

NARRATIVE REVIEW

Fasiha Kanwal, Section Editor

Improving Patient-Provider Relationships to Improve Health Care

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Changes in our health care system have posed challenges for the patient-provider relationship (PPR) and may have negative consequences. For the clinician, due to lower reimbursements from third party payers, and increased administrative tasks such as the electronic medical record (EMR) and certification requirements, clinic visit time is now one-fifth that of decades ago. Clinicians may order diagnostic studies and imaging as a substitute for face to face time as it is seen to save time and increase relative value units (RVUs). As a result, the medical interview is very abbreviated, and the physical examination is disappearing. This occurs at the expense of the physician-patient relationship. Now there is limited time to gather relevant information, to understand the context of the illness, and address patient needs. For the clinician there is reduced satisfaction, loss of the meaningfulness of caring for patients, and possibly increased risk for burnout, and malpractice. This may lead to negative attitudes and behaviors toward patients, particularly for those with nonstructural diagnoses (eg, disorders of gut-brain interaction) which are given lower priority than those with acute or structural illness. In turn, patients experience a diminution in their role in the relationship and respond to adverse clinician behaviors with a lack of connection, frustration, and at times self-blame and stigmatization. To reverse this downward trend and re-establish an effective PPR changes are needed: 1) improving educational methods to provide skills to enhance patient-centered care, 2) incentivizing educators who teach and clinicians who practice patient-centered care, and 3) research support to demonstrate successful outcomes in satisfaction, adherence and clinical outcomes.

Keywords: Patient-provider Relationship; Communication; Medical Interview; Patient Care; Health Care; Diagnosis.

Changes in health care are moving clinicians away from the ideals of providing the patient-focused type of care that brought them into the field. There is greater pressure to see more patients in less time and, with lower reimbursements, to order expensive and often unnecessary tests that ultimately raise healthcare costs. Further, mounting administrative tasks leave clinicians fewer hours to see patients and may even drive doctors to disengage from patients during the visit. As a result, patients voice their dissatisfaction,¹ and doctors become frustrated,

and increasingly vulnerable to burnout; this may negatively affect patient safety and the clinical outcome.² Is there a way to bring back the joy of the patient-provider relationship (PPR) and save health care?

In this article the authors, a gastroenterologist (D.D.) and a patient advocate (J.R.) use evidence from the literature and personal experience^{3,4} to discuss how the changes in the business of medicine has impaired the patient-provider relationship (PPR) leading to a deterioration in health care. We must reverse this vicious cycle to improve clinical outcomes. Our aims are (1) to describe the bases for these healthcare system changes and (2) provide the rationale and methods to educate providers to implement effective communication skills and improve the PPR.

Part 1: The Provider

The Historical Perspective Leading to the Current Dilemma

Fifteen years ago, the author (D.D.) published an article⁵ about the changes in medical practice and education that led to a degradation of teaching and patient care. The 1950s through the 1970s was the era of TV doctors Marcus Welby and James Kildare. These were times when doctors had autonomy, treated patients at the bedside, and made diagnoses from the history and physical examination (“Listen to the patient; he is telling you the diagnosis.”—Sir William Osler, late 19th century)⁶ and there were few available tests. Imaging studies were limited, and endoscopy and advanced imaging methods such as computed tomography scans were just beginning. Although medical science had not yet acquired dramatic breakthroughs occurring in recent

Abbreviations used in this paper: DGBI, disorder of gut-brain interaction; EHR, electronic health record; IBS, irritable bowel syndrome; PPR, patient-provider relationship; RVU, relative value unit.

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decades, with limited third-party involvement, the physicians had time to listen and examine their patients and make decisions with their patients. From the 1970s and 1980s to the time of the article's publication in 2004,⁵ the growing influence of insurance companies led to reduced reimbursements influencing physicians to see more patients, and primary care office time dropped from 45 to 15 minutes.⁷ The physical examination became limited, highly focused, and often just a brief formality. While newer medical technologies and imaging led to improved diagnostic capabilities, less information came from the patient who alone could provide the context of the illness. In 2001 the Institute of Medicine published, "Crossing the Quality Chasm: A New Health System for the 21st century"⁸ and decried that there was a chasm between patient and provider in American health care due to physician centered practice and poor communication. To close this gap, "Patient centered care" was needed: clinicians needed to be respectful and responsive to patient needs and preferences with the patient helping to guide clinical decisions. Unfortunately, the publication was limited in its exposure, and with growing influence of decisions being made by third-party payers, few of the suggested recommendations were adopted.

The Current Health Care Environment

Since then, multiple issues have interfered with the PPR.

First, clinicians spend much less time with patients. Since 1975, despite the 4-fold increase in health-related jobs and over 20-fold rise in healthcare spending per person, by 2019, the average office visit time had dropped to 12 minutes.⁹ Physicians need to see more patients to earn enough relative value units (RVUs) to keep up their income. Additionally, RVUs prioritize procedure-based reimbursements over cognitive time, thus making face to face time a financial disincentive.

Second, the qualitative aspects of patient care, the "art of medicine," have all but disappeared. The responsibility to take a complete medical history and do a physical examination, to sit with the patient at the bedside and to quickly return patient emails and phone calls are now mostly done by a diminishing group of seasoned experts who lived thorough and benefitted from the experience. One man, after seeing multiple doctors, told the author (D.D.), "This is the first time any doctor has actually touched me to examine me." Staring at the computer screen and clicking boxes has replaced interpersonal engagement. What is lost are the essential nonverbal elements: being in close proximity, leaning forward, making good eye contact, and using affirmative nods and gestures.¹⁰ As a result, patient needs for engagement are not being met.¹¹

To the uninitiated, these activities possibly seen as "rituals" are highly valued by patients. They improve the

PPR via verbal and nonverbal engagement, and including when a patient is distressed, a physical touch. They increase patient satisfaction, produce positive neurobiological changes,¹²⁻¹⁴ and lead patients to provide more specific and meaningful information that helps establish clinical priorities. Yet, these behaviors are being jeopardized due to fragmentation of care to multiple providers and "shift work" schedules. Patients and even the healthcare team may not know who the main physician is as the sense of "ownership" is lost.

Thus, the "art of medicine" is no longer consistent with personal workstyle because of time pressure, the perception that technology is more efficient, limited understanding of the positive consequences of effective communication skills, and little training to implement these skills. The rectal examination is rarely done especially by younger physicians who claim discomfort and lack of training yet up to 10 potential diagnoses can be made at no extra cost.¹⁵ Importantly, the loss of these clinical behaviors diminishes the patient's role by removing them from participation in their care. Yet, effective communication methods and patient-centered care brings the patient and provider fully into human to human interaction, which then facilitates more effective technology is a diagnostic resource and may be relied upon by some clinicians as a replacement for clinical observation and reasoning. One resident noted about a patient with a cough, "Why talk with the patient or examine the chest when I can get a CT [computed tomography]?" Chronic human illness follows a biopsychosocial, not a morphological construct,¹⁶ so too much reliance on technology can be ineffective, misleading, and costly. Within gastroenterology, the medical interview uses symptom based criteria to diagnose disorders of gut-brain interaction (DGBIs),¹⁷ and confidently communicating the diagnosis increases patient acceptance and reduces unneeded endoscopy.¹⁸ Good clinicians are aware that patients with active inflammatory bowel disease may have little or no symptoms, and patients with minimal or no observant disease may have severe symptoms.^{19,20} Even with gastroparesis, delayed gastric emptying does not correlate with symptoms.²¹ Thus, learning the illness experience from the patient leads to proper diagnosis, which is then correlated with the pathological or physiological features.²²

Fourth, clinicians are forced to spend more administrative time studying and documenting to maintain credentialing requirements: Maintenance of Certification, 2-year reappointment credentialing, Occupational Safety and Health Administration certification, training for sexual harassment, bloodborne pathogens, tuberculosis infection, fire and environmental safety, Health Insurance Portability and Accountability Act, and opioid use. The electronic health record (EHR), required for billing services, occupies two-thirds of clinic visit time and reduces

Effective communication creates a collaboration of care. Some physicians, having a “hypertrophied sense of responsibility,” think that they should do more when the clinical encounter does not go well. However, patient-centered care means shared responsibility. This empowers the patient and offloads any undue sense of burden on the part of the clinician. Shared decision making often identifies other treatment options that the patient is motivated to engage in, and may reduce malpractice suits.³³ When collaboration of care through effective communication is established, clinicians like their patients more and vice versa.^{34,35}

Effective communication establishes meaningfulness. Beyond pleasure or happiness (ie, “hedonism”), the highest levels of well-being and satisfaction relate to the ability to actualize our human potential, by finding meaningfulness in what we do (“eudaimonism”).³⁶ Job dissatisfaction, burnout, and early retirement are attributed to multiple encumbrances that divert attention away from what clinicians find meaningful in the workplace. In a qualitative narrative study of physicians addressing what is meaningful, Horowitz et al³⁷ found that nontechnical humanistic experiences with patients (“...crossing from the world of biomedicine into their patient’s world...”) was the critical factor; being human and present with the patient was most valued. The PPR is the most commonly reported and powerful determinant of physician satisfaction.^{37,38}

Effective communication saves time. Clinicians may say that they are too busy to use communication skills as they perceive their time must be prioritized toward making a proper diagnosis (implying the use of focused, disease-based questions). However, a skilled patient-centered interview saves time by asking fewer questions while capturing the key features of the diagnosis and an understanding the patient’s biopsychosocial world. Effective nonverbal and verbal questioning style also increases trust and engagement, which facilitates shared decision making, leading to optimal treatment. A patient-centered communication style compared with a more traditional one brings more meaningful and accurate information in the same amount of time (https://www.youtube.com/watch?v=BeHPpvuB_mc).

Effective communication provides benefits to the patient and clinician and improves the clinical outcome. The benefits to the patient include creating engagement and trust, establishing the patient’s agenda, determining the relevancy of the data, receiving clear information, and determining a mutual set of goals and treatment plan.³² For the clinician, studies show that communication skills training improves satisfaction and empathy, reduces the sense of emotional exhaustion, and reduces “flooding” (the emotional response to an overwhelming clinical situation with no perceived control) and burnout.^{39,40} Finally, regarding outcome, an effective patient-provider interaction reduces symptom severity and emotional distress, improves satisfaction and coping, and reduces the use of healthcare services.^{32,41,42}

Putting Technology and Evidence-Based Medicine in Perspective

In his book, *Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again*,⁹ Dr Eric Topol addresses the future impact of artificial intelligence to virtually eliminate the human component to diagnosis. Artificial intelligence will be more accurate than humans in interpreting imaging or laboratory data and making diagnoses from a wide array of clinical information. However, he cautions that this will then require providers to address the clinical context to which this information is applied.⁴¹ For this to occur, communication skills are needed to engage with the patient to interpret the information. By transitioning away from being a technician, the clinician may re-establish a personal relationship and enjoyment in the process of the care.

In the 1990s, evidence-based medicine offered to advance intuition-based medicine by applying scientific evidence for making clinical decisions. However, many clinicians did not feel it met the needs of everyday practice.⁴³ For example, when guidelines from clinical trials are applied to patients, only a proportion of patients will respond, and if not advised on the rationale for a medication, the patient may not take it. Evidence-based medicine addresses statistical likelihoods for treatment benefit but does not cover the nuances that differentiate patient motivation to take medication or even their personal likelihood for clinical response. Chang and Lee⁴³ proposed to replace evidence-based medicine with “interpersonal medicine”: an approach that is responsive to individual patient circumstances, capabilities, and preferences. It requires that clinicians not rely on hard data alone, but rather use it in the context of collaborative relationships built on empathy, trust, and effective communication.

How Can We Make It Happen?

Given these challenges, a great deal must occur to implement the adoption of patient-centered care and improve communication skills.

Medical education needs to address the process of care. Medical school, graduate, and postgraduate educational curricula and continuing medical education training prioritize content-based information as well as the diagnosis and treatment of disease. They must also include programs in clinical reasoning, communication skills, and the overall process of care using experiential learning and active participation. While lectures can provide a knowledge base, retention is limited. Learning best occurs with andragogic (as opposed to pedantic) principles: being learner-centered, problem-focused, addressing the important work needs, and motivating learning through internal drives.⁴⁴ Optimal learning also requires educational modalities beyond the classroom: small group learning, patient-provider demonstrations using patient

simulators, case video presentation and discussion, facilitated role-play exercises, and sharing of personal challenges in the care of patients (eg, Balint groups).⁴⁵ In this way, clinicians can capture the critical skills of interview technique, the physical examination, nonverbal communication, body language, and proxemics. [Table 1](#) offers verbal and nonverbal methods that can be applied to improve communication. These skills are useful across disciplines and can help when coordinating team-based care. We believe that providing such educational programs can be an immediate achievable goal.

To meet some of these needs, the Rome Foundation has made efforts to improve education in the communication area. These include at no cost a study guide (<https://romedross.video/2YphMDd>) for self-learning and programs to teach clinicians and train facilitators to implement this knowledge (<https://romedross.video/2KPTYzC>).

Support for research is needed to provide validation. There is limited research assessing patient-centered care and effective communication skills. A National Institutes of Health consensus conference proposed that communication skills training programs could be studied as an intervention that leads to improved patient-provider satisfaction and clinical outcomes.⁴⁶ This has not yet been implemented. Research studies need to go beyond assessing patient satisfaction to also demonstrate improvement in medication adherence, reduced healthcare utilization, improved clinical outcomes, and ultimately reduced healthcare costs. In addition, qualitative research could capture what key stakeholders' needs and desires are when it comes to patient-centered care. With this type of evidence, it would be easier for payers to reward clinicians for a job well done, and the patients will benefit. We believe this to be an achievable goal over the next decade.

Teaching and learning effective communication skills and patient care must be incentivized. Incentives are needed for clinicians to maintain their motivation for and practice of these skills. We must reward scholarly clinicians by having their learning institutions, third-party payers who benefit from these clinicians and even congress show their support financially.⁵ Third party payers should reward clinicians who reduce healthcare expenses through good patient care by prioritizing RVUs to favor cognitive skills at least as much as procedural tasks. Certification requirements such as Maintenance of Certification, and continuing medical education credits should include patient care skills as well as disease-based knowledge. Finally, specialty boards must include expertise in communication as well as patient-centered care and implement certification programs for acquiring these skills.

We also must reward the educators that teach these curricula with salary support via reallocation of institutional overhead and providing increased administrative, teaching, and research time. Unfortunately, the schedules of good educators are often consumed by clinical service

because they do their job well, yet this limits their career development. Finally, bonuses and promotions should be provided to those demonstrating good educational skills. We believe that evidence from research that validates communication skills will drive incentivization.

Part 2: The Patient

In Part 2, experiences are reported from the patient's (J.R.) perspective.

"Satisfaction, the idea of how positive someone feels about an encounter is an important metric, but experience encompasses more than just a sense of satisfaction. Satisfaction is in the moment, but experience is the lasting story."—Jason A. Wolf, PhD, President of the Beryl Institute

The Patient's Role in the Care

This quote struck me that patient satisfaction and the overall patient-provider experience could be improved when communication also includes the patient's experience. Many healthcare organizations today are assessing patient satisfaction developed by payers to provide proper reimbursement more than addressing true patient satisfaction. Traditionally, the patient's perspective has been overlooked, ignored, or dismissed.^{4,47,48} However, since 2000, this has been changing, with a growing number of published articles by patients and from physicians about patient-reported outcomes and quality goals. Patients now voice their frustrations of the healthcare system, their unmet needs, and at times the poor care they receive in online forums, blogs, and even mainstream medical journals.

Patients and physicians must take responsibility for their distinctive and equally important roles to improve outcomes. As a patient with a chronic gastrointestinal illness and patient advocate, I learned that when I passively accepted a physician's directive, the outcome was nowhere as positive as it is now when I share the responsibility of care with my current provider.³ Why is that experience so hard to achieve in our healthcare system? Let us look at the issues that drive the negative patient experience and ultimately, poor outcome.

Gender Stereotyping

Just like female providers compared with male providers are not given the same salaries or career opportunities, female patients are not treated with the same attention in their medical care. Historically, many women are taught to observe certain social codes: be polite; ask nicely; wait your turn. Because of this, when seeking care, we often find ourselves begging, rather than asserting, to be taken seriously, and providers may come to expect this. With wait times in emergency rooms as long as 110 minutes and no real follow-up or established

Table 1. Verbal and Nonverbal Behaviors Affecting Communication³²

Behavior	Facilitates	Inhibits
Nonverbal		
Clinical environment	Private, comfortable	Noisy, physical barriers
Eye contact	Frequent	Infrequent or constant
Listening	Active listening—questions relate to what patient says	Distracted or preoccupied (eg, typing)
Body posture	Direct, open, relaxed	Body turned, arms folded
Head nodding	Well timed	Infrequent, excessive
Body proximity	Close enough to touch	Too close or too distant
Facial expression	Shows interest and understanding	Preoccupation, boredom, disapproval
Voice	Gentle tone	Harsh, rushed
Touching	Helpful if well timed and used to communicate empathy	Insincere if inappropriate or not properly timed
Synchrony (arms, legs)	Concordant	Discordant
Verbal		
Question forms	Open ended to generate hypotheses Closed ended to test hypotheses	Rigid or stereotyped style Multiple-choice or leading questions (“You didn’t...did you?”)
	Use of patient’s words	Use of unfamiliar words or jargon
	Facilitates patient discussion by “echoing” or affirmative gestures	Interruptions, undue control of conversation
	Uses summarizing statements	Not done
Question/interview style	Nonjudgmental	Judgmental
	Follows lead of patient’s prior comments (patient-centered)	Follows own preset agenda or style
	Use of a narrative thread	Unorganized questioning
	Appropriate use of silence	Interruptions or too much silence
	Appropriate reassurance and encouragement	Premature or unwarranted reassurance or encouragement
	Communicates empathy	Not provided or not sincere
Recommendations	Elicits feedback and negotiates	No feedback, directly states views
Asks/provides medical information	As appropriate to the clinical issues	Too many biomedical questions and too detailed information
Asks/provides psychosocial information	Elicits in a sensitive and nonthreatening manner	Ignores psychosocial data or asks intrusive or probing questions
Humor	When appropriate and facilitative	None or inappropriate humor

plan of care,⁴⁸ I found myself offering excuses: “I am sorry to bother you, I know you are busy. You probably have patients who are sicker than I am, but could you please help me.” After a car accident, I recall sitting for 3 hours on a gurney in the ER with a male colleague who was also injured. I had chemical burns all over my face, chest, eyes, and mouth, left from air-conditioner coolant, yet I was not offered wet cloths to wipe off excess chemicals. My male colleague was immediately called back to triage, given a clean gown and wet cloths to clean up, and was immediately seen by providers, while I was left in stained, dirty clothes, on a gurney in the hallway for hours. Unfortunately, the attending physician came to see me just after I tried to clean myself up in the restroom, and after not finding me went on, leaving me with burning skin, eyes and breathing difficulties until he returned 4 hours later.

Pain Management

Gender stereotyping also leads to the belief that emotional rather than physical causes lead to women’s

pain, even in the presence of clinical tests which show their physical nature.^{47,49} One week after having a rectocele and cystocele repair, I developed severe pain and went back to the gynecologist. I was not examined and instead shamed; I was told that even 78-year-old women have the same procedure as I did without such postoperative pain. Then I was told there was nothing wrong, offered ibuprofen and gabapentin, and sent out without any effort to follow up on the outcome. A few days later, I was examined by another physician who discovered I had an internal ulcer from a ruptured stitch that became infected, and I was then treated appropriately.

This story reaffirms studies that show that female suffering with pain is minimized, mocked, and coaxed into silence.^{48,49} In her comedy special, Wanda Sykes recalled having severe postoperative pain following a double mastectomy. She asked for stronger pain medication but was treated with ibuprofen while her male friends were given opioids for much less severe conditions. This has been referred to as “Yentl” syndrome: the paradox of women being underdiagnosed and undertreated, leading to adverse healthcare outcomes.^{50,51}

Similarly, physicians may incorrectly diagnose women with chronic pain as having a mental health condition without proper evidence and are more likely to prescribe psychotropic drugs.^{48,50} Thus, men and women can receive different diagnoses and treatments, and respond differently, even with the same clinical presentation!

Impact on the Patient

These experiences have consequences. When you ask a woman with chronic pain about their illness experience, you will often hear stories of guilt, shame, embarrassment, and even depression. They are vulnerable to become self-critical unnecessarily, and experience frustration, anger, and social isolation.⁴⁸ Further, the burden of a chronic illness can impair their ability to work, care for loved ones, interact with others, and perform basic personal tasks. Concerns about bowel habits with IBS impact on dating, intimacy, and sexuality, leading to further isolation.^{3,50,52}

Provider Stigma and the Patient

When physicians attribute a negative stigma to patient symptoms, the impact on the patient is profound, especially if they adhere to this stigma. Some may just reject the diagnosis, but if they accept it, they may develop feelings of guilt and self-blame for having a condition not perceived as “real.” The sense of shame that follows inhibits their ability to adequately express their thoughts and feelings with their providers, leading them to minimize the severity of their symptoms.^{4,53} Statements or inferences of being “crazy” “hysterical,” or “unstable” disengages patients from their care, fearing that they will be labeled as untrustworthy or not credible. About 50% of IBS patients do not inform their family members and friends about being diagnosed with these disorders based on a fear of being misunderstood or not believed.⁵²

As a patient with IBS, when a physician told me that I was “fine” because of a lack of structural evidence for my symptoms and that I should eat yogurt and practice yoga, I immediately went to a place of shame. I was embarrassed for wasting my and the physician’s time for what he felt was “nothing serious.” I was no longer willing to share the impact of the symptoms on my life because I assumed that he no longer cared.³

Physicians are often ineffective in providing education. If they see these disorders dualistically, they might not clearly communicate that their diagnosis is “real,” because they do not believe it themselves.^{3,28} Furthermore, tentativeness in conveying the diagnosis leads to more tests and leaves patients unconvinced.¹⁸ Then, any recommendation for a neuromodulator will be rejected

by the patient because of the perceived stigma and a lack of rationale for it. Why would a patient coming to the doctor for bowel disturbance and abdominal pain, understand or agree to taking such a medication or a psychological treatment unless the physician first gives a clear diagnosis and provides the physiological rationale to justify these treatments?^{3,4}

The Role of Stress

All of this diminishes patient understanding as to the role of “stress,” as it directs it to being “in my head.” Even the best clinicians struggle to reframe this understanding into a clear perspective. Proper validation and patient acceptance involve communicating the bidirectionality of stress and gastrointestinal symptoms: chronic and severe symptoms can cause psychological distress, which affects the severity and chronicity of the illness; it is not a psychiatric illness.⁴ Explanations that cover the dysregulation of the brain gut axis for these disorders can be very enlightening for patients. For me, hearing that my symptoms were part of a real, medical diagnosis of postinfection IBS validated my years of uncertainty and emotional distress wondering if I was overreacting to the pain and physical symptoms. The diagnosis made me more willing to listen to my doctor’s suggestion for treatment, including the use of a neuromodulator.^{3,4}

The Power of a Physical Exam

A physical examination can make a patient feel validated because the clinician has demonstrated a commitment to engage with the patient in the effort to diagnose. Many physicians are moving away from this practice because of shortened time with patients, and perhaps less training in this skill, and this may lead to more testing.⁵⁴ In the last 10 years, I can count on one hand the number of times that a doctor performed a physical examination. But when done, it had a profound impact on my perception of the physician’s concern for me and their interest and understanding of my symptoms. After spending so much time doing their electronic medical record on the computer, a doctor stepping away to do a physical examination can provide a much needed connection. It changes the dynamics of the visit by communicating confidence, a sense of security, and trust. Then the patient feels more connected to the doctor and to trust in their diagnosis and proposed treatment. Thus, the physical exam provides a more positive experience, prompting the patient to continue to engage with the physician.⁵⁴

Patient Education

The Latin word for *doctor* is *docere*, which means “to teach.” Isn’t that amazing? As a former teacher, I love this as it conveys that physicians are in the perfect role not

only to diagnose and treat, but also to educate patients about their conditions and treatment options. Patients want to be educated, and if physicians do not provide the proper information to them, they will seek it from less reliable sources (Think Dr Google).

There has been a remarkable growth in educational information available to patients through brochures, videos and internet programs targeted toward patients. While this is an educational asset, patients also want this information to be a resource rather than a substitute for knowledge acquisition. The physician needs to provide the proper context for this information and to target it toward the patient's interests and level of understanding. Patients desire scientifically backed education that is relevant and thorough,^{52,54} and when they go to the internet, the physician needs to address misinformation to help the patient gain an accurate understanding.⁸ The best and most effective form of education is in the office, one on one with a physician or clinical care team member having a dialogue and then using diagrams and manipulatives to show mechanisms of action, physiology and the rationale for treatment. No matter what type of education a physician chooses, there needs to be frequent checks for understanding along the way.^{3,47} This interactive learning creates improved understanding, shared decision making, and treatment adherence. It also motivates the patient to take some control back and develop self-management strategies.^{3,8,32}

Setting the Follow-Up Appointment

With chronic illness, the physician should initiate a return appointment instead of leaving that responsibility with the patient. Until I met my current gastroenterologist, I was told that I should return if needed; there was no long-term plan of care. Patients do not want to be abandoned in their pain. When a provider takes the initiative to establish ongoing care, an unspoken commitment is communicated that the physician is invested in the patient's well-being, and the patient no longer feels alone. This sets the stage for positive encounters going forward.⁵⁴

Hopeful, Not Hopeless

Finally, patients need hope. From struggling with a chronic condition, I frequently feel alone. I wonder how to communicate how I feel even though I might look "healthy." As a patient advocate, I hear from patients with IBS, inflammatory bowel disease, gastroparesis, chronic constipation, and chronic pain about their struggles and their searching for a glimmer of hope. The stories are the same; they wonder if they are alone in their experience, whether or when it will end, or will they ever be able to live a "normal" life again. These thoughts and feelings are often associated with severe symptoms, poor quality of life, and feelings of being a

burden on others, all of which cause them to withdraw from family, friends, and coworkers.⁵² As a "people pleaser," when my symptoms are severe and I am unable to participate in activities with friends or family, I feel guilty for letting others down because of my illness.³ These thoughts and feelings and negative provider interactions leave the patient with a profound sense of hopelessness, doubt, and self-blame.^{50,52}

A physician can provide hope by rephrasing explanations of the condition to include optimism and availability in the care. Yes, even a lifelong condition can be managed and people can regain a sense of control, manage their symptoms and live an active life.⁵⁵ Let patients know that they are not alone, that other patients struggle with the same symptoms, and that together you will work to get better no matter what arises along the way.^{3,32}

William Osler once said, "The good physician treats the disease, the great physician treats the patient who has the disease." This is so true for patients and really all that we are looking for. Someone to listen, to care, and to provide long-term support. This is the experience that encompasses more than patient satisfaction. It is the lasting patient-provider story that we all desire.

References

1. Drossman DA, Morris C, Schneck S, et al. International survey of patients with IBS: Symptom features and their severity, health status, treatments, and risk taking to achieve clinical benefit. *J Clin Gastroenterol* 2009;43:541–550.
2. Panagioti M, Geraghty K, Johnson J, et al. Association between physician burnout and patient safety, professionalism, and patient satisfaction: a systematic review and meta-analysis. *JAMA Intern Med* 2018;178:1317–1330.
3. Ruddy J. From pretending to truly being OK: a journey from illness to health with postinfection irritable bowel syndrome: the patient's perspective. *Gastroenterology* 2018; 155:1666–1669.
4. Drossman DA. From pretending to truly being OK: a journey from illness to health with postinfection irritable bowel syndrome: the provider's perspective. *Gastroenterology* 2018; 155:1664–1665.
5. Drossman DA. Medicine has become a business. But what is the cost? *Gastroenterology* 2004;126:952–953.
6. Gandhi JS. William Osler: A life in Medicine. *BMJ* 2000; 321:1087.
7. Frankel R, Morse DS, Suchman A, et al. Can I really improve my listening skills with only 15 minutes to see my patients? *HMO Pract* 1991;5:114–120.
8. Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academies Press, 2001.
9. Topol EJ. *Deep medicine : how artificial intelligence can make healthcare human again*. First edition. New York, NY: Basic Books, 2019.
10. Hall JA, Harrigan JA, Rosenthal R. Nonverbal behavior in clinician-patient interaction. *Appl Prev Psychol* 1995;4:21–37.
11. Jackson JL, Chamberlin J, Kroenke K. Predictors of patient satisfaction. *Soc Sci Med* 2001;52:609–620.

12. Verghese A, Brady E, Kapur CC, et al. The bedside evaluation: ritual and reason. *Ann Intern Med* 2011;155:550–553.
13. Costanzo C, Verghese A. The physical examination as ritual: social sciences and embodiment in the context of the physical examination. *Med Clin North Am* 2018;102:425–431.
14. Dimatteo MR, Taranta A, Friedman HS, et al. Predicting patient satisfaction from physicians' nonverbal communication skills. *Med Care* 1980;18:376–387.
15. Wong RK, Drossman DA, Bharucha AE, et al. The digital rectal exam: a multicenter survey of physician and students' perceptions and practice patterns. *Am J Gastroenterol* 2012;107:1157–1163.
16. Drossman DA. Gastrointestinal illness and the biopsychosocial model. *J Clin Gastroenterol* 1996;22:252–254.
17. Drossman DA. Functional gastrointestinal disorders: history, pathophysiology, clinical features and Rome IV. *Gastroenterology* 2016;150:1262–1279.
18. Linedale EC, Chur-Hansen A, Mikocka-Walus A, et al. Uncertain diagnostic language affects further studies, endoscopies, and repeat consultations for patients with functional gastrointestinal disorders. *Clin Gastroenterol Hepatol* 2016;14:1735–1741.
19. Long MD, Drossman DA. Inflammatory bowel disease, irritable bowel syndrome or what? A challenge to the functional-organic dichotomy. *Amer J Gastroenterol* 2010;105:1796–1798.
20. Drossman DA, Ringel Y. Psychosocial factors in ulcerative colitis and Crohn's disease. In: Sartor BR, Sandborn WJ, eds. *Kirsner's inflammatory bowel disease*. 6th ed. London: W.B. Saunders, 2004:340–356.
21. Pasricha PJ, Colvin R, Yates K, et al. Characteristics of patients with chronic unexplained nausea and vomiting and normal gastric emptying. *Clin Gastroenterol Hepatol* 2011;9:567–576.
22. Oudenhove LV, Levy RL, Crowell MD, et al. Biopsychosocial aspects of functional gastrointestinal disorders: how central and environmental processes contribute to the development and expression of functional gastrointestinal disorders. *Gastroenterology* 2016;150:1355–1367.
23. Friedberg MW, Chen PG, Van Busum KR, et al. Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. *Rand Health Q* 2014;3:1.
24. Shanafelt TD, Dyrbye LN, Sinsky C, et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc* 2016;91:836–848.
25. Dorn SD, Morris CB, Schneck SE, et al. Development and validation of the Irritable Bowel Syndrome Satisfaction with Care Scale (IBS-SAT). *Clin Gastroenterol Hepatol* 2011;9:1065–1071.
26. Kurlander JE, Chey WD, Morris CB, et al. Development and validation of the Patient-Physician Relationship Scale among patients with irritable bowel syndrome. *Neurogastroenterol Motil* 2017;29:1–8.
27. Singletary B, Patel N, Heslin M. Patient perceptions about their physician in 2 words: the good, the bad, and the ugly. *JAMA Surg* 2017;152:1169–1170.
28. Drossman DA. Functional GI disorders: what's in a name? *Gastroenterology* 2005;128:1771–1772.
29. Dalton CB, Drossman DA, Hathaway MD, et al. Perceptions of physicians and patients with organic and functional gastroenterological diagnoses. *J Clin Gastroenterol Hepatol* 2004;2:121–126.
30. Engel GL. The biopsychosocial model and medical education. *N Engl J Med* 1981;306:802–805.
31. Boeckxstaens G, Camilleri M, Sifrim D, et al. Fundamentals of neurogastroenterology: physiology/motility - sensation. *Gastroenterology* 2016;150:1292–1304.
32. Drossman DA. 2012 David Sun Lecture: Helping your patient by helping yourself: How to improve the patient-physician relationship by optimizing communication skills. *Am J Gastroenterol* 2013;521–528.
33. Beckman HB, Markakis KM, Suchman AL, et al. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med* 1994;154:1365–1370.
34. Hall JA, Horgan TG, Stein TS, et al. Liking in the physician-patient relationship. *Patient Educ Couns* 2002;48:69–77.
35. Matthews DA, Suchman AL, Branch J. Making "connexions": enhancing the therapeutic potential of patient-clinician relationships. *Ann Intern Med* 1993;118:973–977.
36. Ryan RM, Deci EL. On happiness and human potentials: a review of research on hedonic and eudaimonic well-being. *Annu Rev Psychol* 2001;52:141–166.
37. Horowitz CR, Suchman AL, Branch WT Jr, et al. What do doctors find meaningful about their work? *Ann Intern Med* 2003;138:772–775.
38. Suchman AL, Roter D, Green M, Lipkin M Jr. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. *Med Care* 1993;31:1083–1092.
39. Penberthy JK, Chhabra D, Ducar DM, et al. Impact of coping and communication skills program on physician burnout, quality of life, and emotional flooding. *Saf Health Work* 2018;9:381–387.
40. Boissy A, Windover AK, Bokar D, et al. Communication skills training for physicians improves patient satisfaction. *J Gen Intern Med* 2016;31:755–761.
41. Roter DL, Hall JA, Kern DE, et al. Improving physicians' interviewing skills and reducing patients' emotional distress. A randomized clinical trial. *Arch Intern Med* 1995;155:1877–1884.
42. Weiland A, Van de Kraats RE, Blankenstein AH, et al. Encounters between medical specialists and patients with medically unexplained physical symptoms; influences of communication on patient outcomes and use of health care: a literature overview. *Perspect Med Educ* 2012;1:192–206.
43. Chang S, Lee TH. Beyond evidence-based medicine. *N Engl J Med* 2018;379:1983–1985.
44. Knowles MS. *The adult learner: a neglected species*. Houston, TX: Gulf Publishing, 1973.
45. Luban-Plozza B. Empowerment techniques: from doctor-centered (Balint approach) to patient-centered discussion groups. *Patient Educ Counsel* 1995;26:257–263.
46. Chang L, Di LC, Farrugia G, et al. Functional bowel disorders: a roadmap to guide the next generation of research. *Gastroenterology* 2018;154:723–7635.
47. Zanini C, Sarzi-Puttini P, Atzeni F, et al. Doctors insights into the patient's perspective: A qualitative study in the field of chronic pain. *BioMed Res International* 2014;014:1–6.
48. Hoffmann DE, Tarzian AJ. The girl who cried pain: a bias against women in the treatment of pain. *J Law Med Ethics* 2001;29:13–27.

49. Zandbelt LC, Smets EM, Oort FJ, et al. Satisfaction with the outpatient encounter: a comparison of patients' and physicians' views. *J Gen Intern Med* 2004;19:1088–1095.
 50. Halpert A. Irritable bowel syndrome: patient-provider interaction and patient education. *J Clin Med* 2018;7:E3.
 51. Merz CN. The Yentl syndrome is alive and well. *Eur Heart J* 2011;32:1313–1315.
 52. Drossman DA, Chang L, Schneck S, et al. A focus group assessment of patient perspectives on irritable bowel syndrome and illness severity. *Dig Dis Sci* 2009;54:1532–1541.
 53. Rocque R, Leanza Y. A Systematic review of patients' experiences in communicating with primary care physicians: intercultural encounters and a balance between vulnerability and integrity. *PLoS One* 2015;10:e0139577.
 54. Regula CG, Miller JJ, Mauger DT, et al. Quality of care from a patient's perspective. *Arch Dermatol* 2007;143:1592–1593.
 55. Chey WD. Keeping to time and keeping the patient happy. Presented at: Digestive Disease Week 2019; San Diego, CA; May 18–21, 2019.
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Reprint requests

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Conflicts of interest

The authors disclose no conflicts.