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Study Of Physician And Patient Communication Identifies Missed Opportunities To Help Reduce Patients' Out-Of-Pocket Spending

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Abstract

Some experts contend that requiring patients to pay out of pocket for a portion of their care will bring consumer discipline to health care markets. But are physicians prepared to help patients factor out-of-pocket expenses into medical decisions? In this qualitative study of audiorecorded clinical encounters, we identified physician behaviors that stand in the way of helping patients navigate out-of-pocket spending. Some behaviors reflected a failure to fully engage with patients' financial concerns, from never acknowledging such concerns to dismissing them too quickly. Other behaviors reflected a failure to resolve uncertainty about out-of-pocket expenses or reliance on temporary solutions without making long-term plans to reduce spending. Many of these failures resulted from systemic barriers to health care spending conversations, such as a lack of price transparency. For consumer health care markets to work as intended, physicians need to be prepared to help patients navigate out-of-pocket expenses when financial concerns arise during clinical encounters.

In recent years an increasing number of Americans have chosen health insurance plans with high out-of-pocket expenses, in the form of deductibles, copayments, or coinsurance rates.[1] According to economic theory, such plans should make consumers more sensitive to the price of health care services.[2] Indeed, copayments have been shown to reduce health care

use.[3] However, high out-of-pocket spending can also create financial burdens for patients. In 2014 one in three Americans reported having difficulty paying health care bills.[4] Many patients did not adhere to prescribed health care interventions because of difficulty paying for them.[5–7] In addition, some patients reported that the financial burden of paying for medical care caused them to miss mortgage payments[8] or led them to personal bankruptcy.[9,10]

On the one hand, patients with high out-of-pocket spending have an opportunity to behave as informed consumers in the health care Marketplace. On the other hand, their status as consumers exposes them to potential financial burden. Ideally, patients will recognize this trade-off between the medical benefits and the financial costs of receiving health care services, incurring out-of-pocket expenses only when the benefits of receiving the services outweigh the costs.

So how close do patients come to reaching this ideal? In the RAND Health Insurance Experiment, families were randomly selected to receive either first-dollar insurance coverage —no out-of-pocket spending—or a range of out-of-pocket expenses, from minimal copayments to steeper ones.[11] The RAND study showed that it is often difficult for patients to know when they need specific health care interventions; therefore, their behavior in the face of high out-of-pocket spending is not always ideal. The study showed that copayments reduce health care use, causing people to scrutinize the need for health care services. However, patients' scrutiny of health care services was relatively uncritical, with copayments causing patients to forgo necessary services as well as unnecessary ones.[12]

To help patients factor their spending into health care choices, physician experts and patient advocacy groups have recommended routine physician-patient communication about out-of-pocket expenses.[13,14] Theoretically, such communication would allow patients to weigh medical and financial trade-offs and facilitate informed choices about health care services.[15] In effect, the cost of care would be discussed as another side effect to be factored into the pros and cons of available treatment alternatives, with physicians and patients engaging in shared decision making to choose the best alternatives given patients' preferences.[13]

To date, however, there is very little research assessing how often, or how well, doctors and patients discuss health care costs during clinical encounters. Estimates of cost discussion frequency vary widely in the published literature, from as low as 14 percent of patients ever discussing their health care spending with physicians[16,17] to as high as 44 percent of patients discussing their health care expenses in a single year.[18] The heterogeneity in estimates may be in part as a result of differences in study design, with higher estimates reported from studies of actual dialogue with physicians than from self-reports from patient surveys.[19] In fact, our research analyzing actual clinical encounters discovered that patients and physicians discussed health care spending during 22 percent of breast cancer clinic appointments, 33 percent of rheumatoid arthritis appointments, and 38 percent of depression appointments.[20] As for how effectively such conversations help patients navigate out-of-pocket spending, our prior research showed that when the topic of health care spending arose during clinical encounters, patients and physicians discussed strategies to reduce such

expenses 44 percent of the time.[20] Discussing health care spending can be an important step toward helping patients decide whether lower-cost services are in their best interest.

Unfortunately, in our study of clinical interactions, we discovered that physician-patient spending conversations did not always enable patients to successfully navigate out-of-pocket expenses. In this article we present a qualitative content analysis of health care spending discussions from outpatient clinic visits for patients with breast cancer, rheumatoid arthritis, or depression who saw specialists who treat these conditions. We present a series of physician behaviors that interfered with patients' efforts to either lower their out-of-pocket expenses or understand the pros and cons of less costly health care alternatives.

Study Data And Methods

SAMPLE DESCRIPTION

We analyzed physician-patient interactions drawn from the Verilogue Point-of-Practice™ database of audiorecorded clinical interactions. Verilogue recruits physicians randomly from available lists of active, board-certified physicians and pays them to record patient visits for the purpose of marketing or health services research. All protected health information is removed during the transcription process. The Duke University Institutional Review Board determined this study to be a secondary analysis of deidentified data and declared it exempt from review.

We obtained the most recent 1,000 interactions for management of each of these conditions: breast cancer, depression, and rheumatoid arthritis. We chose these three health conditions because they often involve expensive health care interventions that could lead to high out-of-pocket expenses. From this sample of 3,000 transcripts, we excluded visits that were conducted by primary care physicians, nurse practitioners, or nurses (n = 800) because these clinicians are often not the ones that prescribed the expensive interventions relevant to the diseases in question. We also excluded visits that occurred outside of the United States (n = 350); involved patients younger than age eighteen (n =41); were primarily concerned with management of axial spondyloarthropathy instead of rheumatoid arthritis (n = 42); or contained only physicians' dictation (n = 12). The final sample consisted of 1,755 visits: 677 breast oncology interactions, 656 rheumatoid arthritis interactions, and 422 psychiatry interactions. These interactions occurred between May 2010 and February 2014 in outpatient, private practice offices across the United States.

ANALYTIC APPROACH

In this analysis we present thematic categories capturing physician behaviors we observed that led to missed opportunities to reduce patients' out-of-pocket expenses. In our earlier work we identified and quantified the strategies patients and physicians discussed to reduce patients' out-of-pocket spending.[20] In conducting that work, our team of coders flagged interactions in which they believed communication between doctors and patients broke down in ways that thwarted any effort to use such strategies. The coding team reviewed these flagged interactions and developed a scheme characterizing which physician behaviors led to these missed opportunities. To develop this scheme, we assembled a multidisciplinary

team made up of two researchers experienced in analyzing physician-patient interactions, a medical student who had finished a year of clinical rotations, and an experienced physician with expertise in shared decision making.

Members of the coding team independently reviewed transcripts and identified potential examples of missed opportunities. The team then met to discuss these examples and debate whether they qualified as missed opportunities and by what reason they qualified as such. These reasons eventually became the coding categories. Our primary coding goal was to gather examples illustrating the range of behaviors that could lead to missed opportunities. We continued collecting and deliberating upon case examples until we reached a point of thematic saturation,[21] whereby subsequent missed opportunities were a result of behaviors we had already categorized. All coding disagreements were resolved by group consensus. Given our inability to combine the transcript data with survey or interview data to find out whether patients left the clinic appointment with unresolved financial concerns, we did not quantify the frequency of the behaviors. Another barrier to quantifying frequency were co-occurrences of physician behaviors, which resulted in categories that were not always easily distinguishable, as we explain below. Therefore, what we present in this article are exemplars of various behavioral phenomena drawn from these interactions.

LIMITATIONS

Our study had several limitations. First, it involved only three health conditions. If we had studied other health conditions, we might have uncovered other physician behaviors that impede resolution of patients' financial concerns. Second, we did not have longitudinal data for these physician-patient relationships, which limited our ability to fully comprehend the specific behaviors we observed in any of these single interactions. Third, our study is qualitative, and we did not address how often each of these behaviors occurred. In part, we avoided quantification of these behaviors out of recognition that we could not confidently conclude that any given instance of a behavior reflected a true failure. In addition, the categories of behaviors we describe reside on a continuum and would be difficult to sharply delineate from each other. Instead of meeting rigorous criteria as unique categories, the categories we studied lay out the range of behaviors that interfered with patients' ability to function as informed health care consumers. Nevertheless, in a separate article we determined that the majority of times when physicians and patients discussed health care expenses during clinical directions, they did not discuss any strategies for how to reduce out-of-pocket spending.[20]

Study Results

Our qualitative content analysis revealed two broad categories of physician behaviors that led to missed opportunities to reduce out-of-pocket expenses. The first set of behaviors involved the physician's failure to address the patient's financial concerns, in which the physician did not make an explicit effort to either acknowledge or deal with the seriousness of the patient's concerns (Exhibit 1). The second category involved instances where physicians did make explicit efforts to deal with patients' financial concerns but failed to

resolve such concerns satisfactorily (Exhibit 2). Below, we provide examples of each type of behavior.

MISSED OPPORTUNITIES TO ADDRESS PATIENTS' FINANCIAL CONCERNS

FAILURE TO RECOGNIZE POTENTIAL FINANCIAL CONCERN—For patients to productively discuss out-of-pocket spending with their physicians, they need physicians to recognize that they have financial concerns. However, patients do not always state their financial concerns explicitly ("Doctor, I can't afford these medicines; are there any less expensive alternatives?"). Instead, they sometimes express their concerns implicitly ("Wow, that medicine is expensive"). As a result, physicians have to pick up implicit cues to hold productive conversations about such concerns.

Even when patients' expressions of financial concern were explicit, physicians sometimes failed to recognize such concerns because of clinical distractions. Human attention is limited, and people are less likely to pick up on cues they are not already expecting to see.[22] Behaviors such as entering data into electronic medical records or examining patients can divert physicians' attention, making them less likely to pick up on unexpected topics such as patients' financial distress. For example, in one interaction, a woman with breast cancer complained of weight loss, explaining that she was taking a nutritional supplement but had to "stretch it out because it's a little bit expensive." The physician responded with a series of "uh-huhs" while typing on the computer and then shifted to examining the patient, without returning to the unaffordability of the supplements. In another interaction, a physician discussed prescribing an expensive rheumatoid arthritis medication, even going so far as to inquire about the patient's lack of insurance. He then examined the patient and did not return to the topic of how the patient would pay for the medication.

DISTRACTED FROM PATIENTS' FINANCIAL CONCERNS BY FRUSTRATION WITH SYSTEM—When physicians discuss health care expenses with patients, they sometimes spend considerable time complaining about the systemic factors contributing to high out-of-pocket spending. Occasionally, voicing those frustrations seems to distract them from exploring how to reduce patients' expenses. For example, after a breast cancer patient complained about the expense of her bone strengthening drug, her oncologist agreed that the price was "crazy," and then went on to elaborate: "What usually happens is the hospital or clinic will charge 300 times what they think they can get and the insurance company pays one-twentieth of the original. So it's just a game." "That's crazy," the patient replied. The doctor continued: "It'd be like going to your car mechanic and them saying, 'It's going to be $17,000 to get this fixed,' and you say, 'Well how about $149?'" The patient laughed at this analogy, and they continued discussing the "insanity" of the US health care system, with the oncologist adding that "a lot of those CEOs, the United Healthcare [CEO] made $124 million last year"—without ever returning to the patient's difficulty paying for her medication.

DISMISSAL OF PATIENTS' FINANCIAL CONCERNS—Even when physicians pick up on and acknowledge patients' financial concerns, they sometimes dismiss such concerns before exploring whether it is possible to reduce patients' financial burden. For example, in

one interaction, a patient explained that "[I] cannot take my pills, because there is now a copay." She mentioned that she had "zero income," to which the physician replied, "That's what happens, yeah," without addressing her inability to pay for her medications.

HASTY ACCEPTANCE OF PATIENTS' DISMISSAL OF FINANCIAL CONCERNS—Sometimes, patients express financial concerns to physicians, and then they, the patients, dismiss those same concerns. When physicians readily accept such dismissals, they miss out on opportunities to find out whether such concerns are legitimate. For example, in one interaction, a patient with rheumatoid arthritis was not responding to current therapy, so the rheumatologist stated that: "We can put you on another biologic if you can afford it." The patient responded: "I guess I can, because I have to." The rheumatologist did not follow up to determine if there was any way to estimate and perhaps even reduce the patient's out-of-pocket expenses.

LIMITED RESOLUTION OF PATIENTS' FINANCIAL CONCERNS

In the examples presented above, the physicians never thoroughly engaged in discussion of how to potentially reduce patient out-of-pocket expenses, either because they failed to recognize patients' financial concerns or because they became distracted by other matters. In the examples below, the physicians did attempt to discuss expense-lowering strategies but potentially failed to make sure these strategies would succeed.

ASSUMING 'COVERAGE' MEANS FULL COVERAGE—Many insurance plans do not fully cover services but leave patients with copayments or coinsurance.[23] When physicians mistakenly assume that "coverage" means full coverage, they might unwittingly expose patients to burdensome out-of-pocket spending. For example, in many interactions, when patients inquired about whether specific services were "covered by insurance," physicians responded "yes," without acknowledging (or perhaps recognizing) that patients could still face significant out-of-pocket expenses. In one interaction, a rheumatologist explained that the treatment he was prescribing was "a very expensive medication, but usually insurance covers pretty good." He never addressed the possibility that the patient would be responsible for a significant portion of the cost or that paying even a relatively small portion of the cost might be a burden.

ASSUMING GENERIC MEDICATIONS ARE AFFORDABLE—In recent years, consolidation among manufacturers has led to significant increases in the price of some generic medications.[24] Even absent such price increases, the cost of generic medications can burden those patients who are stressed to their financial limit. But physicians do not always recognize that "inexpensive" generics can be unaffordable for their patients. For example, one rheumatoid arthritis patient complained that methotrexate was too expensive. The physician responded with surprise, "considering it's a generic medicine." This response raises the possibility that the physician did not inquire in earlier visits about whether the patient could afford the methotrexate because he assumed that, as a generic, it would be affordable.

ASSUMING COPAYMENT ASSISTANCE PROGRAMS AND COUPONS RESOLVE FINANCIAL CONCERNS—Sometimes pharmaceutical companies create programs to help patients pay for expensive medications. These programs do not always eliminate all out-of-pocket expenses. And not all patients who seek such assistance receive it. Nevertheless, physicians sometimes direct patients to such programs under the assumption that they will resolve patients' financial concerns. In a number of interactions, physicians encouraged patients to "call the drug company" to find out about such assistance but with no plan for what to do if it was not forthcoming.

TEMPORIZING FINANCIAL BURDEN WITHOUT DISCUSSING LONG-TERM SOLUTIONS—Sometimes physicians make earnest efforts to address patients' financial concerns but focus on temporary solutions without discussing steps necessary to yield long-term financial relief. Physicians offer free samples of medications to treat patients' problems even when such samples only delay the day when patients will face significant expenses. In some cases, in fact, the free samples are expensive drugs, and use of the free samples might distract physicians from trying less expensive alternatives first. Other times, physicians turn to short-lived drug discount cards or coupons. For example, in one interaction, a psychiatrist recommended a patient begin taking Latuda, used for treating depression in people with bipolar disorders. When the patient expressed concern about the expense, the psychiatrist asked the nurse whether they had free samples. When the answer came back no, the psychiatrist told the patient, "I think there's a fourteen-day discount card." The patient was still concerned, asking, "Do you think insurance will cover it?" to which the psychiatrist responded: "I hope so. If nothing else, they'll cover at least fourteen days for free." There was no discussion about whether the patient would know, within fourteen days, whether the drug was effective or whether it was wise to start the drug now without knowing whether the patient would be able to afford it after the fourteen-day discount expired.

FAILURE TO CONSIDER LESS EXPENSIVE ALTERNATIVES—One way to reduce patients' out-of-pocket spending is to try less expensive alternatives when they are as good or nearly as good as the current, high-price option. Physicians sometimes fail to consider such alternatives. For example, in one interaction, a patient told his rheumatologist that "the nerve medication you tried to give me, they said the card would not cover it." The rheumatologist responded by saying, "OK, I am sorry about that. There is nothing we can do when they decide not to cover it. Let's get you out of here, young man," and the visit ended. The physician did not explore whether less costly nerve medications were available.

Discussion

Many health care policies are ultimately played out "at the bedside," by influencing the way doctors and patients make medical decisions. In the case of policies promoting health care consumerism, many patients are faced with important decisions about whether the benefits of health care interventions justify their financial cost. In this qualitative, observational study of outpatient interactions, we identified a range of physician behaviors that stand in the way of helping patients make informed decisions about ways to potentially lower their out-of-pocket spending. Some behaviors reflect physicians' failures to fully engage with patients' financial concerns, from never acknowledging such concerns, to dismissing them too

quickly, to getting sidetracked discussing frustration with a system that creates such high out-of-pocket spending. Other behaviors reflect physicians' efforts to engage patients about their financial concerns but efforts that potentially fall short, because physicians fail to resolve uncertainty about out-of-pocket expenses or turn to temporary solutions without making long-term plans to reduce patients' spending.

In reporting these behaviors, we are not implying that physicians should be blamed for the high out-of-pocket expenses their patients incur. Importantly, we recognize that all of the examples we present here reflect only a single interaction and that full understanding of the interaction would require familiarity with previous clinic visits. In a given interaction, a physician may have appeared to be ignoring a patient's financial concerns, but on a previous interaction that physician may have explored such concerns in depth. Similarly, a physician may have turned to a temporary solution in the visit we analyzed but may have had an unstated plan to address long-term concerns on a follow-up visit. In other words, the examples we present here cannot be "proven" to be missed opportunities for physicians to help patients reduce out-of-pocket spending. Instead, they stand as snapshots of the kinds of behaviors that potentially lead to such missed opportunities, lacking other efforts to reduce patient expenses.

In addition, we recognize that physician-patient communication is a two-way street and that some of the failures described here resulted in part from patients having difficulty clearly and explicitly expressing their financial concerns.[16] Patients have difficulty partly because health care consumerism is a relatively recent phenomenon in the United States for most people, meaning that patients have not had substantial experience that would help them become savvier about the health care marketplace.[25] Nevertheless, it is still incumbent on physicians to do their best to overcome patients' difficulties communicating about their expenses.[26] As an analogy, patients often have difficulty describing clinical symptoms to their physicians. Instead of taking patients' initial descriptors at face value, physicians are trained to ask follow-up questions that illuminate patients' symptoms. In the same manner, if physicians want to help patients make financially informed medical decisions, they need to learn how to recognize when patients have concerns about the cost of their care.

Some readers may wonder not just how clinical interactions go astray, leading to missed opportunities to reduce patient out-of-pocket spending, but how often they go astray in such a manner. Unfortunately, our data did not allow us to make such estimates. We had access only to transcripts of clinical encounters and, therefore, were not able to survey or interview patients and providers to uncover whether there were missed opportunities to reduce out-of-pocket spending. In our previous article we did estimate how often physicians and patients discussed health care expenses and discovered that they failed to hold such discussions in almost two-thirds of clinical interactions.[20] Some readers might wonder whether each of these encounters represents a missed opportunity to reduce patients' out-of-pocket expenses. But we do not think that our data support that conclusion, especially given that most of the patients in our study were seeing these physicians for follow-up appointments, which raises the possibility that financial concerns were addressed in previous appointments. Our goal in this article, therefore, was not to quantify missed opportunities but to characterize them.

When patients are burdened by the expense of interventions, physicians should consider whether there are less expensive alternatives.

We acknowledge that many of the potential failures we have identified here, if they truly do reflect physician failure, also reflect more general failure of the US health care system. Physicians in the United States have difficulty factoring financial concerns into health care decisions in part because out-of-pocket spending is often difficult to determine and health care prices are often opaque.[27] Consequently, physicians under time constraints cannot be expected to fully resolve patients' financial concerns in the space of any single outpatient appointment.

Nevertheless, many physicians want to help relieve patients of their financial burdens, to increase the likelihood that they will receive prescribed interventions and improve their overall quality of life. To achieve this goal, physicians need to recognize when their own behaviors interfere with these efforts. For example, when patients are burdened by the expense of prescribed interventions, physicians should consider whether there are less expensive alternatives. When the best solutions are short in duration, it behooves physicians to make plans to find longer-term solutions. And when patients raise and then dismiss financial concerns, physicians should take a moment to assess whether such dismissals are warranted.

In fact, anytime patients express concern about particular health care expenses, physicians should be cognizant of the possibility that patients are expressing symptoms of more general financial distress. When a patient complains about the expense of a sleeping pill, a physician should consider not only whether there is a less expensive way to address the cost of treating the patient's sleep disorder but also whether other unnecessarily expensive interventions are burdening the patient.

Conclusion

Ideally, when people face high out-of-pocket spending for health care services, they will act like savvy consumers, exploring the pros and cons of their alternatives with full knowledge of the financial consequences of those alternatives. This confidence is undermined whenever clinical interactions lead patients to miss opportunities to explore less costly alternatives or to identify means by which they can receive their current interventions at lower prices. Ultimately, when policies promote or allow people to experience high out-of-pocket health care expenses, those policies play out in the context of clinical interactions. Understanding the nature of those interactions is critical in understanding the impact of those policies.

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NOTES

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EXHIBIT 1

Examples of physicians' failure to address patients' financial concerns

Example	Sample conversation
Failure to recognize potential financial concerns	PT: Is why we stopped stuff, because of the surgery. But I know there's a new thing out for the, um, ulcer, besides the Nexium, because that's so expensive. Expensive would be—
	DR: Um-hum. Let me see. We did use the methotrexate.
Distracted from patients' financial concerns by frustration with system	DR: What else do we need? The Restoril? Folic acid?
	PT: Not the folic, and the Restoril…they won't approve that one, either. I don't know why.
	DR: Those insurance companies, they don't want to pay.
	PT: I know.
	DR: For anything.
	PT: I also need the Tylenol 3.
	DR: [Writes prescription for Tylenol 3 but never returns to discuss inability to pay for Restoril.]
Dismissal of patients' financial concerns	DR: We'll see if the insurance company is going to pay for your BRCA [test].
	PT: How much does it cost if I have to pay for it?
	DR: Oh, we don't want to talk about that.
Hasty acceptance of patients' dismissal of financial concerns	DR: The Tykerb, we have not given you for a long time, and these are pills, if I remember correctly, you have tolerated rather well.
	PT: I think so. I think I did.
	DR: Okay, and your insurance had no problem paying for it?
	CG: Well, we paid yeah, they paid,
	DR: They paid?
	CG: Yeah, that was a lot of copay. But that's okay. That's not a problem.
	DR: Okay.

SOURCE Authors' analysis of audiorecorded clinical interactions drawn from the Verilogue™ Point-of-Practice database.

NOTES BRCA is a genetic test for breast and ovarian cancer risk. CG is caregiver.

EXHIBIT 2

Examples of limited resolution of patients' financial concerns

Example	Sample conversation
Assuming "coverage" means full coverage	DR: Why do the genetic testing? To see if there is anything else [to worry about].
	PT: I don't know. It's super expensive.
	DR: The genetic testing?
	PT: Yeah.
	DR: No. Insurance should take care of it.
Assuming generic medications are affordable	PT: I told you I didn't buy the patch because I'm between halftime. I had to go borrow money to get my medicine and stuff.
	DR: Do you got—
	PT: Them pills is high, and them patches is, too.
	DR: But it's a generic patch, though.
	PT: I know, but it's still high.
	DR: It still costs money?
	PT: Yes, $40 something, that's generic price.
	DR: Oh, yeah.
	PT: High.
	DR: Oh, okay. So then—
	PT: Yeah, I have to pay $45 for the insulin, now, then I told them, good God.
	DR: Yeah, yeah. Unfortunately, we cannot use steroids so that's why that's out. So are you taking the Plaquenil twice a day also?
Assuming copayment assistance programs and coupons resolve financial concerns	DR: We talked about some injection like—
	PT: Enbrel.
	DR: So, what's happening on that?
	PT: I think it's going to be too much for me to afford.
	DR: What do you mean? What kind of insurance do you have?
	PT: I have Blue Cross.
	DR: Blue Cross Blue Shield?
	PT: Um-hum.
	DR: Because the insurance company will give you some, uh, the drug company give coupons like for the copay.
	PT: And then do you have the coupons for that or…?
	DR: Yeah. I think if you call the drug company, they will tell you exactly where to contact.
Temporizing financial burden without discussing long-term solutions	DR: [Asks nurse] What's going on with her Xeloda?
	NR: She never got it.
	DR: [Asks patient] Well, did you get a sample? Did the insurance pay for it?
	PT: No. When I was last here, the bottle you gave me was, that was it.

Example	Sample conversation
	DR: [To nurse] Do you have any samples of Xeloda? [Gives patient new sample.]
Failure to consider less expensive alternatives	PT: [Discussing OxyContin for metastatic bone pain] I have to spend $200 on pain medication, that's how much these pills cost me.
	DR: For three a day?
	PT:Yep. $198 for 120 of them. So I'd rather go back to the 80s [a higher dose, to reduce cost].
	DR: All right. [Never discusses lower-cost narcotics.]

SOURCE Authors' analysis of audio-recorded clinical interactions drawn from Verilogue™ Point-of-Practice database.