctor and the patient the edited videotapes with both sets of comments. The results were often instructive and sometimes dramatic. In one case of a 47-year-old mother of six with diabetes that was out of control and seeing an intern who had been caring for her for the better part of a year, the review process uncovered important but untested assumptions that each had made about the other. The details of this case are reported elsewhere.²⁵ The patient's blood sugar had remained out of control despite several attempts and reprimands from the intern about the dire consequences that might follow if the patient continued to "disobey doctor's orders." Over time, the intern had become more and more frustrated with the patients "inability" and "unwillingness" to stick to the recommended diet and lose weight.

Invited to view a videotape of her last visit with the patient, the intern stopped the tape at a point at which she had just reprimanded the patient by saying, "You're not doing very well, you gained a half a pound since your last visit." The intern's recorded commentary stated "I don't know whether my saying this ("You're not doing very well, you gained half a pound . . .") really bothers her because she never loses any weight." Approximately 3 seconds later during her review, the patient stopped the tape and said, "All this doctor cares about is my weight and blood pressure. She doesn't care that I'm not from a middle-class family and that I can't afford to feed my five children and stay on the diet my doctor is recommending."

Within a short time after the edited tape was assembled, both the doctor and the patient were invited to view their own and each other's comments. When the doctor heard herself say "I don't think she really cares because she never loses any weight" and immediately thereafter heard the patient say ". . . I can't afford to feed my five children and stay on the diet my doctor is recommending.", she was embarrassed and chagrined that she had failed to assess the patient's ability to pay for the diet. She immediately saw that her approach to the patient was partially responsible for creating the very problem she had reprimanded the patient for. Likewise, when the patient heard the intern's comments she said, "I know that my doctor actually cares for me a lot, and I feel embarrassed not to be able to tell her that I can't afford to do what's she's telling me I need to do."

Before their next visit, we brought the doctor and patient together to talk about their reactions to the comments they had each made about the encounter. The doctor was very apologetic about not having asked if the patient could afford the diet and offered to put the patient on a less expensive one. The patient stated that she appreciated how concerned and caring the doctor was and was grateful for a less expensive alternative. The intern's chart notes for the next visit included observing that the patient's blood pressure was the lowest it had been in almost a year, that the patient had lost 2.5 pounds, and seemed to be doing much better. We

would contend that giving both the doctor and patient equal opportunities to respond to the data of their own performance allowed a cognitive realignment or reframing to take place, the consequence of which was the creation of a more optimal healing environment.

From dyadic to organizational performance

To this point, we have considered the individual doctor-patient dyad as the unit of measure. In this section, we ask whether doctors with traditionally high patient satisfaction ratings see themselves differently from doctors who have low patient satisfaction ratings. At the same time, we ask whether the patients of high-performing and low-performing doctors view their doctors' behavior differently. The relevance of these questions to creating optimal healing environments is to identify "best practices" of high-performing physicians that may systematically differ from low-performing physicians. Ultimately, the goal of such study is to transfer best practices in order to raise the overall level of organizational performance.

As part of a larger study of best communication practices in Kaiser Permanente, we conducted 30 IMPACT video reviews in a purposeful sample of 15 practicing doctors stratified by historically high and historically low patient satisfaction scores. The doctors were all from internal medicine or family medicine departments and were employed at facilities in a large integrated delivery system (IDS) in southern California. All had at least 1 year's worth of experience in the IDS. Each doctor was videotaped with 2 regularly scheduled established patients. Patients were adults over 18 years of age, English-speaking, active members of the IDS and had regularly scheduled appointments with the participating physicians.

Instructions to the doctors and patients were similar. For patients, the instructions were: "As you review the videotape of your visit, please pause the tape at any point where your physician communicated particularly effectively with

TABLE 1. MOST FREQUENT COMMENTS MADE BY DOCTORS WITH PERCENTAGE OF PATIENTS MAKING SIMILAR COMMENTS

<i>Skills and behaviors</i>	<i>Doctors</i>	<i>Patients</i>
Visit management	93.3%	20.0%
listening	86.7%	43.3%
familiarity	80.0%	30.0%
Nonverbal behavior	80.0%	30.0%
Visit length	73.3%	36.7%
Asking questions	73.3%	30.0%

Table 1 displays the most frequent comments made by doctors with the percentage of similar comments made by patients. The rate at which comments were made by patients is relatively low when compared with doctors, suggesting that each group may have different foci.

TABLE 2. MOST FREQUENT COMMENTS MADE BY PATIENTS WITH PERCENTAGE OF DOCTORS MAKING SIMILAR COMMENTS

<i>Skills and behaviors</i>	<i>Doctors</i>	<i>Patients</i>
Explanation skills	56.7%	66.7%
Doctor attitude	46.7%	0.00%
Listening skills	46.7%	86.7%
Putting patient at ease	43.3%	53.3%
Visit length	43.3%	73.3%

you or any time you see anything significant, new, unusual, or important." For the doctors, the instructions were: "As you review the videotape of your visit, please pause the tape at any point where you were effectively communicating with the patients or any time you see anything significant, new, unusual, or important."

Using a qualitative content-analysis approach, two research assistants independently categorized responses from the transcribed interviews into 18 different categories. Agreement between the RA on the coding categories was 0.70. Discrepancies and disagreements were resolved by having a third independent coder review the responses. Using this approach, we were able to code 100% of the commentaries. We then compared the physician and patient perspectives overall and stratified by historical satisfaction scores (Table 1).

Table 2 displays the most frequent comments made by patients with the percentage of doctors making similar comments. For all of the categories except Doctor Attitude, there is a much closer alignment between the percentage of patients and doctors making similar comments. It is striking that almost half the patient commentaries dealt with physician attitudes, yet this category was never mentioned by physicians. This is perhaps an organizational learning edge in terms of divergent views. On the other hand, it is worth noting that two of the categories most frequently mentioned by patients and doctors, Explanation Skills and Putting the Patient at Ease, are nearly evenly distributed. This is good news, as skill improvement in both of these areas has been associated with positive outcomes of care.^{6,8} The proportion of patient and doctor comments in these skill areas suggests that they may have similar relevance for each group.

What are the implications of these findings for organizational learning? Three decades ago, Eliot Mishler²⁸ proposed that there were two voices that could be seen in the medical dialog: the voice of the lifeworld (patient's experience of care) and the voice of medicine (the physician's power and authority). Mishler argued that the voice of medicine frequently overshadowed and silenced the voice of the lifeworld, relegating it to an inferior epiphenomenal status. The findings from this and other studies that carefully elicit and track patient and doctor experiences suggests that the medical encounter is a good deal more complex than Mishler's rather black and white characterization.

In terms of creating the conditions for optimal healing to

take place, aggregating patient and doctor commentaries points out where an organization’s learning edges may be. In this case, doctors’ attitudes may be an area for education and dialog as they learn that almost half the patients who reviewed videotapes of their encounters commented on this category, while none of the physicians did. Similarly, there may be opportunities to close the gap or at least develop a better understanding of the relatively strong differences in commentary rates by group. Finally, convergence around issues like providing an explanation and putting the patient at ease may identify a strength of the organization that is worth building upon. Obviously, more work in larger study populations would have to be done before one could expect wholesale adoption. Nevertheless, the results from this small study are tantalizing.

Comparing doctor-patient pairs with high and low satisfaction

The last use of video review commentaries we will explore is a comparison of doctors with high historical satisfaction scores and their patients with doctors who had low satisfaction scores and their patients.

In total, 904 comments were made across the 30 IMPACT reviews (mean = 15.1; 17.1 physician comments and 13.0 patient comments). Physicians with high historical satisfaction scores tended to make more comments than physicians with lower scores (mean = 19.4 versus 12.9 comments). Although the absolute difference in frequency between the high and low satisfaction doctors did not reach statistical significance, the comments of the high satisfaction doctors indicated clear-cut qualitative differences in style and approach to care that was more aligned with patients’ commentaries. For example, while reviewing a videotape of her encounter with a physician who had historically high patient satisfaction scores, a patient stated:

Uh, here, uh, when, when, when she described the result of the tests, uh, I think, at least for me, it was real important, ‘cause the tests were not that pleasant, first—but secondly, I, I, I really didn’t know what was going on with it

When the doctor reviewed the same videotape, her comment about the patient was:

I’ve known this patient for a long time, and I think she generally knows what’s going on. Even so, I make it a point to give her the information about the test results. It certainly can’t harm her to get the information again, and there’s always the possibility that it can help.

It is clear from these comments that the patient and doctor are both in alignment about the importance of describ-

ing test results. Although she knows the patient well and believes the patient probably understands the situation, this high satisfaction doctor is explicit about not making assumptions. As it turns out, from the patient’s perspective, this is a good thing to have done, since the patient states that she really didn’t know and understand what was going on.

By contrast, in reviewing a tape of her patient encounter, a physician with historically low satisfaction commented about her patient that:

I’d, I had a lot of information there that [that] I didn’t necessarily have to repeat.

Reviewing the same tape, the patient stated:

So I said I kind of figured what I thought it was. She could’ve explained. I think she—, it’s like, I feel like doctors don’t have time to explain but I think they need to.

In this commentary, the patient notes that the doctor’s tacit assumption of patient understanding is incorrect. The patient goes on to state that she believes that it is time pressure that prevents doctors from taking time to explain things to their patients, a tacit but plausible assumption on the patient’s part.

Both in number and content, the historically high satisfaction doctors tended to make fewer tacit assumptions about their patients and saw it as their job to be vigilant on their behalf. Doctors with low satisfaction scores, on the other hand, tended to make untested assertions and assumptions about their patients and their state of knowledge and/or need for information. Patient commentaries tended to confirm the value of the high satisfaction doctors not making assumptions and disconfirm the assumptions made by the low satisfaction doctors. In essence, the difference in the number of times the tape was stopped by historically high and low satisfaction physicians was a proxy for their vigilance and the importance of making one’s thinking and actions an explicit part of relationship formation and maintenance.

The perception that some physicians might not take the time to share information because they are under time pressure seems true for some, but not all, physicians. Table 3 displays doctors by satisfaction scores and average time taken in visits.

TABLE 3. BEST PRACTICE ACTUAL VISIT LENGTH BY HISTORICAL SATISFACTION SCORE RANK

	n	Mean	Overall SD	Median	p
L	51	17.30	6.70	17.36	0.073
M	69	19.99	6.89	18.89	
H	65	19.85	7.12	19.45	

Again, although it did not reach statistical significance, there is certainly a trend in the direction of historically low satisfaction doctors taking less time to see their patients compared with high satisfaction doctors. There is a 2¹/₂-minute difference on average between the historically high satisfaction and low satisfaction doctors in our sample. Patients of high satisfaction doctors rarely mentioned time as an issue, whereas patients of low satisfaction physicians mentioned it frequently. It may be that one of the key ingredients of creating optimal healing environments is additional time to check assumptions and provide information and counseling to patients. While this may be bad news in terms of productivity and throughput, this and other studies have shown that a time difference of 2–3 minutes per visit differentiates physicians who have a history of medical malpractice from those who have never been sued,²⁹ those who engage in collaborative decision making from those who don't,³⁰ and physicians who elicit the full range of patient concerns at the beginning of the visit.^{29,31}

Lessons learned from IMPACT studies

We began with the observation that optimal healing environments are created when there is mutual respect, as well as an intention to act on behalf of healing and health. It was then suggested that knowledge of what observably happens in a medical encounter, coupled with the lived experience of the participants, are necessary ingredients in creating and sustaining optimal healing environments. Much contemporary research has focused on the professional or the patient side of the encounter, frequently using “my side” tellings to represent what is clearly a two-sided story.

Videotape review represents a fusion between objective and subjective points of view. As a research tool, giving doctors and patients equal access to the data of their own performance creates a “natural experimental design,” since both parties are responding to the same stimuli using the same instructions. Mapping the results provides a window into both what is observable on the surface and the interpretations that often accompany the events observed. It is notable that the doctors and patients we studied shared some foci and did not share others. In terms of aligning the goals and outcomes of care to the communication process, it seems critical to explore the implications of shared and divergent interests, meanings, and interpretations that accompany the observed interactions.

The primary lessons that arise from these studies suggest that individual doctors and patients can learn from one another by exploring and challenging their own tacit assumptions about the behavior of their interactional partner, be it the doctor or the patient. Professionals have a special responsibility to advocate and act on behalf of their patients. It is clear from the video review process that this is not always the case and that it is often unwittingly so. Patients also have a responsibility to advocate for their needs and

wants and to do so in a fair and nonjudgmental way. This is not always so easy to do if one assumes the worst in one's interaction partner and doesn't feel safe enough to test their assumptions.

CONCLUSIONS

We believe that it is both possible and desirable to intervene on both sides of the stethoscope to facilitate the creation of optimal healing environments. We recognize that the IMPACT method and examples presented in this paper have been drawn from small, nonrepresentative samples of physicians in residency and research contexts. As such, the method is recommended primarily for educational, as compared to quality of care, improvement. We also recognize that more research is necessary to better understand the cognitive and communication processes that are involved. As well, the motivation and will to make and bring about change will require the best that we have to give as individuals and as a profession. Creating and sustaining optimal healing environments will take time, commitment, and resources. Can we as individuals and as a society afford to bring about such radical change? We would ask, can we afford not to?

REFERENCES

1. Eliot TS. *Collected Poems: 1909–1962*. New York: Harcourt Brace & Co., 1963.
2. GPEP Report. *Physicians for the Twenty-First Century. The Committee on General Professional Education of the Physician and College Preparation for Medicine*. Washington (DC): Association of American Colleges, 1984.
3. American Board of Internal Medicine. Evaluation of humanistic qualities in the internist. *Ann Int Med* 1983;99:720–724.
4. Gibbs S, Waters WE, George CF. The benefits of prescription information leaflets. *Br J Clin Pharm* 1989;27:723–739.
5. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington (DC): National Academies Press, 2001.
6. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on patient outcomes. *J Fam Pract* 2000;49:796–804.
7. Tresolini C, Force P-FT. *Health Professions Education and Relationship-Centered Care: Report of the Pew-Fetzer Task Force on Advancing Psychosocial Health Education*. San Francisco (CA): Pew Health Commissions, 1994.
8. Frankel RM, Stein T. Getting the most out of the clinical encounter: The Four Habits Model. *Permanente J* 1999;3:79–88.
9. Stein T, Frankel RM, Krupat E. Enhancing clinician communication skills in a large healthcare organization: A longitudinal case study. *Pat Educ Counsel* In press.
10. Frank A. *At the Will of the Body: Reflections on Illness*. Boston: Houghton Mifflin, 1991.
11. Murphy RF. *The Body Silent*. New York: Henry Holt, 1987.
12. Toombs K. *The experience of illness*. Boston: Kluwer Academic Publishing, 1992.

13. Broyard A. Doctor talk to me. *The New York Times Magazine*. 1990;26:32–36.
14. What your patients think of you—and vice versa: A Hippocrates/Roper poll. *Hippocrates* 1995;9:40–44.
15. Cleary PD, McNeil BJ. Patient satisfaction as an indicator of quality care. *Inquiry* 1988;25:25–36.
16. Ware JE, Jr, Davies AR. Patients' perspectives on the quality of medical care. *J Fam Pract* 1998;26:489–490.
17. Rubin HR, Gandek B, Rogers WH, et al. Patients' ratings of outpatient visits in different practice settings. Results from the Medical Outcomes Study. *JAMA* 1993;270:835–840.
18. Flanagan JC. The critical incident technique. *Psychol Bull* 1954;51:327–358.
19. Branch W, Pels RJ, Lawrence RS, Arky R. Becoming a doctor. Critical-incident reports from third-year medical students. *NEJM* 1993;329:1130–1132.
20. Kuzel AJ, Woolf SH, Gilchrist VJ, et al. Patient reports of preventable problems and harms in primary health care. *Ann Fam Med* 2004;2:333–340.
21. Korsch BM, Freemon B, Negrete VF. Practical implications of doctor–patient interaction analysis for pediatric practice. *Am J Dis Child* 1971;121:110–114.
22. Mehan H. *Learning Lessons: Social Organization in the Classroom*. Cambridge (MA): Harvard University Press, 1979.
23. Jordan B, Henderson A. Interaction analysis: Foundations and practice. *J Learn Sci* 1995;4:39–103.
24. Kagan, N. *Interpersonal Process Recall: A Method of Influencing Human Interaction*. Mason MI: Mason Media, 1975.
25. Erickson F, Schultz J. *The Counselor as Gatekeeper*. New York: Academic Press, 1982.
26. Frankel RM, Beckman HB. Impact: An interaction-based method for preserving and analyzing clinical transactions. In: Pettegrew LS. (ed.). *Straight Talk: Explorations in Provider and Patient Interaction*. Louisville (KY): Humana, 1982:71–85.
27. Parsons T. *The Social System*. New York: Free Press, 1951.
28. Mishler EG. *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood (NJ): Ablex Publishing Corp, 1984.
29. Levinson W, Roter DL, Mullooly JP, et al. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997; 277:553–559.
30. Kaplan SH, Gondek B, Greenfield S, et al. Patient visit characteristics related to physicians' participatory decision-making style: Results from the medical outcome study. *Med Care* 1995;32:1176–1187.
31. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Int Med* 1994;154:1365–1370.

Address correspondence to:
Richard M. Frankel, Ph.D.
1481 West Tenth Street
Indianapolis, IN 46202

E-mail: RFrankel@IUPUI.Edu

Copyright of Journal of Alternative & Complementary Medicine is the property of Mary Ann Liebert, Inc.. The copyright in an individual article may be maintained by the author in certain cases. Content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.