Unhurried Conversations in Health Care Are More Important Than Ever: Identifying Key Communication Practices for Careful and Kind Care

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ABSTRACT

Unhurried conversations are necessary for careful and kind care that is responsive and responsible to both patients and clinicians. Adequate conceptual development is an important first step in being able to assess and measure this important domain of quality of care. In this article, we expand on a preliminary model to identify the key microlevel communication practices that support an unhurried conversation, defined as an ongoing, mutual accomplishment between patient and clinician that proceeds through a range of verbal and nonverbal communication practices wherein one or more participants (mutually) regulate the sequence, spacing (temporal and spatial), and speed of interaction to make themselves available to the other and remove or suspend distractions from the environment in order to improve care. We draw from the rich, qualitative descriptions found in earlier work that point to specific, observable practices in clinical encounters and identified empirical and theoretical work across a range of disciplines to expand our understanding of these practices. Ultimately, we identify and elaborate on 10 observable indicators of patient-clinician communication: engaging in shared turn taking, establishing rapport through discussion of off-task topics, pausing to allow the other ample time to speak, moderating the pace of spoken language, avoiding conversational interruptions, minimizing external interruptions, triaging topics as needed to create adequate time, expressing emotions, encouraging participation through inviting questions, and displaying open body language. These indicators work together to cocreate unhurried conversations.

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INTRODUCTION

Unhurried conversations[1] are a fulcrum around which effective health care operates, as they lead to careful and kind care that is responsive and responsible to both patients and clinicians.[2] Montori and colleagues[1] conceptualize unhurried conversations as a communicative practice cocreated by patients and clinicians and propose a model of its determinants and consequences. Our purpose here is to expand on their preliminary model to identify the key microlevel communication practices that support unhurried conversations.

IDENTIFYING KEY COMMUNICATION PRACTICES

We define an unhurried conversation as an ongoing, mutual accomplishment between patient and clinician that proceeds through a range of verbal and nonverbal communication practices wherein one or more participants (mutually) regulate the sequence, spacing (temporal and spatial), and speed of interaction to make themselves available to the other and remove or suspend distractions from the environment in order to improve care. Building on the rich, heuristic descriptions of unhurried conversations observed by Montori and colleagues[1] and relevant literature from communication, time studies, and shared decision making, our multidisciplinary team engaged in an iterative process to identify communication practices that influence the unhurriedness of consultations. This process involved a comprehensive literature review and 6 months of weekly deliberations.

We conducted broad searches on Google Scholar and PubMed for patient-clinician conversations and leveraged systematic reviews in medical and health communication disciplines to identify relevant studies, especially those incorporating

terms related to perceptions of consultation time (eg, "interruptions," "pauses," "time"). Over 6 months, our research team critically discussed and evaluated this multidisciplinary literature, including in relation to clinicians' lived experiences. This process led to the identification of 10 observable practices that, together, allow clinicians and patients to fully participate in cocreating an unhurried conversation: (1) engaging in shared turn-taking, (2) establishing rapport through discussion of off-task topics, (3) pausing to allow the other ample time to speak, (4) moderating the pace of spoken language, (5) avoiding conversational interruptions, (6) minimizing external interruptions, (7) triaging topics to create adequate time, (8) expressing emotions, (9) using inviting questions to encourage participation, and (10) displaying open body language.

It is crucial to note that although each of these practices has the potential to contribute to unhurried conversations, no single practice is adequate on its own. It is the collective engagement in all of these behaviors that shapes unhurriedness, and overemphasizing any specific behavior may not produce the experience of unhurriedness; for example, on its own, triaging is not a solution and can pose its own challenges. This is because each behavior has its own advantages and disadvantages. Rather, our goal is to highlight how, collectively, the 10 communication practices foster an environment conducive to unhurried conversations.

COMMUNICATION PRACTICES FOR UNHURRIED CONVERSATIONS

Shared Turn Taking

The issue of shared turn taking emerges in the literature at the intersection of rhythm and participation and is important to coconstructing an unhurried conversation. Montori[2] describes it as a dance, where the ratio of turn taking between the clinician and patient is negotiated so that both participants have equal speaking opportunities. Shared turn taking can be facilitated by using open-ended questions (elaborated later) and is coconstructed by participants.

Although turn taking is mutually negotiated, patients may rely on the clinician to extend a verbal or nonverbal invitation to participate in the conversation; as one focus group participant explained: "I mean, if my doctor had said to me, how do you feel about that … that would open up the possibility to say … is there anything else that can be done? ... But because that was not in the dialogue, I could not initiate something like that."[3] Patients also fear clinicians may view them as difficult if they assert themselves or ask too many questions. This issue occurs in a context where clinicians may be concerned that allowing patients to speak more will extend the visit with long monologues.[3] Nonetheless, a simulation study has suggested that patients actually tend to speak for a shorter time but offer useful contributions when allowed to share.[4] The same study also found both clinician and patient speak more as shared turn-taking behaviors increase.

Discussion of Off-Task Topics

Discussing topics unrelated to the medical problem during clinical encounters, called small talk, also supports an unhurried conversation. It is a communication strategy that helps to establish rapport, enhancing the depth of conversation.[5] Talking about light-hearted, off-task topics (eg, weather, hobbies) can help establish a natural conversational rhythm. Humor, used in about 6 out of 10 clinical encounters,[6] often accompanies this small talk. In unhurried conversations, this strategy allows participants to get to know each other outside of clinical roles.

Off-task talk can help reduce the experience of hurry, avoid depersonalization, and increase patient satisfaction.[7] Talking about non–health-related topics such as weekend plans or weather can make patients feel seen as individuals and not simply as patients.[7] In one study, mere seconds spent discussing off-task topics helped establish rapport during the history-taking phase of oncology consultations.[8] Such interactions reduce the experience of hurry and increase patient satisfaction with the length of the visit.

Use of Pauses

Unhurried conversations involve pauses and moments of silence. Initiated through a break in the conversation, pauses may naturally emerge in response to relevant conversational or cognitive demands.[9] For example, clinicians may be silent as they consider the best answer to a medical question. Additionally, in unhurried conversations, the patient is allowed to stop and reflect on medical news they receive. The collaborative flow of conversation allows participants to pause without being interrupted. Using pauses may help reduce the pace of the conversation and contribute to a sense of unhurriedness during consultations.

An observational study found that pauses created by the use of an electronic health record (EHR) in clinical settings were welcomed by patients as an opportunity to engage with the clinician: "…[electronic medical record] use appeared to slow down the medical interview, which perhaps gave patients more time to talk and ask questions about their illness."[10(p112)] These pauses facilitated patient participation. When clinicians pause to use the EHR, often turning away from the patient, it may reduce the performance anxiety patients sometimes feel due to perceived status differences between themselves and the clinician.[10] This reduction in pressure may help them regain a measure of comfort and personal agency that leads to more participation.

Although EHR use facilitated pauses and patient participation in this study,[10] it is important to acknowledge that it can also negatively impact patient-clinician communication if multitasking limits eye contact and divides attention.[11] To mitigate these effects and use the EHR constructively to introduce pauses, clinicians can turn toward patients while typing, maintain eye contact, and share their screens.[11,12] The strategic use of pauses, whether through EHR or other means, can enhance patient engagement and support unhurried conversations.

Moderation of Pace

Pacing refers to the number of words uttered per unit of time. Although unhurried conversations generally have a slower pace than hurried conversations, conversational pacing is rarely uniform. For instance, an unhurried conversation may begin with a patient excitedly sharing a positive health report and then gradually slowing the pace to discuss the implications. An unhurried pace therefore refers to a rhythm of conversation that allows both participants to speak without having to constrain their rhythm choices (to accelerate or decelerate) for reasons extraneous to care.

Classic communication research shows that speech rate, or speaking tempo, can influence perceptions of trustworthiness, honesty, and likeability.[13] Additionally, during conversations, speech rate convergence can promote mutual intelligibility and reduce uncertainty, particularly in initial conversations between strangers.[14,15] When speakers reciprocate each other's speech rate, it increases cooperation and comfort between them,[16] reflecting Montori's dance metaphor.[2]

Clinician-patient interactions are shaped by the same social norms. Clinicians who match the speech rate of their patients may reduce their dominance within the conversation, leading to a more reciprocal interaction.[17] Rather than a simple pleasantry or stylistic preference, reciprocity leads to better care. Patients reciprocate and become more comfortable during the visit when clinicians speak at a similar speed and volume as the patient. If clinicians speak at a faster tempo and simply recite medical information, patients may try to match their pace, hindering the patients' ability to ask clarifying questions or share additional concerns.[18]

Avoidance of Conversational Interruptions

Conversational interruptions prevent participants from completing their turn and disrupt the flow of conversation. This occurs when either the clinician or patient cuts off the other midsentence to change the topic. Research estimates that clinicians interrupt patients 77% of the time during their opening statements[19,20] and these interruptions occur after a median of only 11 seconds.[21] In contrast, in unhurried conversations, participants cocreate a shared rhythm that involves fewer conversational interruptions. Notably, not all interruptions are disruptive: highly trained clinicians interrupt to elicit more information while maintaining the conversational rhythm.[22] We thus emphasize *conversational* as a modifier of this type of interruption: by conversational interruption, we mean an utterance that disregards what the other is saying rather than one related to an interest in exploring it further.

A collaborative interested exchange supports unhurried conversations. In particular, cooperative interruptions are used to express support and understanding or to obtain more information through follow-up questions.[23] If well-timed, cooperative interruptions can improve communication quality between clinician and patient by aligning their agendas.[23] For example, when medical residents interrupt in a cooperative manner, patients report greater confidence in the residents' abilities and expertise compared with when residents interrupt to disrupt the flow of the conversation.[24] Because unhurried conversations are mutually negotiated, acknowledging patient interruptions also matters. When clinicians ignore patient interruptions, patients can leave feeling unimportant, resulting in a weakened relationship with their physician.[25] Instead, when patients interrupt clinicians to ask a question, the interruption can be used to promote a partnership-style relationship.[25] Unhurried conversations are thus shaped by an agreement to welcome each other's interruptions to ensure a productive conversation flow.

Minimization of External Interruptions

External interruptions refer to a person (eg, family members or staff entering the room unexpectedly) or an external event (eg, a technology problem or pop-up alert) that requires attention and disrupts the flow of the visit. Unhurried conversations are characterized by fewer, less severe external interruptions. In one study of outpatient surgical consultations, external interruptions occurred in 24% of 182 appointments.[26] These interruptions included telephone calls (22%), surgeons leaving the room (52%), and another person entering the room (26%). Although they do not lower patient satisfaction, external interruptions increase clinician stress levels and decrease clinician satisfaction with the visit.[27,28] This may be because external interruptions are often followed by more questions[26] and increased consultation length.[28] Ultimately, external interruptions interfere with the quality of communication and create an unfavorable environment for unhurried conversations.[29]

Triage of Topics

One approach to support an unhurried conversation is to delay addressing nonurgent topics to give more time to health concerns that require immediate attention. This approach is similar to triaging in emergency medical settings where the demand for services exceeds staff capacity. Beyond the emergency department, clinicians can adopt this approach when a demand-capacity mismatch arises. When faced with myriad topics relevant to a patient's care that compete for time and attention, clinicians can manage this competition by allocating more time to major topics and limiting the time spent on less central medical issues.[30] This strategy can keep the visit length about the same[30] and allow participants to maintain an unhurried rhythm of conversation. In contrast, addressing more topics with less time devoted to each topic may decrease key measures of the quality of care.[31]

We note that simply delaying topics can require more return visits and create a backlog of appointments.[32] A solution to this problem is clinicians taking the initiative to invite patients to jointly prioritize multiple topics, with follow-up on lower-priority issues managed by another care team member through telemedicine or a telephone call.[33,34] Additionally, asking agenda-setting questions such as "Do you have some other concerns you would like to discuss today?" early in the

conversation allows clinicians to address more topics without leading to a longer visit or a proliferation of new topics.[35] Ultimately, although delaying topics may be used strategically to enable an unhurried conversation, several other reasons support use of this practice (including managing emotional reactions),[9] so topic triage is only one part of a larger, holistic strategy in the shared accomplishment of an unhurried conversation.

Use of Open-Ended Questions

Questions that encourage participants to freely share information, elaborate answers, and increase knowledge are vital to an unhurried conversation. Patients and their caregivers often want to participate in their own health care decisions yet may require encouragement from physicians to feel invited to ask questions regarding procedures, treatments, or general health concerns.[36] A physician's asking of clarifying questions and encouraging patients to ask questions is therefore associated with improved health outcomes.[37,38] Patient satisfaction also increases when they can ask questions, describe problems from their viewpoint, and present concerns regarding treatments.[39]

Although one might assume this approach lengthens a visit, research suggests that uninterrupted patients often provide brief responses, typically less than 30 seconds, even to open-ended questions asked at the start of the consultation.[21,40,41] Additionally, physicians can use the time spent accessing the EHR during history taking to ask patients open-ended questions about psychosocial or informal topics (eg, hobbies, weather),[5,8] allowing them to develop rapport with the patients and potentially facilitating an experience of unhurriedness.

Expression of Emotion

Unhurried conversations are characterized by having the opportunity to passively and actively express emotions. Montori and colleagues[1] highlight the importance of being emotionally available to ensure full participation in an unhurried conversation. Research shows that clinicians' sharing of emotions with their patients builds rapport and enhances communication. For instance, eliciting questions about psychosocial topics increases patient responsiveness and expression of latent emotional health concerns.[42] Expressing empathy also reduces a patient's psychological distress without increasing demands on busy physicians.[43]

To manage the demands of a busy practice, physicians can conduct more focused conversations while also displaying emotionality to ensure patients feel heard and supported.[44] Through a warm demeanor and simple gestures such as compliments and small talk, they can positively impact a patient's mood and willingness to share health information.[44] Moreover, these changes do not necessarily take more time, as more information can be exchanged when patients feel comfortable expressing their concerns.[44] Together, these findings suggest that integrating emotional expression into visits enhances care and patient satisfaction.

Use of Open Body Language

Unhurried conversations are supported through open body language, which reflects embodied listening. These nonverbal communication behaviors help establish clinician presence, "a purposeful practice of awareness, focus, and attention with the intent to understand and connect with patients," that supports the mutual accomplishment of unhurried conversations and may help participants express emotions.[45] It is characterized by behaviors such as leaning forward, head nodding, sitting close together, and smiling.[46-48]

Open body language predicts patient satisfaction, patient participation, and clinician-patient collaboration.[49,50] These positive outcomes may be attributed to patients being more inclined to respond and speak freely when they feel clinicians direct their gaze and body toward them.[51,52] For instance, although we described previously how the pause created by EHR use can facilitate unhurried conversations,[10] clinicians' body language during this pause is also important for interaction. The appearance of being distracted through multitasking may cause concern. An analysis of videotaped rheumatologist–patient consultations revealed that patients use various gestures and linguistic strategies to redirect clinicians' gaze and attention.[51] Body language can thus be used to invite and support unhurried conversations.

CONCLUSIONS

Consistent with the practices we elaborate here, research on "time work" suggests unhurriedness is at the heart of what drives effective health care.[53] On the basis of participant observation and patient interviews about what constitutes a "good" clinical relationship, the strategic, agentic use of time emerges as central: a good relationship is one in which the clinician makes time for the interaction. As one patient explained,

> It's very important that you feel the doctor has time for you—and that you feel that you're allowed to be worried or scared so that he doesn't go like: "argh … I've looked at this a hundred times," but that there's room for you. The thing about not feeling that they have to hurry or that they are in a hurry. That they have time to figure out what to do about this, so that you are not seen as a patient but as a human being.[53(p151)]

Thus, the question throughout extant literature is not about whether (un)hurriedness matters: an entire body of literature suggests that it does. What had remained unsynthesized across disparate fields—what we have identified in this article—are the interrelated practices that clinicians and patients rely upon to coconstruct unhurried conversations.

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Key words: office visits; doctor-patient relationship; communication; time pressure; time perception compassion

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