Physicians Interrupting Patients

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To the Editor

The art of physician-patient communication is necessary in obtaining accurate information diagnostically and in ensuring that the patient's needs are met during medical encounters. Drs. Singh Ospina and Phillips et al. present a sound and timely analysis that brings to the forefront the concepts of medical agenda setting and the skill of medical interviewing as part of a critical, yet, declining art.[1] The authors present evidence that doctors interrupt patients after an average of 11 s and often do not set agendas for the encounter. The authors conducted an analysis of 112 interviews from a total of 6 prior studies. The study cites time constraints, limited education about patient communication skills, and physician burnout as possible explanations of the results.

Language-discordant settings—in which physician and patient do not speak the same language—present further challenges to the significant time crunch and communication-related frustrations that both patients and physicians may feel in patient care settings, resulting in decreased patient satisfaction, physician satisfaction, and clinical outcomes.[2] In particular, Spanish-speaking population trends in the USA have resulted in a recent call-to-action to explore medical Spanish education and certification for physicians as a means to respond to medical student demand and patient need for linguistically appropriate communication and quality of care.[3]

However, none of the 6 studies used in this secondary analysis included non-English–speaking patients—a population in which the cited barriers (i.e., time constraints, limited education, and physician burnout) are often significantly magnified. Presumably due to these barriers, such as linguistic challenges to providing informed consent, studies often intentionally and explicitly exclude non-English–speaking patients from research. Certainly, it is the case that patients without English proficiency present additional challenges to informed consent, legally and ethically requiring either a competent and qualified bilingual physician or a certified medical interpreter and translated written materials.[4] However, it is these same difficulties that make this population particularly vulnerable to the consequences of limited access to care, poor medical interviewing skills, and physician time constraints, and thus important to include in future study.

For instance, the complexities of medical interpretation or provider second language acquisition may result in the perceived need for shorter phrases or increased pauses and clarifications during medical encounters, and barriers for usage of professional interpreters may lead to tendencies to using ad hoc untrained interpreters including family or ancillary staff. Precisely due to these patient encounters being fraught with risk of medical error, the vulnerable non-English–speaking population requires as much or more uninterrupted time with a physician. Further, since physician burnout, increased workload, and communication difficulties are typically magnified in the care of non-English–speaking patients,[5] language-discordant physicians may be more likely to interrupt patients sooner and ask less open-ended, agenda-setting questions.

Future research should promote and explore physician medical interviewing skills with non-English–speaking patients, including (1) physicians who speak languages other than English in language-concordant encounters with major languages such as Spanish and (2) physicians in language-discordant encounters who rely on medical interpreters for appropriate communication.

Increased attention to patient-physician communication skills in medical education should include support of physician linguistic development, such as medical Spanish courses, and physician training to work with medical interpreters as strategies to reduce barriers to quality patient-centered care for the growing non-English–speaking population and the physicians who care for them.

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