

The medical visit context of treatment decision-making and the therapeutic relationship

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Abstract

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The ascendancy of the autonomy paradigm in treatment decision-making has evolved over the past several decades to the point where few bioethicists would question that it is the guiding value driving health-care provider behaviour. In achieving quasi-legal status, decision-making has come to be regarded as a formality largely removed from the broader context of medical communication and the therapeutic relationship within which care is delivered. Moreover, disregard for individual patient preference, resistance, reluctance, or incompetence has at times produced *pro forma* and useless autonomy rituals. Failures of this kind, have been largely attributed to the psychological dynamics of the patients, physicians, illnesses, and contexts that characterize the medical decision. There has been little attempt to provide a framework for accommodating or understanding the larger social context and social influences that contribute to this variation. Applying Paulo Freire's participatory social orientation model to the context of the medical visit suggests a framework for viewing the impact of physicians' communication behaviours on patients' capacity for treatment decision-making. Physicians' use of communication strategies can act to reinforce an experience of patient dependence or self-reliance in regard to the patient-physician relationship generally and treatment decision-making, in particular. Certain communications enhance patient participation in the medical visit's dialogue, contribute to patient engagement in problem posing and problem-solving, and finally, facilitate patient confidence and competence to undertake autonomous action. The purpose of this essay is to place treatment decision-making within the broader context of the therapeutic relationship, and to describe ways in which routine medical visit communication can accommodate individual patient preferences and help develop and further patient capacity for autonomous decision-making.

Introduction

Whilst medicine is recognized as serving patients' needs, even above self-interest and

gain, it has traditionally relied on the judgement of physicians to define those needs.¹ Many, however, would argue that physicians' judgement is neither a sufficient nor adequate basis for

the definition of patient need. Even the very earliest medical writings have linked patient autonomy and physicians actions. In distinguishing between the actions of physicians to slaves and a freemen, Plato views the defining element to be imposition of treatment versus education and dialogue:

A physician to slaves never gives his patient any account of his illness...the physician offers some orders gleaned from experience with an air of infallible knowledge, in the brusque fashion of a dictator... The free physician, who usually cares for free men, treats their diseases first by thoroughly discussing with the patient and his friends his ailment. This way he learns something from the sufferer and simultaneously instructs him.²

In anticipating our current attachment to the principles of autonomy and self-determination, Plato's admonition to learn something from the sufferer has been transformed such that a patient ought/should/must provide the physician with a definition of medical need for themselves. Ascendance of the autonomy paradigm has evolved over the past several decades to the point where few bioethicists would question that it is the guiding value driving health-care provider behaviour.³ Indeed, it has been argued that patient autonomy has achieved paradigmatic status superseding principles of beneficence and social justice in bioethics and medical law.⁴

The formalization of decision-making as a discrete act with legal standing has had the effect of setting these exchanges apart from the larger context of communication and the therapeutic relationship within which care is delivered. Thus, decision-making has come to be regarded as a dichotomous outcome – either present or not present, rather than an 'in-context' dynamic process reflecting the richness and depth that defines the therapeutic relationship.

The purpose of this essay is to place treatment decision-making within the broader context of the therapeutic relationship, and to describe ways in which routine medical visit communication can accommodate individual patient preferences and help develop and further patient capacity for autonomous decision-making.

Treatment decision-making and the autonomy paradigm

Legal support for the doctrine of patient autonomy originated as a largely protective principle designed to inoculate patients against the possible transformation of legitimate medical authority to medical paternalism.^{4,5} Within this context, the most fully discussed area of contention is in regard to access and ownership of medical information, as it relates to medical and treatment decision-making and informed consent.

The traditional sociological debates proffer two views: the first is one of consensual accommodation and the second is outright conflict. The consensual view has been articulated by Talcott Parsons⁶ who argued that conflict between physician and patient is diffused by well-defined societal expectations for role performance; both doctors and patients have their job to do. In contrast, Freidson⁷ sees conflict over information as fundamental to the very nature of the doctor-patient relationship. Parsons argues that inherent in the definition of a physician is the dedication of a lifetime to mastery of knowledge and the gaining of experience in the application of that knowledge. The fund of medical knowledge is so vast and complex, the schooling so intense and gruelling, and the daily experience so unique, that an unbridgeable competence gap exists between physicians and the lay world. Moreover, the knowledge is learned and transmitted only in the encrypted foreign code of medical jargon. Thus, medical knowledge is earned and owned by doctors and impossible to share, at least not in any meaningful manner with the lay person. There are protections afforded patients since they must accept medical practice on faith. Central to this protection is a higher order of moral conduct that physicians are held to, including a code of ethics defining the special duty of physicians to protect the interests of their patients. Patients, for their part, rely on physician adherence to this moral code and therefore trust that they will be given what information they need, if not all that they want.

In contrast, Freidson views information exchange in terms of rights and obligations;

patients have the right to information and physicians have the obligation to convey it in an understandable and useful manner.⁷ Freidson sees the disinclination of physicians to share information with patients less as a function of an irreducible competence gap than as a safeguard for high status and professional standing. A less knowledgeable patient is less likely to contest medical conduct, second-guess medical decisions, or detect medical errors.⁷

Agreeing fundamentally with Freidson, others have elaborated the conflict between the physician and patient to reside not only in the control of information but in a paradigmatic conflict of perspectives and language.⁸⁻¹¹ Depending on the resolution of this conflict, the patient's problem will be anchored in either medicine's biomedical and disease context or the broader and more integrated context of the patient's illness experience. Based on this anchor, the visit's agenda and therapeutic course will be set and the foundation for treatment decision-making will be established.

The vehicle through which the competition over paradigms and perspectives takes place is the medical dialogue. The boundaries of autonomy and paternalism are negotiated through the determination of how much information, with what level of detail, given when, under what circumstances, in whose language, and in what context. As a result of the great variability in patients' ability to negotiate the medical dialogue, ethicists have identified protection from verbal coercion with almost universal regard as a necessary and important element of civilized and enlightened medical care.¹¹

Is the autonomy paradigm illusory?

That the protections against medical paternalism have achieved some success is evident in such pronouncements of victory as those made by Arthur Caplan:

The Freddy Kruger of bioethics for the better part of two decades has been the doctor who pushes his or her values onto the patient... This devil has been completely exorcised and a large part of contemporary bioethics scholarship seems to be devoted to the task of assuring that the paternalistic doctor stays dead and buried...³ (p. 259).

This victory, however, may only be illusory; whilst the letter of the law has produced the appearance of protection against paternalism, the spirit has often been neglected. More often than recognized by either bioethicists or the law, disregard for individual patient preference, resistance, reluctance, or incompetence has resulted in *pro forma* and useless autonomy rituals.⁴

The failure of the autonomy principle in practice has been attributed to a growing depersonalization of the doctor-patient relationship, exacerbated within the context of increasingly technological and bureaucratic care.^{4,12,13} Ironically, the legal protections designed to encourage and support open communication have often acted as a constraint. As argued by Schneider:

Rights exacerbate the impersonality of the relations between doctor and patient...and the process is self-reinforcing: trust wanes as relationships become more bureaucratic and less personal. This creates a call for rights. The rights solution further alienates doctor and patient because it distances them and because the doctor resents the distrust that motivated the solution⁴ (p. 201).

Although patients want information from their physicians, information is not all that they want. Physicians are not simply expert consultants, although they are that; they are also someone to whom people go when they are particularly vulnerable.⁶ There are some patients, and perhaps many patients at especially vulnerable junctures and in particular circumstances, that do not want to or cannot assume the burden for their medical decisions.⁴

Individual variation in preferences and capacity along the autonomy continuum have been largely attributed to the psychological dynamics of the patients, physicians, illnesses, and contexts that characterize the medical decision.⁴ There has been little attempt to provide a framework for accommodating or understanding the larger social context and social influences that contribute to this variation.

The work of Paulo Freire may be helpful in this regard.¹⁴ Whilst originally applied to the teaching of basic literacy skills to adults, and

more widely used in the area of community development and health education,¹⁵ Freire sees the economic, political, and social relations that often characterize vulnerable populations as mirrored in their educational experiences. Traditional approaches to teaching in which learners are treated as passive and dependent objects act to reinforce powerlessness and helplessness. In contrast, participatory learning strategies that treat people as active subjects of their own learning can have the effect of changing patterns of dependence and passivity by providing and reinforcing empowering experiences.

Empowering experiences foster the competence and confidence necessary for personal transformation and the realization of 'critical consciousness'. This transformation is attributed to three key consciousness raising experiences: relating and reflecting on experience, engaging in dialogue, and taking conscious action. These steps provide a framework for Freire's participatory social orientation approach to the design of effective educational strategies. As illustrated in Fig. 1(a) parallel approach reflecting a participatory social orientation to treatment decision-making maps the experience of patients to those steps delineated by Freire. The areas of overlap are highlighted in the central boxes of the figure; key Freirian consciousness raising

experiences are listed on the left and key aspects of the medical dialogue are on the right.

Applying these ideas to the social context of the medical visit, implications for the impact of physicians' communication behaviours on patients' capacity for treatment decision-making can be drawn. As is the case for educators, the use of particular communication strategies act to reinforce an experience of dependence or self-reliance. Some communication strategies enhance patient participation in the medical visit's dialogue, contribute to patient engagement in problem posing and problem-solving, and finally, facilitate patient confidence and competence to undertake autonomous action.

Table 1 identifies participatory physician communication skills likely to enhance autonomy in decision-making by enabling patient experience of participation, activation, and empowerment. (For illustrative purposes, the Appendix presents examples of medical dialogue drawn from studies using the Roter Interaction Analysis System [RIAS]¹⁶).

Participation continuum

Relating and reflecting life experiences with all of their emotional and social significance carries a force that Freire found to be critical in building confidence at the most fundamental level in which the self is expressed. A similar

Freire's steps to critical consciousness		Decision-making communication continuum
Disclosure and reflection		Participation
Validation of experience	Affirmation of self-worth and self-knowledge	Full telling of the patient story and adoption of 'co-investigator' role
Dialogue		Activation
Critical analysis of social problems	Analysis of root causes of problems	Engagement in question-asking, information appraisal, joint problem solving and negotiation in regard to health problems
Action		Empowerment
Melding of reflection and action	Taking action to transform the status quo	Taking choice, control, and responsibility for health actions

Figure 1 Participatory social orientation approach to treatment decision-making.

Table 1 Physicians' participatory communication skills related to the facilitation of patient autonomy in medical decision-making

Decision-making continuum	Participatory communication skills
Patient Participation	Data gathering skills (open questions and probes, particularly in the psychosocial domain) Relationship skills (emotional responsiveness, including empathy, reassurance, concern and legitimation; not interrupting) Partnering skills (indicating interest both verbally and nonverbally, paraphrasing and interpretation, not being verbally dominant)
Patient activation	Patient education and counselling (giving medical and treatment information, giving lifestyle and self-care information; counselling about treatment; counselling about lifestyle and psychosocial issues) Partnering skills (indicating interest both verbally and non-verbally, paraphrasing and interpretation; asking for patient expectations, opinions, suggestions; joint problem solving) Relationship skills (emotional responsiveness, including empathy, reassurance, concern, and legitimation; not interrupting)
Empowerment facilitation	Patient education and counselling (verification of information; counselling about treatment; counselling about lifestyle and psychosocial issues) Partnering skills (paraphrasing and interpretation; asking for patient opinions and suggestions; brainstorming options, negotiation and joint problem solving) Relationship skills (support and reassurance)

sentiment has been expressed by George Engel in recognizing the power for the patient in telling his/her story:

...interpersonal engagement required in the clinical realm rests on complementary and basic human needs, especially the need to know and understand and the need to feel known and understood¹⁷ (p. 124).

In affirming the worth and relevance of life-experience, self-reflection is encouraged and the patient is transformed from a reporter of symptoms to a 'coinvestigator' of his/her health problems.¹⁵ The issues uncovered in self-

reflection may then constitute the agenda of the medical visit.

The critical communication skills that facilitate active patient participation in the medical visit include those originally derived from the psychotherapy literature and applied to interviewing skills: data gathering, relationship-building, and partnering skills.¹⁸ At its most elementary level, patient participation in the medical visit can be seen as reactive; physicians inquire and patients respond. Data gathering skills reflect a variety of questioning behaviours that encompass variation in both form and

content. Restricted opportunities for patient participation in the visit are provided through closed-ended questions to which the patient provides direct answers. The transformation from restricted to full participation is contingent on broadening the parameters of elicitation so that patients can fully and most meaningfully tell their story. Open questions by their very nature allow more room for patient discretion in response than closed-ended questions. Questions about things patients know and care about and that are relevant to daily experience and context will enhance the parameters and meaning of disclosure.

Relationship-building skills, include emotional support, empathy, reassurance, and personal regard create an atmosphere that facilitates open and sensitive disclosure by optimizing rapport and trust. Partnership skills also make it easier for a patient to tell their story by actively facilitating patient input through prompts and signals of interest, interpretations, paraphrase, requests for opinion and probes for understanding. In addition, patients may be encouraged to more actively participate in the visit by having the physician assume a less dominating relationship stance. This includes lowered verbal dominance by listening more and talking less, using head nods and eye contact and forward body lean to signal interest.

Activation continuum

The second Freirian step is 'dialogue'. This raises the level of active engagement from disclosure to critical analysis and includes a process that encourages examination of one's situation and the core conditions and circumstances that have contributed to it. As applied to health, the medical dialogue provides the vehicle of patient activation in agenda setting, information-seeking, reflection, problem-posing and joint problem-solving.

Active involvement in the dialogue transforms the patient role from reactive to proactive with patients taking the initiative in assuring that their agenda is presented and their needs met. Activation interventions have generally included guides or algorithms to help patients identify,

phrase, and rehearse questions, concerns, and issues to be included in the agenda of the visit.^{19,20} Physicians can assist patients by providing full and relevant information and counselling, by the use of partnership-building skills, including the solicitation of patient questions, expectations, preferences, probing the patient's explanatory framework, and by engaging in a process of negotiation and problem solving related to treatment and lifestyle regimens. A particularly important partnership-building behaviour is simply not to interrupt. A frequently cited study by Beckman and colleagues found that patients were interrupted after an average of 18 seconds with follow-up of the first but not necessarily most important stated concern.²¹

Empowerment continuum

The third and final step to autonomy in the Freirian process transforms the dialogue of problem posing and problem solving to recognition of one's ability to control and transform life circumstances through action. Patient empowerment implies the ability to assume control and responsibility for one's health and health related actions.

Whilst medicine has long recognized the importance of patient responsibility for health behaviours, there has been relatively little attention to the extent to which physicians may facilitate this process. A contribution in this regard has been made by the Medical Outcomes Study (MOS).²² This study surveyed over 7000 patients after visits with 300 physicians to determine the extent to which the patients report having been offered choice, control, and responsibility over treatment decisions. Physician practices and patient experience in terms of shared decision-making was found to vary widely. Most notably, physicians with primary care or interviewing skills training were reported to be more facilitative of active patient engagement in the decision-making process than were other physicians.

Whilst the MOS study did not identify particular facilitative skills for participatory decision-making, other observational studies have found that physicians trained in interviewing skills

differed from other physicians in key ways: trained physicians were more likely to engage in discussion of psychosocial issues, be emotionally supportive, ask questions in an open manner, ask for patient opinion, be skilled in interpersonal communication, be psychologically minded, and be less verbally dominant.^{23–25} These skills are likely to extend the influence of the therapeutic relationship to the building of patient confidence and competence to act on one's own behalf.²⁶ In using these skills for empowerment, the physician's communication role is to provide an atmosphere in which confidence and competence is built, emotional support given, and in which support for choice, control, and responsibility for health behaviour is recognized and reinforced. Key skills are those related to relationship-building to provide emotional support and reassurance and partnering skills to enhance behavioural competence and confidence in following through on an action plan.

Conclusions

The incorporation of patient preferences into treatment decisions is far from simple or direct. Patients are not all of one mind in this matter, nor are individual patients always consistent in their preferences.^{4,5,27} Although most patients will express a desire (to interviewers) for more information about their illness and treatment options than they are generally given by their physician, they rarely explicitly demand either more information or increased involvement in decision-making.^{5,19,27} Moreover, physicians are largely unaware of patients' views on these matters, and their time, commitment, and capability to elicit patients' preferred choices appears limited.^{4,27}

Fortunately, physician training in patient-centred communication skills may provide the mechanism of address for these difficulties. Whilst communication skills still constitute only a small part of most medical school curriculum, its' contribution has increased steadily over the past 30 years to the point where virtually all medical schools offer some kind of interviewing skills training.^{28,29} Evidence suggests that teaching of

these skills can be effective^{30–32} and even short postgraduate training programmes can produce significant changes in the interviewing performance of clinically experienced physicians.^{23–25,33}

Despite these training successes, medicine has been slow to embrace the patient-centred paradigm of medicine, and the patient perspective is still largely absent.^{8,10,26} The need for a paradigm shift may be all the more pressing as practice efficiencies pressure physicians to see more patients in shorter time periods. For Mechanic,¹² the consequences of time pressures go to the very core of the doctor-patient relationship by undermining patient trust and inhibiting patient disclosure of concerns, particularly of a sensitive psychosocial nature. Mechanic suggests that it is the socio-emotional rather than the technical aspects of care which are most likely to be abandoned under time pressures, further reinforcing the most alienating aspects of the biomedical model of care and undermining the possibility of negotiating perspectives and the definition of patient need. Similarly, Emanuel and Dubler¹³ suggest that time efficiencies may act to encourage medical paternalism by limiting discussion of patient values, alternative treatments, or the impact of therapy on the patient's overall life. Arguments for a more patient-centred and mutual medicine are not limited to societal demand and ethical deliberations, although these are indeed present and convincing. Patient-centred medicine and its associated communication skills are important because they are linked to both patient and physician well-being.³⁴ Stewart's³⁵ comprehensive review of physician-patient communication interventions found strong supporting evidence linking patient-centred communication elements with a variety of patient health outcomes, including emotional health, symptom resolution, function, physiologic measures (i.e. blood pressure and blood sugar level) and pain control. The supportive function of communication may be seen at the intersection of the patient's experience and the physician's expertise. Patient-centred skills hold the key to personal, responsive, and fulfilling communication between patients and physicians. These skills will continue to be the most meaningful

training challenge to help nurture and develop the capacity of meaningful autonomy and sensitive and respectful medical care.

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Appendix Categories of Roter interaction analysis system (RIAS)

Functional grouping	Communication behaviour	Example
Data gathering skills	Open-ended question asking about medical condition, therapeutic regimen, lifestyle and self-care, psychosocial topics	What can you tell me about the pain? How are the meds working? What are you doing to keep yourself healthy? What's happening with his father?
	Closed-ended question asking about medical condition, therapeutic regimen, lifestyle and self-care, psychosocial topics	Does it hurt now? Is your sleep better? Do you take your meds? Are you still smoking? Is your wife back?
Patient education and counseling skills	Biomedical information about medical condition, therapeutic regimen	The medication may make you drowsy. You need to take it for 10 days
	Lifestyle and self-care information	Getting plenty of exercise is always a good idea. I can give you some tips on quitting
Relationship skills	Psychosocial exchange about problems of daily living, issues about social relations, feelings, emotions	It's important to get out and do something daily. The community centre is good for company
	Positive talk (agreements, jokes, approvals, laughter)	You look fantastic, you are doing great
	Negative talk (disagreements, disapproval, criticisms, corrections)	I think you are wrong, you weren't being careful. No, I wouldn't want that
	Social talk (non-medical, chit-chat)	How about them O's last night?
Partnering skills	Emotional talk (concerns, reassurance, empathy, partnership)	I'm worried about that. I'm sure it will get better. We'll get through this
	Facilitation (asking for patient opinion, asking for understanding, paraphrase and interpretation, back-channel)	What do you think it is? what would help? Do you follow me? Let me make sure I've got it right. I heard you say you the meds didn't work for you. Uh-huh, right, go on, hmm
	Orientation (directions, instructions)	I'd like to do a physical now. Get up on the table. Now we'll check your back