FROM THE EDITORS' DESK

Getting Back to Basics

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The physician–patient relationship is full of enough subtleties and surprises to challenge even the most seasoned clinician. Many high-stakes encounters are a balancing act. How do you tell a young mother that the finding of peritoneal metastases means her cancer is incurable? Assess a request from a patient with chronic pain who may also be drug-seeking? Convince a depressed widower that antidepressants aren't a “crutch,” but a key to recovery? Or help a patient with recurrent low back pain recognize that what she needs is physical therapy and a solid weight loss plan, not another MRI.

Honing the skills to deal with these communication challenges is, for many general internists, a key source of professional satisfaction. Words can injure patients just as surely as an errant scalpel, or heal as effectively as the most potent medication. As with technical procedures, becoming a more effective communicator takes effort, practice, and additional training. Not all of us can become expert communicators, but we all can get better. And a good place to start is with the basics.

In this issue of *JGIM*, Tackett et al. look at the execution of six communication behaviors by 24 academic hospitalists in Baltimore.¹ These behaviors, collectively coined “etiquette-based medicine” by Michael Kahn, are so basic they might deserve the label “common courtesy.” But as the study highlights, courtesy on the hospital wards is not so common. Physicians introduced themselves in less than half of all encounters and sat down in less than a third. Asking patients for their perspective on their illness or the hospitalization was vanishingly rare. The authors suggest that use of a simple checklist could allow health care providers “to start every patient interaction with overt displays of respect and humanism.”

Other articles this month also touch on the value of the basics. For example, an article by Patel et al. examines readiness for meaningful use of electronic health records

(EHRs) among primary care and specialty practices.² Among the more interesting findings, primary care practices with “basic” EHR functionality almost always met criteria for “core” meaningful use; the same was not true in specialty practices. In a different vein, Chretien and Chretien argue that the country is underprepared to deal with the health problems of returning veterans from Iraq and Afghanistan, and that non-Department of Veterans Affairs (VA) providers will need rapid remediation (“basic training”?) to cope effectively with the influx.³ And a provocative study by Davydow et al. suggests that inadequately treated major depression is a major risk factor for hospitalization for ambulatory-sensitive conditions.⁴ A Capsule Commentary by *JGIM* Deputy Editor Matt Bair puts the findings in context.⁵

It is accepted wisdom in the business world that execution beats strategy six days out of seven. Executing on the basics, and executing well, may be a principle the medical world would do well to adopt.

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