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Practices to Foster Physician Presence and Connection With Patients in the Clinical Encounter

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IMPORTANCE Time constraints, technology, and administrative demands of modern medicine often impede the human connection that is central to clinical care, contributing to physician and patient dissatisfaction.

OBJECTIVE To identify evidence and narrative-based practices that promote clinician presence, a state of awareness, focus, and attention with the intent to understand patients.

EVIDENCE REVIEW Preliminary practices were derived through a systematic literature review (from January 1997 to August 2017, with a subsequent bridge search to September 2019) of effective interpersonal interventions; observations of primary care encounters in 3 diverse clinics (n = 27 encounters); and qualitative interviews with physicians (n = 10), patients (n = 27), and nonmedical professionals whose occupations involve intense interpersonal interactions (eg, firefighter, chaplain, social worker; n = 30). After evidence synthesis, promising practices were reviewed in a 3-round modified Delphi process by a panel of 14 researchers, clinicians, patients, caregivers, and health system leaders. Panelists rated each practice using 9-point Likert scales (−4 to +4) that reflected the potential effect on patient and clinician experience and feasibility of implementation; after the third round, panelists selected their "top 5" practices from among those with median ratings of at least +2 for all 3 criteria. Final recommendations incorporate elements from all highly rated practices and emphasize the practices with the greatest number of panelist votes.

FINDINGS The systematic literature review (n = 73 studies) and qualitative research activities yielded 31 preliminary practices. Following evidence synthesis, 13 distinct practices were reviewed by the Delphi panel, 8 of which met criteria for inclusion and were combined into a final set of 5 recommendations: (1) prepare with intention (take a moment to prepare and focus before greeting a patient); (2) listen intently and completely (sit down, lean forward, avoid interruptions); (3) agree on what matters most (find out what the patient cares about and incorporate these priorities into the visit agenda); (4) connect with the patient's story (consider life circumstances that influence the patient's health; acknowledge positive efforts; celebrate successes); and (5) explore emotional cues (notice, name, and validate the patient's emotions).

CONCLUSIONS AND RELEVANCE This mixed-methods study identified 5 practices that have the potential to enhance physician presence and meaningful connection with patients in the clinical encounter. Evaluation and validation of the outcomes associated with implementing the 5 practices is needed, along with system-level interventions to create a supportive environment for implementation.

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Scientific and technological advances have greatly improved disease treatment and care delivery, but these same advances have contributed to physician and patient dissatisfaction. In attempts to personalize health care, the delivery of care has become more impersonal.[1] A patient's need to connect and a physician's need to find meaning through connection are frustrated by an intrusive electronic health record, brief visits, and administrative demands. This mismatch of time and expectations is associated with physician frustration, emotional exhaustion, and "burnout" rates that affect many clinicians.[2,3]

The word *presence* refers to a purposeful practice of awareness, focus, and attention with the intent to understand and connect with patients.[4,5] The interpersonal interactions of clinical care give physicians insight that cannot be garnered from an electronic health record. This gathering of nuanced, personal data (eg, what is important to a patient; how a patient's symptoms affect her or his life, goals, and preferences for treatment) cultivates respect and trust between patients and physicians and can reduce the miscommunication and oversight that leads to medical error.

The objective of this study was to identify evidence-based practices that foster this time-honored ritual between physicians and patients to create connection, particularly in the first moments of a clinical encounter. To ensure that these measures are useful and easily implemented, the study focused on specific actions, behaviors, and communication strategies that clinicians could easily adopt and utilize in a busy clinical practice.

Key Points

Question What are the most promising practices to foster physician presence and connection with patients?

Findings This mixed-methods study identified 5 practices that may enhance physician presence and meaningful connection with patients in the clinical encounter: (1) prepare with intention; (2) listen intently and completely; (3) agree on what matters most; (4) connect with the patient's story; and (5) explore emotional cues.

Meaning For busy clinicians with multiple demands and distractions, 5 recommended practices have the potential to facilitate meaningful interactions with patients.

Methods

We derived a preliminary set of presence practices through formative research that included a systematic literature review of effective interpersonal interventions; clinical observations of diverse primary care encounters; and qualitative interviews with primary care physicians, patients, and nonmedical professionals whose occupations involve intense interpersonal interactions (ie, individuals who work with clients or other service recipients under time-pressured or stressful conditions). We then conducted a 3-round modified Delphi process[6] with experts who represented multiple perspectives on the patient-physician relationship to identify a final set of core practices.

Literature Review

The research team conducted a systematic literature review of the medical and social sciences literature to identify evidence-based interpersonal interventions that could form the basis for presence practices. As previously described,[7] we searched PubMed, EMBASE, and PsycInfo (January 1997 to August 2017) for randomized controlled trials and controlled observational studies that examined the association between patient-clinician interpersonal interventions and included at least 1 outcome measure of the "quadruple aim" (ie, patient health outcomes, patient experience, clinician experience, or cost).[8]

Using the Covidence (Veritas Health Innovation Ltd) online systematic review tool, 2 trained independent investigators abstracted information about intervention content, structure, and study design quality and methods from each article. A third investigator reviewed abstracted data and resolved discrepancies. Abstracted data included intervention focus (ie, motivational interviewing, health literacy, patient-physician relationship, patient-centered care, communication skills, shared decision-making, communication technique, psychological/therapeutic interview, mindfulness), intervention structure (ie, education, practice, instructions, tool), demand on clinician (time and effort requirements), target of intervention (ie, clinician, clinician and patient), and outcome effect size and significance. Study design quality was assessed using the Cochrane criteria for grading randomized controlled trials and the Effective Practice and Organisation of Care for controlled observational studies; the level of evidence was assessed using Oxford Centre for Evidence-Based Medicine criteria. A multidisciplinary team of primary care physicians and researchers with expertise in linguistics, health communication, and public health synthesized findings to identify interpersonal interventions associated with positive outcomes across the quadruple aim. eAppendix 1 in the Supplement includes a full description of study criteria, search terms, and abstraction methods. A bridge search was completed in September 2019 to identify additional articles that met search criteria.

Clinical Observations and Interviews With Physicians and Patients

To supplement literature-based findings about practices that foster physician presence and connection with patients, team members observed and analyzed 27 physician-patient interactions in 3 diverse primary care settings: an academic medical center (n = 10), a Veterans Affairs facility (n = 7), and a federally qualified health center (n = 10). At each site, we used convenience sampling to select 2 to 5 internal medicine or family medicine physicians who (1) were identified by leadership or peers as having exceptional interpersonal skills and (2) represented diversity in terms of clinician gender, years in practice, and race/ethnicity. We used convenience sampling to recruit English- and Spanish-speaking adult patients who had appointments with participating physicians during prespecified observation days. Researchers trained in qualitative methods observed and video- or audio-recorded the clinical encounters. After the encounters, clinicians and patients were interviewed about strategies that clinicians use to establish presence and forge meaningful connections with patients. Data were synthesized using a rapid ethnography approach that incorporated training to build consensus capabilities, multiple observations of several encounters to support reliability and validity, and written and oral debriefs shortly after each observation.[9] Additional details

about observation methods, procedures, and analysis are presented in eAppendix 2 in the Supplement. Observation procedures were approved by the Stanford University institutional review board (IRB 42397). Physicians and patients provided written informed consent for encounter observations and recordings, interviews, and surveys.

Interviews With Nonmedical Professionals

Guided by human-centered design theory,[10,11] researchers trained in qualitative methods conducted and analyzed interviews with 30 professionals outside the field of clinical medicine whose jobs involve relational care and intense interpersonal interactions. The objectives of these interviews, described previously,[12] were to learn from analogous experiences and to identify cross-disciplinary practices that foster human connection and might have applications in medicine. Convenience sampling was used to identify 3 to 5 individuals from each of 7 categories of profession[13]: management; business/finance; community and social service; educational instruction; arts, design, entertainment, and media; protective services; and personal care and service occupations. Recruitment continued until we obtained a sample stratified by profession category and achieved data saturation. Interviews were anonymous and coded by professional role; this component of the study received an exemption from the Stanford University institutional review board (IRB 43314). Additional details about the interview methods, procedures, and analysis are presented in eAppendix 3 in the Supplement.

Evidence Synthesis

Through the literature review and complementary qualitative research activities, a list of 31 potential practices was generated that contribute to clinician presence and connections with patients (eAppendix 4 in the Supplement). The research team met weekly and held 2 half-day workshops over a 2-month period to review the evidence for each practice. During this time, the team (1) reviewed the supporting and contradictory evidence from the systematic review and examined the existence, quantity, and strength of evidence across quadruple-aim outcomes for each potential practice; (2) categorized promising practices by emerging domain and compared the strength of the evidence for practices within each domain; (3) identified supplementary literature, including established physician-patient communication interventions, qualitative studies, and research from nonmedical fields such as business, education, and sociology; (4) reviewed findings with clinical and research advisors; (5) combined practices with substantial overlap; and (6) eliminated practices with inadequate evidence or insufficient support from qualitative research or advisors. eAppendix 4 provides additional details about the evidence synthesis process and findings.

Delphi

Following evidence synthesis activities, we used a modified Delphi process—a validated method for quantifying expert opinion[6]—to revise and finalize a list of recommended presence practices. A full description of the Delphi methods is available in eAppendix 5 in the Supplement. The panelists (n = 14; not otherwise affiliated with the project) were chosen to represent diverse sociodemographic groups, disciplines, geographies, and practice settings. Individual panelists included physicians, health system leaders, patient and caregiver advocates, and researchers with expertise in physician communication and behavior, implementation of physician-patient interpersonal interventions, and medical education. The Delphi panel was facilitated by an experienced nonvoting Delphi moderator and had 3 rounds: (1) a virtual meeting to introduce the preliminary practices; (2) an in-person moderated discussion; and (3) a virtual meeting to present refined practices.

After each round of the Delphi, panelists rated each practice using 3 criteria: (1) potential effect on patient experience (ie, overall satisfaction, clinician communication, and perceived clinician respect and empathy); (2) potential effect on clinician experience (ie, perception that clinical encounters are meaningful, are productive, and contribute to general well-being and job satisfaction); and (3) feasibility of implementation (ie, ease of integration in diverse outpatient clinical settings, considering practice complexity, time demands, and training requirements). Criteria were rated using a 9-point Likert scale (−4 to +4). For each round, the median ratings (with standard deviations) for each criteria were calculated. We determined a priori that we would prioritize practices that received median ratings of at least +2 for all 3 criteria. Between rounds, practices were refined—and in some cases combined—in response to feedback. After the final round, panelists were asked to list their "top 5" practices (the number 5 was selected because it is within the range of easy recall,[14,15] and implementation and dissemination were explicit goals of this project). The final ratings and practices most frequently listed in the "top 5" were used to generate a final set of 5 practices. Panelists signed an audio/video release and received an honorarium and travel cost reimbursements.

Results

Literature Review

From 21 838 references initially identified, 73 studies met inclusion criteria (eAppendix 1 in the Supplement). A majority (92%) of the studies were level 1 according to the Oxford Levels of Evidence, indicating the highest-quality research; 29 (40%) were from the United States and 44 (60%) were international; 67 (92%) were randomized controlled trials and 6 (8%) were controlled observational studies. More than half of the studies (52%) reported at least 1 health outcome, 74% reported at least 1 patient experience outcome, 37% reported at least 1 clinician experience outcome, and 26% reported costs or cost-relevant outcomes. The most common focus areas of the interventions were interpersonal communication skills (29%) and specific communication techniques (22%). Fewer interventions focused on patient-centered care (19%), motivational interviewing (8%), shared decision-making (7%), health literacy (4%), patient-physician relationship (4%), mindfulness (4%), and psychological/therapeutic interviewing (3%). Specific studies that provided support for the final recommended practices are described in eAppendix 6 in the Supplement.

Clinical Observations and Interviews With Physicians and Patients

Observed clinicians represented diversity in gender (5 men and 5 women) and race/ethnicity (50% Asian, 10% Hispanic/Latino,

and 10% African American/black). Observed patients (n = 27) had a mean age of 58 years (SD, 17 years; range, 20-90 years); 16 identified as male, 11 as female; and the majority were nonwhite (30% Hispanic/Latino, 22% Asian, and 15% African American/black). Nineteen percent reported speaking a second language at home (Hindi, Arabic, Tamil, Ilocano); an additional 26% were exclusively or primarily Spanish speaking. Some examples of practices that were observed or discussed in interviews include checking in and exploring patient concerns (eg, "Does that make sense?"), statements conveying empathy and validation ("I know, man, it's so true"; "Sounds like ..."), indications of partnership (eg, "Let's look at this together"), nonverbal communication (eg, clinician turned swivel chair toward patient while listening to patient's primary concern), and complimenting patient efforts and ideas (eg, "Keep on doing what you're doing!"). Additional findings from the clinical observations and interviews are presented in eAppendix 2 and eAppendix 6 in the Supplement.

Interviews With Nonmedical Professionals

Nonmedical professionals (n = 30) were well balanced in terms of gender (53% male and 47% female) and race/ethnicity (5 Asian, 2 Latino, 2 Middle Eastern, and 1 Pacific Islander). Representation across professional domain and specific roles are presented in eAppendix 3. Cross-professional themes around presence and human connection included trust building ("It comes through the building of relationships and the building of your credibility ... through actions, through words"—school principal), nonverbal communication and silence ("I use a lot of silence ... sometimes I back away physically from people if I see they can't make eye contact with me"—chaplain), adopting mindfulness approaches ("[I remind myself] 'Why are you here? Why did you sign on the dotted line?' ... At the end of the day, it's about the people I'm serving"—fire captain), and connecting on an emotional level ("Usually if I let myself be carried along by someone's story, I find that it pushes them to say more"—documentary filmmaker). Additional findings from these interviews are included in eAppendix 3 in the Supplement.

Evidence Synthesis

Evidence synthesis narrowed the 31 preliminary practices to 18 practices across 5 domains: clinician introspection and mindfulness activities, practices that help a clinician prepare for and personalize a visit, practices that involve nonverbal connection, activities that elicit the patient's perspective, and practices related to partnership. After additional evidence review, this list was narrowed to 13 discrete practices with promising support from the systematic literature review, qualitative research findings, and supplementary review of supporting literature (**Figure 1**). eAppendix 4 in the Supplement provides additional details about the evidence synthesis process and findings.

Delphi

The 14 Delphi panelists included 8 physicians, 1 patient advocate, 1 caregiver advocate, and 2 health system leaders; research expertise included medical education/bedside medicine (n = 7), health care delivery innovation (n = 7), implementation of clinical interventions (n = 3), health care and clinical communication (n = 9), diversity/health disparities (n = 4), and psychology/behavior change (n = 4). eAppendix 5 in the Supplement provides additional details about the Delphi panel demographics and procedures.

Delphi panel ratings are presented in **Table 1**; qualitative feedback is presented in eAppendix 5 in the Supplement. In the first round of the Delphi panel, 3 of the 13 preliminary practices received median ratings of 2 or higher (positioning oneself, stopping and listening, asking "What's important to you?"). All practices were revised in response to quantitative ratings and qualitative feedback, and in the second round, 2 additional practices met threshold ratings (collaborative agenda setting and focusing on progress). Prior to the third panel, 2 practices that had received consistently low ratings were eliminated (emphasizing joint responsibility and recognizing the power of touch), and others were incorporated into practices with similar principles (eg, sharing the screen was integrated into positioning oneself). Eight practices were reviewed in the third round, only 5 of which had been significantly altered and were therefore rerated. The practices that received the greatest number of "top 5" votes were honoring emotions (100%), coming prepared (86%), listening without interrupting (86%), and eliciting and addressing patient priorities (79%). Practices with fewer "top 5" votes (taking a moment [43%], positioning oneself [43%], focusing on the positive [36%], and walking in the patient's shoes [29%]) were combined and/or incorporated into the higher-ranking practices. The final practices were renamed based on discussion with Delphi panelists and project advisors.

Five Recommended Practices to Foster Presence and Meaningful Connection With Patients

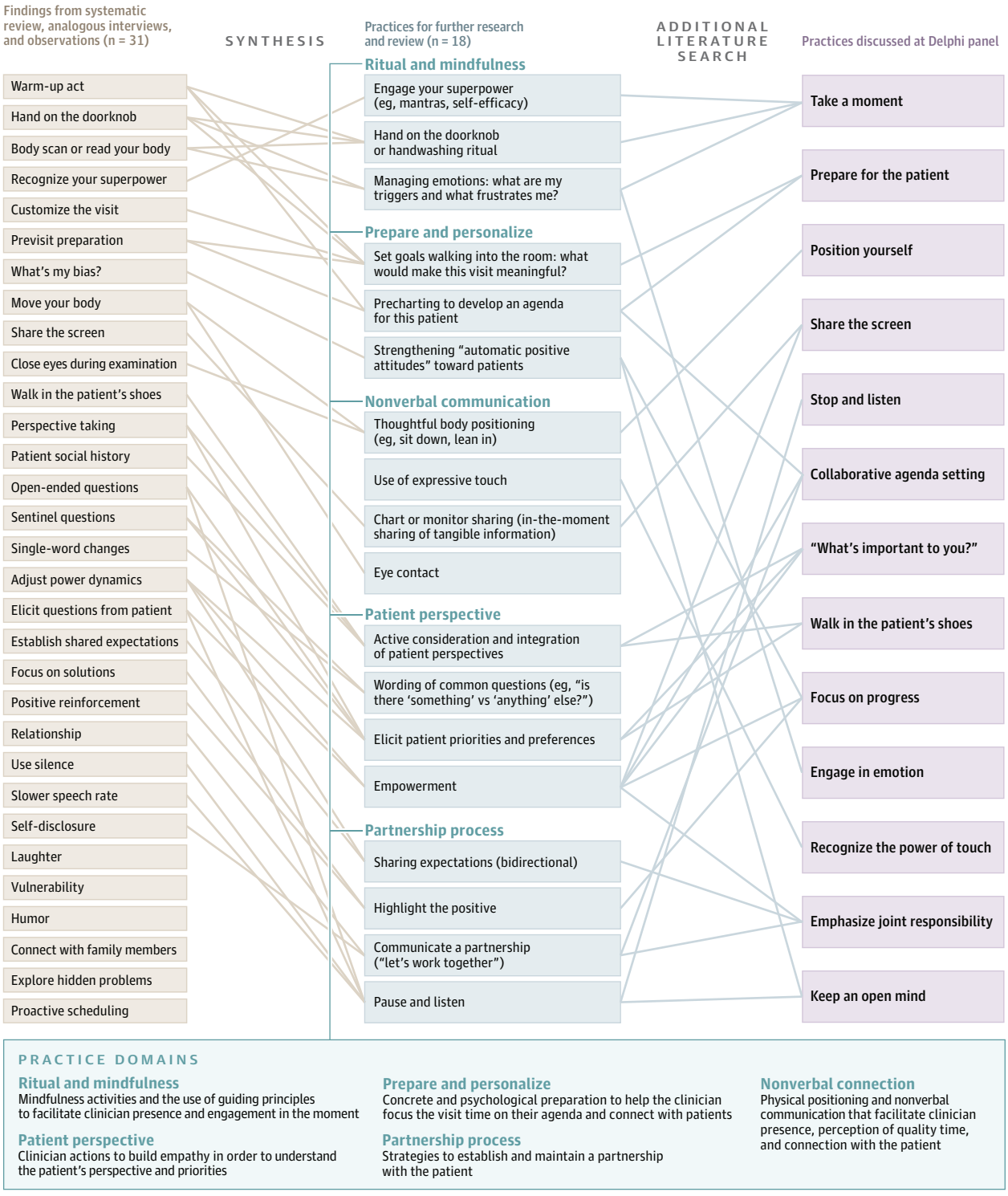
Study activities yielded 5 recommended practices to foster presence and meaningful connections with patients—the "Presence 5 Practices" (**Figure 2**). Below, each practice is summarized, along with examples and supporting evidence from the formative research activities and Delphi panel. Illustrative quotes from physicians, nonmedical professionals, and Delphi panelists are presented in **Table 2**. A detailed description of each practice and supporting evidence is presented in eAppendix 6 in the Supplement.

Prepare With Intention

This practice includes 2 components that comprise physical and psychological preparation for a clinical encounter: (1) personalized preparation for the patient and (2) taking a moment to pause and focus. The first component involves the physician becoming familiar with the person they are about to see, facilitating a more immediate connection with the patient. Although there is limited empirical evidence for physical preparation, in settings that distribute previsit questionnaires, reviewing the patient's responses before an appointment increases patient reports that they received information about their health and medications and increases the number of patient concerns that physicians elicit.[16]

Qualitative findings from physician interviews highlighted that some form of preparation is critical to presence, a perspective that echoes expert commentaries.[17] "Precharting" (reviewing a patient's chart before a visit) has been recommended by the American Medical Association[18] and is standard in many settings but typically focuses on reviewing medical conditions and could be enhanced by a brief review of a patient's life circumstances and back story. Experts commented that for clinicians who do not have time to prechart, preparation can take the form of asking a nurse

Figure 1. Evolution of 31 Preliminary Practices to the 13 Practices Presented to the Delphi Panel



or medical assistant to report any important patient-reported information obtained while rooming a patient or performing a 1-minute chart review of critical social—not just medical—history before the visit. Experts also indicated that implementation might be a challenge in settings with minimal time between visits but could be supported through clinic protocols that elicit updates and priorities from patients before their visits.

The second component of preparation involves a moment before or at the beginning of the visit during which a physician clears her or his mind of distractions and sets the intention for the

Table 1. Delphi Panel Ratings of Practices That Foster Physician Presence and Connection With Patients[a]

Preliminary Practices	First Rating			Second Rating			Revised Practices	Third Rating[b]			Top 5, %[c]	Final Practices
	Patient	Clinician	Implementation Feasibility	Patient	Clinician	Implementation Feasibility		Patient	Clinician	Implementation Feasibility		
Prepare for the person	2.5	2.0	0.0	3.0	2.5	−0.5	Come prepared	3.0	3.0	2.0	86	Prepare with intention
Take a moment	1.5	2.0	3.0	1.5	2.0	2.5	Take a moment	2.5	2.5	3.0	43	
Position yourself	3.0	2.0	3.0	4.0	2.5	2.5	Position yourself	Not rated	Not rated	Not rated	43	Listen intently and completely
Stop and listen	4.0	3.0	2.0	4.0	2.5	2.0	Listen without interrupting	Not rated	Not rated	Not rated	86	
Share the screen	2.0	1.0	−1.0	2.0	2.0	1.0	Combined with "position yourself"					
Collaborative agenda setting	2.5	2.0	1.5	3.0	3.0	2.0	Elicit and address patient priorities	4.0	3.0	2.0	79	Agree on what matters most
Ask "What's important to you?"	4.0	2.5	2.5	4.0	2.0	2.0	Combined with "elicit and address patient priorities"					
Emphasize joint responsibility	1.5	1.5	0.5	1.5	1.5	0.0	Eliminated					
Walk in the patient's shoes	3.0	2.0	1.0	3.5	2.5	1.0	Walk in the patient's shoes	2.0	2.0	2.0	29	Connect with the patient's story
Keep an open mind	2.0	1.0	−2.0	2.0	2.0	−2.0	Combined with "walk in the patient's shoes"					
Focus on progress	3.0	3.0	1.5	3.0	3.0	2.5	Focus on the positive	Not rated	Not rated	Not rated	36	
Engage in emotion	3.0	2.5	1.0	4.0	3.0	1.5	Honor emotions	4.0	3.5	2.0	100	Explore emotional cues
Recognize the power of touch	1.0	1.0	1.0	1.0	0.5	−1.5	Eliminated					

[a] Ratings are median panelist ratings for each practice using 9-point Likert scales (−4 to +4) that reflect the potential effect on patient experience, the potential effect on clinician experience, and implementation feasibility.

[b] For practices listed as not rated, the prior rating stands.

[c] This column shows the percentage of experts (n = 14) who rated the practice in the "top 5" at the conclusion of the Delphi panel.

Figure 2. Recommended Clinician Practices to Foster Connection With Patients

upcoming encounter. While this is not traditionally part of the medical curriculum, some physicians reported finding value in making an explicit effort to pause. Specific practices anchored to routine tasks, such as handwashing (which in some religious rituals is a moment of centering),[19] might remind physicians that they are entering hallowed space, allowing them to be intentional; some might instead take 3 deep breaths before walking into the examination room.[20-22] These practices have been studied most frequently in the context of mindfulness-based stress reduction and physician wellness. A recent systematic review of 81 articles found that mindfulness interventions were associated with improvements in clinicians' anxiety, depression, and stress.[23] Brief breathing and mindfulness exercises have also been incorporated into more complex interventions that improve physician well-being and experiences with difficult visits.[20,22] Although a mindfulness-oriented practice might not appeal to all clinicians, experts generally agreed that it requires minimal training, is easy to implement in varied and busy clinical settings, and can be tailored per personal preference.

Listen Intently and Completely

This practice also incorporates 2 components: (1) listening with one's whole body using open and receptive body language and (2) avoiding interruptions. The first component involves nonverbal behaviors that convey openness and facilitate listening; eg, sitting down,[24-28] leaning in,[29,30] maintaining an open body position,[26,27,29-31] and orienting one's body toward the patient.[32-35] Thoughtful physician body positioning has been shown to support relationship building, trust, and patient satisfaction with treatment.[36] Sitting down has perhaps the greatest empirical evidence, with multiple randomized trials demonstrating that sitting increases patient estimates of visit length[24,25] and their perception that their physician is listening.[28] Physician posture that conveys openness and respect (vs positions that make oneself seem larger and more dominant) can also positively influence patient reports of physician behavior[26] and is modifiable through communication trainings.[27] This practice was noted to be important when using an electronic health record, as sharing the computer screen and orienting the body toward the patient even when typing has a positive influence on physician-patient communication, information transfer, trust, and patient satisfaction.[32-35] Preferences for nonverbal behaviors such as eye contact can differ depending on race, nationality, and cultural identity, but open body position correlates with higher patient ratings of physician warmth and overall care across physician and patient backgrounds.[37] Experts noted that for some clinicians, implementation may require formal training in nonverbal communication skills, but others may be able to adapt their behaviors with minimal intervention.

The second key component of this practice is to avoid interrupting a patient, particularly during the patient's opening description of active health issues.[38-40] Research has shown that, on average, physicians interrupt their patients within 11 seconds.[41] When physicians listen attentively and avoid interruptions during opening monologues, patients communicate more, provide more medical information, and report greater satisfaction.[42,43] The practice can be extended throughout the visit by using silence and "infrequent, timely, and considered questions" when the patient is telling his or her story.[44] When incorporated into complex communication interventions, listening without interruption can reduce patient pain and anxiety[39] and does not substantially extend visit time.[38,40,43] Using silence can also reduce the incidence of "doorknob syndrome," ie, when a patient raises new concerns at the very end of the visit.[45] In terms of implementation, this practice requires minimal training or intervention; for example, one study changed clinician behavior by handing physicians a note before a patient visit that reminded them not to interrupt the patient.[40] Experts also noted that physicians should be attuned to cultural preferences and language barriers that may influence a patient's comfort with uninterrupted speech.

Agree on What Matters Most

This practice focuses on learning about what is most important to a patient and developing shared priorities for a visit.[46] Understanding what matters to a patient is at the core of patient-centered, humanistic care, and when achieved early in the visit, helps set the stage for meaningful encounters.[47] Evidence suggests that collaborative agenda setting reduces last-minute new concerns, improves patient satisfaction ratings, and positively influences symptoms such as pain and anxiety.[39,43,48] A simple form of this practice involves beginning the visit with an open-ended question asking the patient to describe in their own words why they are in the clinic: "What brings you here?" or "What is

Table 2. Examples of Quotes From Qualitative Interviews With Physicians and Nonphysicians and Discussion With Expert Panelists

Practice	Physicians	Nonphysicians	Expert Panelists
Prepare with intention	"When I wash my hands, I think about, 'Let me help this person be as healthy as possible.'"	"[I have] a few minutes at least before each interview where I'm not talking to anybody, and just…sort of prepare yourself. Like clear yourself, clear your heart and your mind and be ready for things to come in and out" (filmmaker).	"[Writing something personal about the patient in the notes] is more about building a relationship than anything medical. It makes the patient feel good that you know them" (physician/researcher).
Listen intently and completely	"I've learned to just sit and listen and be present when patients share their story…just giving them the space to talk and overcoming the urge to interrupt or direct the conversation."	"Sometimes I back away physically from people if I see they can't make eye contact with me. That gives them a sense of reassurance that I'm not there to invade them; I really am there to listen deeply and allow them their experience" (chaplain).	"Nonverbal behavior doesn't take place outside of verbal behavior. Tone of voice is important. Timing is important. Walk into the room, sit down, face the patient, and then greet the patient. Don't address the door" (researcher).
Agree on what matters most	"I start from day one with a new patient [with] 'Whatever you have, tell me about it.' And most of the time, they'll tell me everything that I was going to ask. And then I'll say, 'Okay, what do you want to do next?' And I just start from there. I don't start from scratch."	"We put together a statement of work. Once we agree on this program, it's…a recipe we follow. We have an agenda…It's all about setting expectations and shared decision-making" (design researcher).	"At first, [agenda setting] seems so obvious, making sure you're using your time and you're getting to everything, but you need to have buy-in. Making agenda setting collaborative is the important part of this practice" (physician).
Connect with the patient's story	"I really support them in the right things they're doing—which often people don't recognize—and really try to help them help themselves. Finger wagging doesn't really help."	"On the first day of school I always [ask students to] write me a letter of something you want me to know about you. And some students say things like, 'I have 4 brothers and sisters, which means my house is really crowded,' and some students will write, 'I have dyslexia so please don't call on me in lesson.'" (high school teacher).	"If we aren't thinking about the context of a patient's life, we're missing a key piece. This is central to combating prejudice because it helps people understand people as human beings" (physician/researcher).
Explore emotional cues	"Usually if they're very ill they're (1) scared, but (2) they're more focused on their own bodily feelings. What they want from me is reassurance that things are going to be okay. They don't necessarily need me to make a big connection with them."	"A lot of times you can see the stress leave a person when they start to tell you something that you know is going on" (Environmental Protection Agency enforcement agent).	"One of the biggest threats to physician-patient engagement is that we no longer look at our patients' faces. This is something we can do something about; our faces are a road map of emotion" (physician/researcher).

your main question or concern for today?"[49-52] The clinician should then incorporate the patient's priorities into the visit agenda (eg, "I want to make sure we are on the same page about what you want to cover today").[39,43,48,53]

Toward the end of the visit, asking "Is there *something* else you want to address in the visit today?" (rather than asking "Is there *anything* else …") can also reduce the number of unmet concerns and does not meaningfully increase visit length.[54] Eliciting patient concerns can increase the amount of condition-related information that physicians receive[50-52,54-57] and improve patients' perceptions of a physician.[49] Implementation of this practice may vary by context; for example, in clinics that conduct previsit questionnaires, a patient's responses can form the basis for a discussion about visit priorities.[58] While collaborative agenda setting training can be lengthy,[39,48,58] adopting some of the core principles described above requires minimal time and training.

Connect With the Patient's Story

This practice comprises 2 components: (1) consider the personal circumstances that influence a patient's health and (2) focus on the positive, acknowledging a patient's efforts and celebrating successes. The first component involves being curious and forging a connection by asking a patient about his or her sociocultural background and life circumstances.[59,60] Research demonstrates that when medical students are instructed to "look at the world through the patient's eyes and walk through the world in the patient's shoes," they receive higher satisfaction ratings from standardized patients.[61] When physicians show active consideration of a patient's perspective, it demonstrates that they want to understand the patient, and it creates an atmosphere of shared presence[47] and may directly influence quality of care: one randomized controlled trial of general practitioners in the United Kingdom showed that considering the psychological, social, family, and cultural reasons for why a high-utilizing patient is in the clinic can reduce the number of consultations.[62] Other studies have illustrated that this practice can also reduce racial biases.[63,64] Research from psychology and medical education suggests that there may be benefits to moving beyond this perspective-taking to perspective-getting, where clinicians acquire personal knowledge about patients through questions ("Tell me about your tattoo" or "What brings you joy?") instead of making assumptions based on race, ethnicity, gender, socioeconomic status, or past encounters.[59,60,65-67]

The second component of the practice involves acknowledging specific patient efforts in a genuine and positive manner. Examples include using positive language such as statements of approval, empathy, reassurance, and partnership; offering genuine praise for patient efforts; and acknowledging small successes when appropriate.[68,69] A physician's positivity has been associated with positive patient health outcomes,[70] a finding that parallels the evidence for positive coaching in athletes.[71,72] Evidence suggests that acknowledging patient efforts and progress through affirmation statements encourages adherence to treatment and behavior change[69] and encourages patients to participate in their care.[73] In one study, physicians who used encouraging statements when discussing a diabetes diagnosis had better patient-perceived communication, which was significantly associated with patient well-being, less diabetes-related emotional burden, less regimen-related distress, and better self-care.[74] When physicians received interpersonal communication skills training to increase positive talk (approval) and empathy (reassurance) and

decrease negative talk, patient-physician communication scores increased, and patients reported decreased distress and greater satisfaction with the medical encounter.[42,68,75] While rigorous evaluations of this practice examined in-depth training for multiple communication behaviors,[42,68,75] expert panelists thought that the use of positive framing and language could be adopted with minimal time and resource investment, and that this practice could contribute to the joy of practice.

Explore Emotional Cues

The fifth practice focuses on exploring emotion through (1) reading a patient's verbal and nonverbal emotional cues (eg, changes in the patient's tone of voice, facial expressions, and body language)[26]; (2) eliciting patient emotions through questions (eg, "How are you doing?" or "How are you feeling about this?")[76,77]; and (3) reflecting and validating perceptions of a patient's emotions (eg, "That sounds very difficult" or "I can see that this is affecting you deeply").[77-79] A large body of evidence suggests that clinician interpersonal sensitivity, including the ability to perceive patient emotions, is associated with positive patient outcomes, including patient satisfaction, appointment adherence, and learning of conveyed information.[80,81] While individuals' emotional sensitivity may vary widely, research shows that patients appreciate physician attempts to elicit and identify their emotional cues, even when the clinician is mistaken.[82]

Systematic reviews and meta-analyses that have examined the effectiveness of training clinicians to accurately perceive patient emotions demonstrate that brief training, including in a self-administered format,[83] can improve skills in decoding nonverbal emotional cues.[26,79,84] There is also evidence that when clinicians actively attend to patients' emotional concerns, and reflect this through their own emotional expression, patients experienced shorter and less severe illness.[78] From an implementation perspective, adopting this practice may require a greater resource investment than others, and engaging in emotion may at times increase visit length[78]; however, evidence suggests that effective engagement with patient emotion can actually decrease visit length while increasing patient satisfaction,[85] and the association between emotional awareness and clinical outcomes[78] may justify additional visit time.

Discussion

Human connection remains central to medicine but is in jeopardy in the current health care environment. In an era of increasing reliance on technology for health records, diagnosis, and treatment, recognizing and prioritizing the value of human connection and care are crucial. We identified practices grounded in scientific evidence that have the potential to foster physician presence and improve the experience of clinicians and patients.

This report describes an application of human-centered design principles, combined with a modified Delphi process, to identify promising practices related to humanistic care of the patient. Traditionally, Delphi panels have been used to define quality indicators and establish clinical guidelines,[86,87] often around a specific disease or set of conditions, and typically with the benefit of randomized trials and meta-analyses. In this study, however, the focus was on interpersonal interactions with broad relevance to all patient-clinician encounters, and the quantity and quality of evidence for specific practices was heterogeneous. We therefore relied on triangulation among published literature, qualitative interviews with physicians, patients, and nonmedical professionals (whose perspective and wisdom are not traditionally integrated into medical practice), and expert feedback. Our methods and the resulting findings demonstrate a novel approach to Delphi panels that expands the inputs beyond the traditional quantitative data of clinical trials and meta-analyses to include qualitative and human-centered design inputs.

This process ultimately identified 5 distinct evidence and narrative-based practices to be promising with regard to improving clinician and patient experience. The practices incorporate many principles that are intuitively modeled by clinicians such as Peabody and Osler[88] and that have been the focus of foundational training programs for clinicians, such as the 4 Habits Model and the Humanism Pocket Tool[89,90] (other exemplary resources are included in eAppendix 6 in the Supplement). Through our mixed-methods approach, we elucidated specific clinician behaviors, questions and statements, and actions that may serve as steps to implementing each practice in the clinical setting.

It is likely that each of the practices presented could be adopted with minimal training and effort. For some of the more complex practices, such as exploring emotional cues, an intensive workshop may provide a richer and more effective skill set. However, even in these cases, there are simple, concrete actions (eg, tuning into facial expressions, asking how the patient is feeling) that can benefit the patient. While adopting any particular practice individually may have a limited influence, collectively they address many of the domains that are central to effective patient-centered care and partnership. The advantage of these simple and tangible practices is that they are relatively easy to adopt and disseminate—which could result in a greater population-level effect over time.

Importantly, our findings do not fully address the broader pressures that threaten physician presence. Physician-focused interventions cannot alone be the bulwark against various threats to human connection in patient-physician encounters. As technological, business, and regulatory priorities all increasingly place pressure on the clinical encounter, often without additional allotted time, there is ever more need for cultural and structural changes within organizations to prioritize meaningful interactions.

Limitations

This study has several limitations. First, given the breadth of the systematic literature review, our process might not have captured all relevant literature for certain practices, and the strength of evidence varied across practices (eAppendix 6 in the Supplement). A bridge search (August 2017–September 2019) revealed 16 additional published studies of interpersonal interventions. As before, most interventions focused on communications skills (38%), shared decision-making (25%), or fostering the patient-physician relationship (13%). The additional articles reinforced the original literature review's finding that the strongest evidence for interpersonal interventions relates to their potential effect on patient experience (10 articles) and clinician experience (7 articles); only 1 study examined the effect on health outcomes (eAppendix 1 in the Supplement). Second, while international literature was

well-represented and the qualitative research efforts were attentive to diversity, convenience sampling was used for the qualitative formative research, and as such, primary care observation sites were limited to Northern California.

Third, expert panelists were all from the United States. Given that the patient-physician relationship is contextualized by local culture and norms, findings from this work should be validated through international comparative studies and with experts from other countries. Fourth, the recommended 5 practices have not been validated as a group to determine whether collectively they will achieve the intended outcomes. Additional research is needed to evaluate whether an intervention that incorporates the 5 practices will indeed increase physician presence and connection with patients and improve patient and clinician experience and clinical outcomes.

Conclusions

This mixed-methods study identified 5 practices that have the potential to enhance physician presence and meaningful connection with patients in the clinical encounter. Evaluation and validation of the outcomes associated with implementing the 5 practices is needed, along with system-level interventions to create a supportive environment for implementation.

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Acquisition, analysis, or interpretation of data: Zulman, Haverfield, Shaw, Brown-Johnson, Schwartz, Tierney, Zionts, Safaeinili, Fischer, Asch.
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