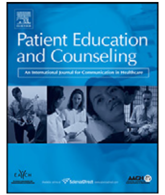
Patient Education and Counseling 85 (2011) 369–374

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou



Communication Study

The importance of physician listening from the patients' perspective: Enhancing diagnosis, healing, and the doctor–patient relationship

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A R T I C L E I N F O

Article history:
Received 20 September 2010
Received in revised form 21 January 2011
Accepted 23 January 2011

Keywords:
Listening
Doctor–patient communication
Patient perspective

A B S T R A C T

Objective: The research findings reported here describe the importance and various functions of physician listening according to patients.
Methods: Fifty-eight patients of the McGill University Health Centre were interviewed using a qualitative, interpretive design approach.
Results: Patients explained why listening was important to them and these findings were organized into three themes: (a) listening as an essential component of clinical data gathering and diagnosis; (b) listening as a healing and therapeutic agent; and (c) listening as a means of fostering and strengthening the doctor–patient relationship. The findings are presented along with a conceptual model on the functions of physician listening.
Conclusion: Elucidating the multiple functions of listening in the clinical encounter from patient perspectives can assist physicians in improving their listening approach.
Practice implications: For training purposes, we recommend that a module on listening should lead to a discussion not only about the skill required in listening attentively, but also to the values, beliefs, attitudes, and intentions of physicians who choose to listen to their patients. This teaching objective may be facilitated by future research that explores the concept of 'authenticity' in a physician's listening approach, which we argue is central to successful clinical outcomes.
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1. Introduction

Listening is a complex and vital feature of clinical practice for physicians. Despite attention paid to teaching and evaluating listening in clinical education [1–3] and practice [4–11], very little has been published on physician listening from the patient's perspective. Elucidating this perspective contributes to the literature and provides empirical evidence on the role and function of listening for medical education.

While 'listening to the patient' has been increasingly accepted as integral to good medical care, two shifts in healthcare over the past few decades provide compelling arguments for understanding its role and function. First is the shift in disease prevalence from acute, infectious and single organ diseases to chronic, complex and often degenerative or incurable conditions [12]. Second is the increased complexity of healthcare service delivery due to progress in medical science and technology [13]. Given these shifts, it is important to understand why physician listening is important and how it may contribute to clinical outcomes and patient satisfaction.

Enhancing communication skills training has been seen to improve health outcomes [14]. A notable benefit is that attentive listening early on in the patient interaction is associated with a greater likelihood that all of the patients' complaints or issues will be revealed; in other words, there is a reduction in so-called 'late-arising concerns' during the encounter [15]. However, physician listening may have benefits far beyond accurate reception, reporting, and recording of patient complaints. Our data demonstrate an expanded range of reasons why physician listening is important.

1.1. Listening defined

The International Listening Association defines listening as 'the process of receiving, constructing meaning from, and responding to spoken and/or non-verbal messages' [16]. Despite the consensus on the importance of listening as a critical element in communication skills, surprisingly little attention has been paid to its definitions in clinical settings and its putative roles in patient care. One of the challenges is the fact that constructing meaning from and responding to patients is a highly subjective endeavour,

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doi:10.1016/j.pec.2011.01.028

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presenting challenges for measuring and evaluating listening skills. Evaluation is challenging because the act of listening is subjective, abstract, subtle, and internal. In addition, educational models of clinical listening distinguish between active and passive modes. Passive listening, in which the physician quietly listens but without necessarily engaging with the patient to address their concerns, can be seen as problematic. 'Active listening' [17] and 'attentive listening' [18] on the other hand are emphasized in medical training. For example, the Calgary-Cambridge guide to communication skills outlines four areas where active listening may have a beneficial impact. These include (a) wait time; (b) facilitative response; (c) non-verbal skills; and (d) picking up verbal and non-verbal cues [1]. Missing from this and other similar models however, is description of the functions of listening from a patient perspective. This article is focussed on that critical perspective

1.2. Background

In 2005, the undergraduate medical school curriculum at McGill University was reorganized and oriented to address "physicianship": the explicit teaching of the physician's two roles as healer and professional, founded on the belief that the primary mandate of medicine is healing and the relief of suffering [18]. In tandem with curricular renewal, patients were consulted on the reform initiatives to guide curricular development. The overall findings of the study have been published elsewhere [19]. The findings presented in this article are a subset of the data from that study in which patients were asked to convey their attitudes, perceptions, thoughts, and feelings about their experiences with physician care.

2. Methods

2.1. Method

The study used an interpretive description (ID) design [20]. ID falls within a constructivist paradigm which assumes that all knowledge is partial and subjective, and that research data are co-constructed by the participant and the researcher. We used ID based on the idea that patients' subjective experiences are a valid and essential location for health care research inquiry, given the belief that change to applied clinical disciplines should come from engaged dialogue with the relevant parties (e.g., patients, health care providers). Following these philosophical and theoretical assertions, our study has engaged patients in dialogue about what really matters to them in the spirit of addressing and improving our patient-centered approach to care.

2.2. Setting

Data was collected from the teaching hospitals of the McGill University Health Centre (MUHC). The research protocol was granted ethics approval by the MUHC research ethics board. Research participants were all recruited from seventeen adult clinical sites of the MUHC, through the recommendations of referring clinicians in each of those sites.

2.3. Sampling

Participant selection was conducted initially through quota sampling — a statistically non-representational strategy in which a sampling matrix is constructed with independent variables. Quota sampling was employed to ensure maximum variation across demographics (particularly cultural and linguistic), clinical sites, and health/illness status. In total, 58 participants were recruited during the period September 2005–April 2006. The sample was diverse in terms of reason for seeking medical care, occupation, and linguistic/cultural background. 10 interviews were conducted exclusively in French, 3 involved a mixture of French and English, and the remaining 45 were conducted exclusively in English. Slightly more than half our sample (55%) reported having a university education. This figure may not accurately reflect the general level of education in the patient population receiving care at the MUHC, given that this institution provides care to significant numbers of urban inner-city poor and disadvantaged refugee populations. We believe this over-representation may be attributed to the fact that referring clinicians selected patients who they felt would be suitable for an interview on our research topic.

Participant demographics are presented in Table 1.

Table 1
Characteristics of participants.

Characteristic	No.
Sex	
Male	26
Female	32
Age category	
18–34	12
35–44	11
45–54	10
55–64	12
≥65	13
Maximum level of education	
Grade school	2
High school	14
College	4
Trade school	6
University	32
Illness category	
Acute–active	19
Acute-resolved	4
Chronic-stable	20
Chronic-progressive	8
End-of-life	4
Healthy	2
Information not available	1
Total	58

2.4. Interviews

Data were obtained through semi-structured interviews. The interview script opened with a dialogue seeking personal accounts of illness and experiences with physicians and then moved on to an exploration of patient expectations of physicians and targeted questioning on the physician as a professional and healer. The interviews were transcribed and subject to an iterative thematic analysis. Two authors (JJ, JDB) coded all of the interviews separately. They then met repeatedly to discuss the themes that had emerged and integrated their analyses. Other members of the research team read a subset of transcripts to corroborate emerging themes. Final results were agreed to by team consensus. Additional details of the research methodology, in particular the process of interview script development and its piloting, along with an outline of the original script, has been reported previously [19,21].

In the early stages of data collection we observed the high frequency with which participants independently identified listening as the primary defining feature of a good doctor. A typical response to the question, 'How would you describe the qualities of a good doctor?' was: "*I would say a good doctor is somebody who will listen to what the problem is and explain to you what it is and what is being done*." Although the research protocol had not purposefully set out to explore physician listening, we found the data obtained to be salient and illuminating.

Transcripts from 2 of our 58 interviews did not get produced due to recorder malfunctioning during the interview. One other interview was truncated after the interview had begun as the

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interviewer realized the participant was unable to answer the research questions. Of the remaining set of 55, 29 participants identified listening as a main characteristic of a good doctor. Following the first 18 interviews, the research team recognized the significance of 'listening' as a recurring theme and decided that in subsequent interviews an attempt would be made to obtain a more robust understanding of its meaning(s) for patient (such mid-stream modifications or revisions to interview scripts is accepted practice in qualitative research approaches [22]).

Those who identified listening as a key ingredient of good doctoring were then asked to expand on the idea of listening. Typical probes included: What does the doctor listen to? What does listening do or accomplish? How does one know the doctor is listening?

3. Results

Three sub-themes help to capture the reasons why and how physician listening was important to patients (see Fig. 1). Listening was perceived as fulfilling three functions: (a) as essential for appropriate clinical data gathering, diagnosis, and choice of therapeutic interventions; (b) as a healing and therapeutic agent; and (c) as a means of fostering and strengthening the doctor–patient relationship.

(a) *Listening as essential for appropriate clinical data gathering, diagnosis, and choice of therapeutic interventions*: Many participants stressed the importance of physician listening as a means to ensure a more accurate clinical diagnosis. They felt that their knowledge of their own bodies and state of health was essential information required for the clinical investigation. For example, one patient commented:

> "They should trust the person in front of them and hear what they're saying...because I know my body better than anybody else, so I know what to expect and I know how to deal with the little aches and pains, and if the little aches and pains don't go away, then it's not just about aging or stress, momentary situations...something is wrong, I just feel something is wrong and I think doctors should listen and investigate."

Another woman, without any overt illness, explained:

> "They don't give any importance to the thoughts that the patient may have about their own health...which is completely absurd considering that the patient is the person who lives with themselves every moment of every single day and knows their physical body and their state of health. I can't understand why a doctor wouldn't listen. What I experienced with my last doctor, the gynaecologist, what made that experience exceptional, was that she listened to me."

A few described how listening was important for good observation of signs and symptoms. The issue was raised in instances when patients perceived that the physician was relying more on second-hand information (e.g. previously formulated patient charts and notes) than on the patients' first-hand accounts. A patient suffering from chronic depression reported her experience as follows:

> "Listen to what they [patients] have to say; not just what other people wrote about them... I know that doctors are pressed for time and I know that they'll look at another doctor's notes and they'll say, 'Oh yeah – this guy.' They're basing too much on [the notes] in front of them instead of listening to the individual, looking at the symptoms and then talking to that individual like a human being, so that they can address the issues."

In a similar vein, some distinguished between listening to patients versus adhering to textbook facts about the disease. A patient who was on long-term hemodialysis, and who therefore had encountered and experienced many different physicians during her chronic illness, explained that physicians need to integrate what they can hear from patients with what they can learn from books:

> "I call them [doctors] 'by the book'. If something doesn't coincide with something that they read in the book about the disease, it doesn't exist. Myself, as a human being, I am different than other people; we all are different, but I find that they don't really listen to the person, as opposed to the disease. They listen to their disease, not the person, so they separate the two. I don' know if it's something that they learned to do in the hospitals or in the teaching they become that way..."

One patient suggested that physician listening will increase the probability that patients will follow through on courses of

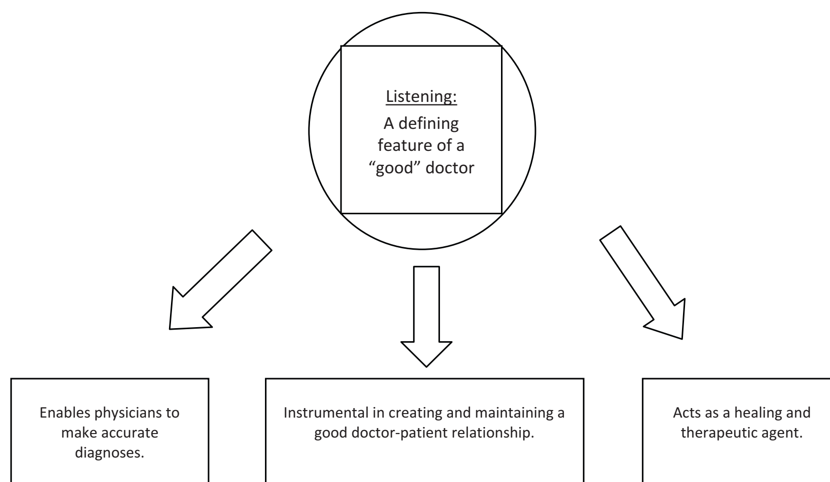

Fig. 1. Patient perspectives on physician listening serving three main functions.

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treatment because they have faith that the doctor accurately understood the nature of their problem as well as their hopes and expectations:

> "[If] I feel that I haven't had enough time with you to tell you exactly what my story is, even when you give me a prescription I'm going to say, 'Really? Is this prescription right for me and for my illness? Or [is it] going to give me more complications?'...and I think sometimes that's why you find patients will take it for 1–2 days and after that they forget about it, because they say, 'He didn't hear what I had to say about this pain. We didn't have enough time to exchange. He didn't ask me many questions, questions that would make me feel that yes he understands what my problem is.'"

Listening was therefore identified as essential to clinical data gathering and proper diagnosis, to recognizing the inherent knowledge that patients have about their health and as an avenue to increasing perceptual accuracy.

(b) *Listening as a healing and therapeutic agent*: The importance of listening for patients was also linked tightly to its therapeutic effects. Patients explained that witnessing or experiencing the doctor listening attentively offered relief from the stress and anxiety that can be induced and exacerbated by illness. Conversely, the lack of respectful listening on the part of the doctor can have a detrimental effect on the patient' health:

> "If a doctor doesn't respect the patient, or doesn't listen, the patient feels more worried and unsettled and this has an impact on their health."

Several patients described how physician listening addresses the psychosocial aspects of illness:

> "Sometimes, listening to a person will cure half of your problem... like it takes two or three months to get an appointment. In those two–three months, you make your problem worse by thinking, 'Oh maybe it is this, or that or that or that.' So, if the doctor doesn't have the time to explain to you or listen to you, he doesn't make your problem easier...Maybe if she had listened to you and said, 'No, don't worry about that'. 50% is just calming you down and make you understand what you have."

The next quotation suggests that one of the purposes of physician listening is to understand and respond to the particularities of each patient, thus tailoring the potential to relieve stress to the individual's unique personality and set of concerns.

> "Oh, by 80% [physician listening contributes to recovery]. 20% is probably only medical because they know their medical stuff; the rest is getting to know the patient and understanding all their little odd ways or odd habits. But everybody is different, so you can't just go ahead and say, OK 90% of the people are going to act this way, 80% are going to act another way. You can't do that, you can't generalize."

Another participant commented that the mere act of the physician listening is empowering to the patient as it motivates them to take ownership over their health. For her, when faced with a non-listening physician, power and agency are taken away:

> "Because if you listen to the patient and give the patient respect, what you are actually doing is helping that person take responsibility for their own health. Just by giving respect and listening to what they say, then you are automatically showing that person that they have the responsibility – that they are also in control of the healing process and are involved somehow. So the doctor has to not take all the power away from the patient."

Also, when the doctor does not listen to the patient's concerns, it can lead the patient to mistrust their own judgement, intuition and the signals their bodies are transmitting:

> "...[by the doctor not listening], you tend to discredit yourself and to mistrust yourself and to not listen to what your body is telling you and what should be alarming you."

Another patient, commented on the importance of listening to the patient rather than spouses and family members, as these may not always know what is best for the patient or have the patient's best interest in mind:

> "I had come in with my husband at the time, that was back in 1997, and I was very upset that being a patient, I'm the patient, you're supposed to listen to me, not to my ex, because you don't know what's going on and there are cases of conjugal violence and there are all sorts of things. So suddenly I find myself in the psychiatric ward and I was having depression and I was having a very difficult time, and I'm not able to make any decisions. My husband is making decisions for me."

These quotations indicate that listening can be instrumental in healing. While disrespectful listening or lack of listening can harm the patient, listening can be a key to helping reduce stress and anxiety. Listening to the particular needs and issues of the patient provides for individualization of care and a mechanism to ensure that the patient's welfare remains the priority.

(c) *Listening as a means of fostering and strengthening the doctor–patient relationship*: For some participants, listening was framed in terms of their relationship with their doctor. Many assumed that their physician would create the conditions for a doctor–patient relationship that promotes healing and recovery, but found that lack of physician listening weakened that relationship:

> "I want the doctor... to have empathy and to listen and to look into my eyes and to make me feel that for that short moment – I don't care how short, that you are listening to me, you are hearing me, you are there for me, and you give me that sense that I matter...that it's a partnership, that you trust my intuition, my knowledge, and that you want me... to feel free to say how I'm feeling."

> "I had a good experience with doctors who listen to me and... For example, my surgeon... put my values first, so when I explained to him how I saw things, he said, 'OK, well I can see that this and this and this... you'll be interested in, and this and this and this you won't'. He really did, I feel, try to make an effort to understand what I was about, and then tailored his responses to that."

By listening, the physicians in these two cases apprehend and engage with the patients' values, thereby strengthening

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the alliance, and one can assume, contributing to quality of care. Alternatively, in other instances a patient felt hurt and ridiculed when her physician listened without an overall sense of respect for her ideas and requests.

> "It still makes me angry when I think about how I was... how I sort of felt ridiculed for my looking into alternative options...I think that he could have just demonstrated even a little respect for my beliefs."

In this example, the physician did in fact listen to the patient, but then proceeded to dismiss her ideas; she continued:

> "...he was rolling his eyes when I said acupuncture and homeopathy. That was like 'Oh my god, you know, it's like, oh, this girl is awfully nutty.' (laughs). I mean... he didn't say that to me but it was clear to me that he believed that there were no other treatments for cancer than what he was offering. And while I understand that that is a generally held perception in our society, I don't actually believe that myself. And I have spoken to people who have healed themselves of cancer, so I knew that it was possible."

Another patient emphasized the healing effect of the doctor–patient bond and the central role listening played in that process. In the following excerpt, the patient not only referred to verbal communication, but also to what the physician observed in her that made her feel like he truly cared:

> "(Participant): The doctor needs to listen to you and to speak to you and it's surprising, sometimes you can overcome some of your problems. A lot of our problems are psychosomatic really I think. (Interviewer): What aspects of Dr. X make him such a good doctor?"

> (Participant): He listens...And he absorbs. He looks at you and he can tell by looking at you – somehow the way I walk – he watches me walk down the corridor – and the way I sit down. Once he said to me, 'I see you're walking better.' He takes his time and you're with him for a while and you talk with him. I think that people would feel better just to have somebody to talk to and I tell him things that I would only tell my husband.

> (Interviewer): Do you feel relieved when you're with him?

> (Participant): Yes...You feel, oh there's somebody that really cares. And he shows his caring by listening – that's the fundamental thing. By listening."

Therefore, listening helps forge a meaningful doctor patient relationship. Although it helps to initiate the bond, it must then be accompanied by respect for the patient's ideas and values. A young patient undergoing a periodic health examination was of the following opinion:

> "I don't think that listening to a patient is caring and compassionate. I think they [physicians] should listen out of respect. Sometimes I think that caring and compassion can be patronizing, if it is insincere. You can still be arrogant and project this caring and compassionate façade. I think that it is better to be professional and respectful and be honest and authentic rather than fake caring and compassionate."

What this last quote demonstrates is that listening is inextricably linked to a physician's authenticity. For this patient, listening without authenticity of intention does not strengthen the doctor–patient relationship, and that honesty and respect are the basis for a proper form of physician listening.

4. Discussion and conclusion

4.1. Discussion

Our research reinforces a common belief within and outside the medical community that physicians who demonstrate attentive and respectful listening reinforce the healing process and may contribute to improved clinical outcomes. It is congruent with the literature on the positive impact of listening on patient satisfaction [23–25] and patient disclosure of problems and emotional content. Davidsen's [26] study found that physicians' listening signaled a '*general giving of permission*' for the patient to disclose emotionally laden content, which is congruent with our findings. However our results go beyond the implications of listening on doctor–patient communication. The contribution of this paper is to elucidate multiple functions of listening in the clinical encounter which covers a broad range of reasons for why listening is essential to clinical care. To better communicate these findings, we created a provisional three-pronged descriptive model (see Fig. 1). The tentative model holds the potential to guide future research in the domain and to spur dialogues about the subjective, abstract and complex characteristic of listening that all physicians and trainees must grapple with.

We found that patients made a strong association between physician listening and a perception that the physician really cares for them and their well-being. Yet, we believe that some of our research participants implied that while listening can be a way to demonstrate caring, listening without authenticity may result in the opposite effect and create challenges for teaching, assessment, and positive clinical outcomes.

Twenty-nine of 54 participants identified 'listening' as a priority characteristic of a physician. For the remainder, many identified other physician attributes to which listening could be seen as a key ingredient; examples of these included 'having good bedside manner,' 'friendliness,' 'encouraging,' and 'speaks frankly and honestly.' A few participants subscribed to a more old-fashioned view of the doctor–patient power dynamic—not expecting to enter into a partnership relationship with their physician and thus not having the desire that the physician to listen intently to them. For these patients, priority may instead be given to physician competence and to the ability to communicate their condition to them. Our findings suggest, not surprisingly, that within the patient population there is heterogeneity in the way doctor–patient relationships are conceived. Despite this heterogeneity; we believe that respectful listening can be applied beneficially to all physician-patient encounters.

4.2. Conclusion

In summary, patients expressed a range of reasons why listening is essential. Listening can determine the outcome of matters of urgency, it can reduce stress, increase joint-decision making, and instil patient confidence in direction of therapies which ensures they will follow-through on treatments. Listening can also foster a deeper connection between physician and patient—one that is bound up with an interpretive activity. In this sense, it contributes to a richer interpersonal dialogue,

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generosity of spirit, an awareness of preconceptions and an active suspension of bias. Cultivating the doctor–patient relationship, listening can generate new understandings and meanings. One might expect such connections to be forged across all medical disciplines, but especially in emotionally charged situations such as the trauma room or in palliative care settings. With all these factors in mind, it could be said that listening is a basic ingredient of a clinical method that must be mastered by all physicians.

We hope that the perspective of patients presented in this paper can help physicians and their trainees understand the profound impact listening has on patients, and develop an appreciation of the diverse functions listening plays in the clinical context.

4.3. Practice implications

This research as well as our examination of the physician communications literature suggests that physician listening is an under-researched, under-evaluated yet crucial skill in medical training. A number of future research areas are required to better understand how the listening function can be taught and evaluated in medical education. For training purposes, we recommend that a module on listening should lead to a discussion not only about the skill required in listening attentively, but also to the values, beliefs, attitudes, and intentions of physicians who choose to listen to their patients. We recommend that training on listening be accompanied by a discussion about the difference between authentic and unauthentic physician listening. Future research also needs to address different requirements of listening for different patients, in terms of culture, class, educational status of patients; variations in medical specialization, and types of illnesses. Finally, research is needed to understand how listening education should be tailored to the different needs of undergraduate medical school training, graduate training and residency, and continuing medical education.

Acknowledgments

This project was supported by grants from the Montreal General Hospital Foundation and the Max Bell Foundation. Author JDB is grateful for financial support from the Arnold P. Gold Foundation.

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