Agenda Setting in the Outpatient Visit

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> *In preparing for battle I have always found that plans are useless, but planning is indispensable.*
>
> *—Dwight D. Eisenhower*

Learning Objectives:

1. Explain the importance of effective agenda-setting in the outpatient clinic
2. Identify potential barriers to effective agenda-setting
3. Demonstrate effective agenda-setting using the exhaustive "What else?" and negotiation of priorities at the outset of the encounter
4. Indicate in case presentations that they have performed effective agenda-setting

Primary Reference:

1. Baker LH, O'Connell D, Platt FW. Setting the agenda for the clinical interview. Annals of Internal Medicine. 2005;143(10): 766-70. http://www.annals.org/cgi/reprint/143/10/766.pdf

Included Resource:

1. 5-step patient-centered interviewing. Adapted by Fortin AH, Stein J from: Fortin AH 6th, Dwamena FC, Frankel RM, Smith RC. Smith's Patient Centered Interviewing: An Evidence-based Method. 3rd ed. New York: McGraw Hill, 2012.

CASE ONE:

You have just finished seeing a three year-old girl, Justa Minit, for what you suspect to be a simple viral URI, explained your assessment and plan, and said goodbye, when her mother, Owata, asks you to take a look at…

1. **What is the "Doorknob Complaint"? Describe an episode where this happened to you. Why do doorknob complaints happen, and what can be done to minimize them?**

Also known as the "late visit concern" (and some less complimentary names!), a doorknob complaint (DKC) is a significant or potentially serious concern brought up by the patient ("Oh, by the way doc…") as the health care provider has his/her hand on the doorknob to leave the room at the close of the visit. The concern may be too major to postpone to a subsequent visit.

Invite a few learners to share particularly illustrative anecdotes (supplement with your own if necessary).

DKCs can happen when a patient/parent is nervous or embarrassed about bringing up a concern, or has (unbeknownst to the provider) used up the visit time on minor/less important issues, or simply forgotten until the end. DKCs can be minimized (although not entirely eliminated) by: (a) careful agenda setting, generating and negotiating a mutual list of concerns at the visit outset (using provider-driven redirection to this task until completed) and (b) use of a patient-centered approach early in the interview, along with explicit empathy, in an effort to "jump-start" the provider-patient relationship and create a safer environment for discussing sensitive issues.

CASE TWO:

You've noticed that your junior colleague seems to spend forever on each clinic visit and is always running behind. When queried about this, she replies defensively that her patients have difficulty getting to clinic and frequently no-show. When they do come in, she feels obligated to "seize the day" and "take care of everything" while she has a "captive audience".

2. How many concerns does a typical pediatric patient or parent bring to an outpatient visit?

Most studies of patient agendas have focused on internal medicine or family practice settings, with an average of 2 to 3 concerns per visit, ranging up to 5 or more. Anecdotal experience suggests comparable agendas for pediatric patient/parent visits. Note that the provider may have some agenda items of his/her own in addition (e.g., addressing a flattening growth curve, a dysfunctional parenting technique, a sparse immunization record).

3. How can you respond to your junior colleague to help her become more efficient?

While provision of comprehensive care is our ultimate goal, it is simply not practical to aim to do this at every visit. First, doing so may overload the patient. Second, it may set us far behind, thus frustrating the patients who come afterwards on our schedules. (Not to mention frustrating us, our clinic staff, our colleagues and our friends/loved ones!)

Patients rarely protest the need to postpone some items in a busy agenda to a subsequent visit if (1) the importance of the patient/parent's concerns are validated (using explicit language to do so); (2) an honest attempt is made to deal expediently with the most pressing ones; and (3) this is all dealt with up-front, early in the visit.

Finally, with all due consideration for the logistical obstacles that our patients face, we need to ask them to shoulder some of the responsibility for care follow-through.

4. What other barriers/difficulties have you encountered in your attempts to set agendas for out-patient visits?

Canvass the group as in question 1 above.

Some participants may cite the perception that it is too time-consuming; point out that in a study by Marvel and colleagues, patients who were allowed to complete their opening "statement of concerns" took only 6 seconds longer than those who were prematurely redirected away from this; and that the substantial reduction in door-knob complaints saves time at the tail end.

Some participants may cite the fear that some patients/parents may just "keep on going" with a "positive review of systems." Point out that a large number of separate concerns is statistically less common, and when it does occur may have some diagnostic meaning in itself (e.g., may indicate parental anxiety/depression or a breakdown in coping).

5. What technique(s), if any, can you use to focus (or re-focus) your patients/parents on generating their list of concerns?

First, go around the room quickly to canvass the group on THEIR experiences.

Hopefully, the group's contributions will include things like:

- an explicit request for the "list" (e.g., "I'd like to get a "LIST" of all the things you were hoping we could focus on today");
- respectful interruption when patients digress, with explicit intent to return to earlier complaints (e.g., "That sounds important, and we'll get back to it very soon, but before we do, is there anything else you want us to work on today?")
- relentless inquiry into other concerns - the exhaustive 'what else?', until the "towel's wrung dry."
- some practitioners also encourage patients to bring a written list of their concerns to the visit. As pointed out by Olson, while these can appear intimidating at first, they can be very helpful in organizing the visit.

Practice exercise: In the process of answering this question, the moderator should consider extemporaneously "playing the role" of an imaginary patient/parent for the learners to demonstrate their techniques on, or delegate this role to a willing and able learner. The purpose is to encourage participants to try out and share different words or phrases for inviting and negotiating an agenda, and to prompt the group to problem-solve obstacles drawing on their own (and your!) experiences. Consider challenging a more senior learner with the scenario of a parent who has several significant concerns but tends to digress with a story about each concern as it is first introduced.

6. **ASSIGNMENT for learners: During your next patient care session begin each presentation to your preceptor with a 20-second description of the agenda you developed for the visit, and which concerns you deferred (if any).**

Example 1: "Ms. Jones was concerned about Johnny's recent respiratory symptoms, a recurrent rash, and toilet-training. We agreed to focus on the first 2 concerns today and the other in 2 weeks"

Example 2: "Mr. Smith was concerned with his daughter's chronic earaches, but then also mentioned that he thought she'd been fondled at school. We agreed to tackle the latter and save the earaches for a follow-up that's already scheduled next week.

Example 3: "Ronnie was brought for his 5-year well-child check today. There have been some concerns with his behavior at preschool. We agreed to complete his vaccinations and routine screenings today, and his mother is going to come back in 3 weeks when she has a babysitter for the other kids. Meanwhile, I asked her to sign permission for me to phone his teacher next week."

Additional References:

1. Olson KP. "Oh, by the way…": agenda setting in office visits. Family Practice Management. 2002;9(10): 63-4.
2. Lipkin M, et al. Performing the Interview. In Lipkin M, Putnam SM, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York: Springer, 1995. 68-71.
3. Marvel MK, et al. Soliciting the patient's agenda: have we improved? JAMA. 1999;281(3): 283-7.
4. Smith RC. Patient-Centered Interviewing: an Evidence-Based Method. 2nd ed. Philadelphia: Lippincott Williams & Wilkins, 2002. 317.
5. Silverman J, Kurtz S, Draper J. Initiating the Session. In Skills for Communicating with Patients. Abingdon, Oxon, U.K.: Radcliffe Medical Press Ltd, 1998. 23-7, 30-3.

Resource:

1. Institute for Family Centered Care. http://www.familycenteredcare.org/