FROM THE EDITORS' DESK

All in a Day's Work: Establishing Rapport, Making Decisions, Reducing Disparities

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Sandy (not his real name) cuts my hair. He and I usually talk about politics and sports. Last week, something else was on his mind—his disappointment with his recent visit to new primary care doctor. As a small business owner, Sandy had finally decided he could afford to pay for health insurance that would cover preventive care and allow him to go for a check-up for the first time in about 10 years. Sandy smokes, and has done so on and off since he was 17 years old. He is 35 years old now and otherwise in pretty good health. He has quit for varying lengths of time in the past, but always goes back to smoking when he confronts another stressful period in his life. He had not made this appointment because he wanted to quit smoking; in fact, he had made it for the same reason that prompts many men to schedule a check up with their doctor. His girlfriend convinced him to do so.

It seems that his well-intentioned internist had an agenda for the appointment. She correctly advised Sandy that the most important thing he could do for his health was to quit smoking. When Sandy tried to steer the conversation in other directions, the risks and benefits of his vegan diet for example, she would turn the focus back to his smoking, educating him on all of its terrible health consequences and why it was imperative for him to quit. Sandy felt frustrated and powerless. He told me that all of the talk about smoking just made him feel like getting out of there and having a cigarette (which in fact he did—after making a compromise with the PCP that he would continue to smoke only “natural” cigarettes, so that at least he would not be inhaling the additives present in the other brands).

One of the main tasks of a primary care doctor is to help patients change unhealthy behaviors and to promote healthy ones. We do so by making a connection with patients—establishing rapport and trust, and then through a combination of education, motivation and shared decision-making, we help patients move in the direction of healthy change. Although well meaning, Sandy's doctor missed the opportunity to help him quit smoking. She let her own

zealousness interfere with her ability to meet the patient where he was at and to roll with his resistance. It may be another decade before another doctor has the same opportunity.

In this issue of *JGIM*, several articles address the key issue of how doctors establish rapport with patients and help them to make decisions about their health. The study by Riess et al.¹ reminds us that it all starts with the most basic yet elusive concept of clinical empathy. It has been two decades since Spiro wrote his seminal paper in which he posed the question: “What is empathy and can it be taught?”² Much has been learned since then. As Riess et al. point out, research over the past 20 years has demonstrated that doctors who use empathy in clinical encounters increase patient satisfaction, improve some clinical outcomes (such as adherence to medication) and remarkably, enhance physician well-being. But is empathy an immutable trait, one that you either have or you don't, or is it a fundamental skill that needs to be taught and reinforced during medical training? Riess presents results of a randomized trial of empathy training for resident physicians from diverse specialties, including internal medicine, surgery, ophthalmology and psychiatry, compared with standard post-graduate education. The training consisted of three 60-minute empathy training modules that contained the following elements: education on the scientific underpinnings of empathy and the physiology of emotions, skills in decoding facial expressions of emotion, and training in the use of empathic verbal and emotional responses. The primary outcome measure was change in empathic and relational skills, as assessed by patients blinded to physician randomization. Using the patient-rated measure of physician empathy, they found an improvement in physician empathy in the intervention group and, consistent with other research, a decrease in empathy in the control group.

Of course, if the goal is to modify patient behavior, empathy alone may not be sufficient. We must also assist patients in making decisions about their health. Elwyn et al.³ describe a new, practical three-step model for shared decision-making (SDM) in the primary care setting. The three steps can be summed up as consisting of “choice talk”, “option talk” and “decision talk.” The authors acknowledge the many challenges to integrating SDM into clinical practice; these include cultural differences that influence the extent to which patients feel comfortable engaging in SDM with their physicians, social disadvantages and

cultural encumbrances such as language barriers, and low health literacy and racism that may lead some physicians to discount their patient's ability to engage in SDM with them, leading to health disparities.

Another article in this issue of *JGIM*, Ng et al.⁴ deals more directly with health disparities by examining the effects of race, socioeconomic status, and insurance on health outcomes. Racial disparities in illness burden and expected longevity are well-known, but have stubbornly resisted our efforts to address them. Lack of health insurance, or lack of adequate insurance, may contribute. One of the legitimate goals of the Affordable Care Act (ACA) is to reduce disparities in healthcare. In this study, Ng et al. report on all patients admitted to three Maryland hospitals with a primary diagnosis of acute MI, coronary atherosclerosis, or stroke. These hospitals represented three distinct populations, roughly corresponding to poor, moderate, and wealthy communities. Patients with no insurance or Medicaid at the time of the index admission were considered "underinsured" and were compared to patients with private insurance or comparable coverage. All patients were followed for all-cause mortality for up to 14 years following the index admission. They found that underinsured patients had reduced survival compared to insured patients, an effect that was independent of race and other confounders. Notably, after controlling for insurance status, race was no longer a significant predictor of survival. While this database lacked sufficient detail to examine the mechanisms through which underinsurance might have led to reduced survival, these provocative results suggest that expanded insurance coverage, as

embodied in the ACA, may play a role in reducing important racial disparities.

One lesson from this issue of *JGIM* is that to improve health outcomes, we need to address both upstream factors such as insurance and downstream factors such as empathy and shared-decision making. Sandy had insurance. He even had a primary care doctor. What he lacked was a PCP trained to engage with patients so as to help them acquire the "audacity of hope" needed to make meaningful change. If the ACA is successful, many more of our patients will have insurance. It is not unreasonable to ask: will their doctors be ready?

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