LUND UNIVERSITY
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The Department of Clinical Sciences in Malmö

Master Thesis in Medicine, 18 May 2012

Good Communication within the Medical Consultation

A qualitative study of patients' and physicians' experiences.

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POPULÄRVETENSKAPLIG SAMMANFATTNING

Det goda samtalet mellan läkare och patient (GS) har många positiva effekter. Tidigare studier har visat att läkarbesöken blir mer effektiva, att såväl läkare som patienter känner sig mer nöjda, att patienterna följer läkarens ordinationer i större utsträckning och blir friskare. Samhället är i ständig förändring liksom den medicinska vetenskapen och vad som anses vara GS. Denna studie eftersträvar att skapa en ny förståelse för vad patienter respektive läkare upplever som GS; vidare att undersöka vilka faktorer som bidrar till uppkomsten av GS samt hur GS kan möjliggöras inom ramen för dagens sjukvård.

För att skapa en förståelse för patienters och läkares upplevelse av vad som utgör GS, intervjuades nio patienter och tio läkare. De ljudinspelade intervjuerna skrevs ut och analyserades därefter. Resultatet från analysen visade att både patienter och läkare använder gemensamma termer för att beskriva GS; och vidare att det gemensamt Goda Samtalet (gGS) möjliggörs i de fall där patienternas uppfattning om GS överensstämmer med läkarnas uppfattning. gGS omfattar även patientens förfrågan, det problem som patienten önskar få hjälp med, samt läkarens tjänst, den lösning som läkaren kan bidra med. Patientens förfrågan består av tre olika foci, vilka motsvaras av tre olika foci för läkarens tjänst. I det enskilda samtalet kan ett fokus dominera, men flera fokus kan även samexistera och därmed ges olika stort utrymme i samtalet. Konsultationens dominerande fokus är situationsberoende och kan variera med läkarens och patientens personligheter samt med det medicinska tillståndet. När patientens mest framträdande förfrågan stämmer överens med läkarens motsvarande tjänst uppstår en allians mellan parterna och gGS skapas.

Vidare har de gemensamma termerna olika betydelse beroende på fokus, vilket indikerar en komplexitet i ordens innebörd och följaktligen i beskrivningen av GS. Istället för att använda sig av en given, okomplicerad samtalsmall är det önskvärt att läkare, oavsett tjänstefokus, inser denna komplexitet. Läkarna kan då börja förstå och möta patienter med olika förfrågansfokus varvid gGS kan skapas i varje enskild konsultation. Sammanfattningsvis ger det positiva effekter för läkare och patienter samt för sjukvårdssystemet i stort.

ABSTRACT

Background: Previous studies have shown the importance of good communication (GC) within the medical encounter; with patients' increased adherence and improved health, more effective consultations and more satisfied patients and physicians. Since society and the concept of GC have evolved over time it is important to continue the research on the characteristics of GC.

Objective: To explore how GC is made possible within the medical encounter, in relation to what physicians and patients experience as good communication.

Methods: Qualitative semi structured interviews of 10 physicians and 9 patients were conducted to enlighten the participants' experiences of GC. A phenomenological method of analysis was used to interpret the transcribed material.

Results: The patients and the physicians respectively described GC with common themes. When the respective themes correspond, the Common Good Communication (cGC) is made possible. Further, cGC is established when the patients' requests, the "problem" that they bring to the consultation, correspond with the physicians' service, their "solution". The requests and services are constituted of three focuses. The focuses can simultaneously be present in the individual consultation and co-exist in various extents. When the patient's main request coincide with the corresponding service of the physician, an alliance of shared understanding arises and cGC is made possible. Further, certain of the common themes differed in meaning due to the different focuses; indicating a complexity of the word's meaning and consequently, of GC.

Conclusion: The main focuses depend on the medical condition, situation and the patient's and physician's personalities. However, it is desirable that physicians avoid a given and simple template of communication; and instead understand the complexity of GC and the whole spectrum of meaning of the terms that describe it. Only then, the physicians can begin to fully understand their patients with their different focuses of requests. The physicians can additionally adopt a meta-perspective, which embraces strategies from all three of the physicians' focus of service. This enables the physicians to meet the individual patients in their requests and establish cGC in every day practice; with positive effects for physicians, patients and the medical care system.

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INTRODUCTION

The communication between physicians and patients is in many aspects considered important within western medicine. The patient's medical history is the basis of the physician's medical work (1). Good communication skills can shorten time to diagnosis, thereby reducing both patient morbidity and mortality (2). The communication is likewise relevant to how much the patients tell their physicians, thus how much medical information the patients provide their physician with (3).

The communication between the physician and the patient is of great importance for their relationship and how satisfied both parties are with the consultation (4). It also affects how pleased the patients are with their hospital stay in general (5). Patients who are pleased with their physicians' behaviour and communication skills are less likely to change physicians, cancel visits (6), report to authorities or alternatively sue their physician (1, 6). A good communication between patients and physicians affects the patients' mental health (7), their perception of their illness (4), how they accept different options of medical treatment (6), how well they follow the physician's ordinations (1, 8-10), and ultimately how well the disease is controlled and how well they are recovering (1).

Furthermore, a number of studies have been able to show increased self-esteem and well-being after good communication between the patient and the physician (1, 7). This has been considered to add to the therapeutic effect (11, 12) and sometimes this can be as effective as medication in a longer perspective (1). Good communication between physicians and patients shortens the total time of the medical consultation (6, 13), require fewer re-visits (1, 6) and may even reduce the number of unnecessary prescriptions for antibiotics (14).

As modern society has changed, health- and medical science have transformed. The view of the physician-patient relationship and what is considered good communication also have changed (15, 16). It has shifted from a paternalistic to a more patient-centred approach and way of working (16-18), principally through the 1940's-1950's psychodynamic interpretations of medical communication in Balint groups (19) and attempts to implement the holistic outlook in the medical care (20). Patients of today have other standards of care, which largely makes the physicians face new challenges (21-24). The patients expect the physicians to have certain characteristics, attitudes and abilities (25-27). This includes an empathic

approach (28-31), that the physician not only understands the medical problem but also understands the patient as a person (32-35), provides an adequate exchange of information (36-38), proves to be trustworthy (39, 40) and to be able to apply patient-centred care (17, 18, 37), as well as applying evidence-based medicine on the individual (41). However, there is a lack in previous research of a parallel perspective of what patients and physicians experience as good communication (42).

In summary, there are many benefits of implementing a favourable physician-patient communication. What is regarded as good physician-patient communication has changed over the decades as the society has evolved and there are no reasons to believe that this will not continue to change. Since good communication affects physicians, patients and health services in general, it is important to explore what good communication is in the modern society of today and the factors that affect the character of good communication; taking the parallel perspective of both parties into account.

The aims of this study were:

(I) To explore what physicians and patients consider as the good communication within the medical encounter.

(II) Which properties and characteristics in the communication each party considers important and by that

(III) How good communication according to both parties can be made possible.

METHODS

A qualitative approach based on phenomenological epistemology (43, 44) was used to explore the aim of this study; what the good communication (GC) mean to physicians and patients, respectively and further, how good communication is made possible within the medical consultation. The study was conducted in the region of Skåne, southern Sweden.

Participants

Physicians

A strategic selection was made among the physicians in the region with regard to gender, ethnicity, age and specialty (Table 1), since these variables have been shown to affect the outcome of the consultation (1, 45, 46). Eleven physicians were asked to participate in the study, one declined because of lack of time, thus 10 interviews were held.

Patients

Each interviewed physician was asked to enlist 1-2 patients, who would be entered in the study. To be included, the patient had to be 18 years old or older and without any need of a third party, e.g. interpreter, parent or supervisor. Age, gender, ethnicity, diagnosis and education have been shown to affect the consultation (1, 39, 46-49) and were therefore taken into account as the selection process advanced. In total, 9 patients were asked to, and all agreed to participate in the study (Table 1).

Interviews

Qualitative semi structural life world interviews (43, 44) were held with the intention to explore the physicians' and patients' experiences and understanding of GC. An interview guide was created for each group (Appendix 1). The questions were constructed to give a reflective view of the participants' experiences and understanding of the phenomenon GC. Interviewing techniques, according to Kvale (44) and Malterud (43) were used. A total of 10 physicians and 9 patients were interviewed. The number differed because enough information was gathered to answer the objective after 9 patient interviews but not until after 10 physician interviews.

Information about the project was sent to the participants and a written consent was contained before the interview. The interviews took place at the office of the participants or at the office

of the interviewers and were carried out by both the authors, in every second interview acting as main interviewer and in every second as complementary interviewer and observer; all this to make sure that the topics were fully discussed. The interviews took between 27 and 62 minutes, and were brought to an end when the participants had discussed the topics of the interview guide. The participants were also encouraged to share their experience of a good medical consultation. The participants discussed the topics in various speed and extent due to different experiences and personalities; hence, the time of the interviews differed. The interviews were recorded on audiotape and transcribed by the main interviewer and were proofread by the observer. The interviews or the parts that were particularly difficult to transcribe were done by both authors. The transcribed material was read continuously to find the point where no new material was found in the interviews and enough information had been gathered to answer the objective.

Analysis

Systematic Text Condensation (43) was carried out to analyse the material (Table 2). The method originates from the phenomenological tradition with the ability to create a horizontal, descriptive analysis to develop new concepts or descriptions of a phenomenon, in this case the good communication. The interviews of the physicians and the patients were analysed in two separate groups and a test-analysis for each group was conducted as 4-5 interviews had been held. This was done to conclude if the method and the interview guide responded to the objective of the study. When all 19 interviews had been held, the main analysis was carried out for each group to overview the life world (43, 44, 50) of the respective group. Further, the results were compared to explore if the two parties could meet in a common good communication.

Ethics

An ethical application was submitted to The Regional Scientific Ethics Committee of Lund. The committee did not find the study under the provision of Swedish law according to studies on human beings. Consequently, the committee did not find any ethical obstacles for the study to be carried out (Registration number: 2011/735). The participants were informed about the study and gave their written informed consents. They participated anonymously. The authors have no financial disclosures. No present or future ethical inconveniences are to be expected.

RESULTS

The analysis showed common themes of what constitutes the good communication (GC) for physicians and patients, respectively. When the respective themes corresponded, the common Good Communication (cGC) was made possible. Further, the patients' common themes entailed a request, what the patients brought to the consultation as their "problem". The physicians' common themes entailed a service, what the physicians brought to the consultation as their "solution". In addition the analysis demonstrated three different focuses of the patient's request (Table 3), which we have chosen to name: 1. disease, 2. emotional experience and 3. existential meaning. Three different focuses of the physician's service (Table 4), which we have chosen to name: 1. to cure, 2. to comfort and 3. to heal. These three respective focuses can be seen as parts of the individual consultation and co-exist in various extents; however in the individual consultation one of the focuses can dominate and make the consultation take a certain path. The focus that dominates the consultation can arise from a certain situation, the patient's expectation on medical care, the physician's preferred way of working or their personalities. The analysis further demonstrated that, the way that the patient's and the physician's focuses met in the consultation, determined if a good communication between the physician and the patient was possible. Certain common themes had different meanings for the patients and physicians depending on their focuses; implicating that the meaning of words is complex and varying (Table 5, 6). The results below display the patient's and the physician's different focuses and are based on the analysis.

Patients

The common themes for the patient's experience of the Good Communication (pt-GC)

The patients described that pt-GC evoke positive feelings within themselves. To describe their mode after pt-GC the patients used words like riddance and satisfaction, happy and pleased. Four patients used the concept of "chemistry" to identify what they experience in pt-GC. They found it difficult to describe this concept further but meant that they shared their story more easily if the "chemistry" was right. All the patients, except one considered being able to share their stories as an important part of pt-GC.

Furthermore, the patients expected to be met with respect by a helpful physician who listened to their problem and took their story seriously. The patients felt that the physician listened to

them when the physician kept eye contact, nodded encouragingly, listened to the patient's whole story without interrupting, gave the patient the opportunity to ask questions and also asked the patient questions on what the physician had heard. The patients stressed the importance of the physician to be mentally present in pt-GC. They expected their physician to have total focus on their patient, even when the physician was under stress or had run out of time. Finally the patients indicated that shared understanding in the consultation was important in order for the experience of pt-GC.

The meaning of certain common themes: *trust, to be heard* and *to be seen as an equal,* differed to some extent in the different focuses of request (Table 5). The patients commonly considered these themes important, since they contributed to an open atmosphere where the patients felt "safe" enough to share their story with the physician. When the physicians gave the impression of being well prepared, e.g. by showing that they had read the patient's medical record, the patients found the physician trustworthy. Another aspect that created *trust* within the consultation was continuity in the relationship between the physician and the patient. The patients described that this created a feeling of being "safe" within the relationship. *To be heard* meant that the physician attentively listened to what the patient had to say. The patients pointed out an imbalance in power between physician and patient, where they considered the physician to have more power than the patient. It was important for the patients *to be seen as an equal* within the consultation. Ways to balance the relationship could be when the physician used a manner of speaking that could be understood by the patient or when the physician made room in the consultation for the patient to take part.

1. Patient's Focus on Disease (FoD)

The "problem" the patient brings to the consultation in the focus of disease (FoD) is the disease. Therefore the ideal consultation will focus on the disease. The patients expected the physician to cure them and wished to leave the consultation with some kind of answer or treatment plan for the future, the patients stressed the importance of a deeper medical understanding for their condition. The physician's role in the pt-GC with FoD is therefore to come up with a medical solution and a plan for the future. In order to achieve this, the physician had to be well prepared by having read the patient's medical record and by having a deep medical knowledge.

The physician had to ask the patient questions during the consultation and further to make room in the consultation for the patient's medical story and questions. All this is to acquire enough information to generate a medical answer. The physician had to be honest and clear about the patient's medical condition and the answer must be described to the patient in an understandable manner. When the patients felt that the physician had enough medical knowledge to come up with an understandable answer to their medical condition, *trust* was established within FoD.

To be heard within FoD meant that the patients felt that their story counted as a reliable source of information, the physicians took their medical story into account when making their medical decision. The patients within FoD pointed out the difference in medical knowledge between patient and physician to be the factor that established the difference in power between the parties. The patients delineated that they can contribute to the goal of being cured by asking questions during the consultation, which helps them to sort out the parts which seem unclear to them. In addition, to tell the physician everything they know about their condition and prepare themselves before the consultation. The preparations varied from writing down questions about their condition or being in good time to the consultation, to doing medical research e.g. on the internet. The preparation helped the patients to better understand the medical aspects of their diseases, but also contributed to a more *equal* atmosphere within the consultation.

2. Focus on Emotional Experience (FoEE)

The "problem" the patient brings to the consultation in the focus of experience (FoEE) is the emotional experience. Therefore, the ideal consultation would also focus on their emotional experience. The patients stressed the importance of being seen, understood and taken seriously in their emotional experience of being ill. If this happened, the consultation was considered good.

In the FoEE, the patients shared their story of emotional experience of being ill, their thoughts and worries about their condition. One patient described that it can be hard to share ones inner thoughts with a physician, but wished that the physician asks questions to make it possible and easier to tell the story. To be able to do so, the patients expected their physician to make room in the consultation for their story of experience and furthermore, to listen carefully and with respect to it. Consequently, they felt that they *had been heard*.

The patients expected the physician to confirm them in their experience of being ill and support them in their feelings about their condition. The patients with a FoEE upon pt-GC meant that this sharing process helped them to handle their feelings about their condition. On the other hand some patients in FoEE did not want their physician to become their therapist. The role of the physician was to identify when the patient needed support and comfort, to listen to and to encourage the patient and to send the patient to a psychologist if therapeutic help was needed. *Trust* within FoEE arose when the patients felt that they had been understood in their experience of being ill.

In the FoEE it is desirable to make the patients' sharing of their emotional experience easier by evening the imbalance of power between physician and patient. The patient felt *seen as an equal* when the physicians showed interest in the patient and listened to what the patient had to say.

3. Focus on Existential Meaning (FoEM)

The "problem" the patients bring to the consultation in the Focus of Existential Meaning (FoEM) is the ways they look upon themselves. In FoEM the patients realize that some conditions cannot be cured and that the patient therefore needs to find new approaches to deal with their condition. Thus, the ideal consultation would focus on the patient, who in the dialogue with the physician becomes a person beyond the medical conditions. *Trust* can only arise when physicians look upon their patients as individuals, neither as diseases nor as biological phenomena. The physicians listened to the knowledge the patients brought to the consultation and saw the patients as "whole persons", beyond their medical condition, the patients then felt they *had been heard*.

Especially the patients with a more long-term or a chronic condition described how the physician in GC could help them to look upon themselves in a new manner. These patients appreciated when the consultation dealt with other subjects than the strictly medical aspects of their disease, since this enabled them to be seen in their whole complexity. This was a process within the patient to reach new insights about how to handle their everyday life, to find an existential meaning, e.g. to see the meaning of the small things in life, to be present here and now, to find hope or something to look forward to. The patients thought that the physician could help them in this process by finding these new approaches. If this happened the consultation was considered good.

The consultation could also make the patient feel healthier and help them look upon themselves from a new perspective. One patient described that the physician knew the patient's whole family and that this contributed to that the patient became "something more, I became John [the patient]". Another patient described how it lies within the concept "to be seen as a person" that the physician makes the patient get a deeper sense of understanding for the disease and the whole situation.

Furthermore, patients with FoEM on pt-GC meant that they have a different understanding of their condition than their physician and that they can contribute with their own expertise of what it means to them as persons to live with this condition. In FoEM the patient contributes with their own experience to find solutions and new approaches to the condition, alone or together with their physician. Some patients thought they to some extent became their own physicians. The patients in FoEM contributed to the consultation with their expertise on what it meant to them as persons to live with their condition, something the physician could not have any knowledge about. This way of sharing knowledge made the consultation more *equal*. One patient described it as a feeling of becoming the physician's colleague during the consultation.

Physicians

The common themes for the physicians experience of "the Good Communication" (ph-GC)

The positive effects of good communication were many, according to the physicians. The majority said that they enjoyed and felt more satisfied with their work after ph-GC. Some physicians believed that only after ph-GC, they could fully disconnect their minds from work when they got home. Two physicians thought their way of communicating with their patients had "saved" them from reports to authorities.

Several physicians felt safer with their medical diagnostic and choice of treatment after ph-GC. One physician pointed out that the patients more often got in touch with the physician after ph-GC if a medical problem arose. "They know there is someone who is willing to listen to [them]." Another physician said that a patient's story could increase the physician's interest in developing new treatments, and that a good meeting could serve as a driving force in the physician's medical research career. Several physicians talked about the positive feeling when the patients had confidence to open up in the consultation and that is why one physician

felt great gratitude for being able to practice medicine. Many physicians claimed that they also could learn a great deal from the patients.

When the physicians talked about what constitutes a good communication three different focuses of the physician's service emerged in the interviews. Overall the physicians used the same themes to describe ph-GC, although the meaning of certain themes differed in the different focuses (Table 6). For the physicians ph-GC was to get a good "connection" with the patient, that the patient could open up during the consultation and that both parties felt satisfied. The physicians stressed the importance of "taking the patient seriously" and to respect the patient. Moreover, *preparing* for the consultation and being *present* in the consultation and further reaching a mutual *understanding*. The physicians showed respect for the patient by introducing themselves properly, by shaking hands with the patient, being and even sitting on the same level as the patient, allowing the patient to ask questions and letting the patient speak without interruptions. In order to get the patient to open up, the physician treated the patient respectfully, asked the patient questions and listened with interest to the answers.

The presence in the consultation was signalled by the physicians by not allowing interruptions by a phone call, other people or other things in the room such as a computer. They turned on the "red light", asked not to be disturbed and switched off the telephone. They kept eye-contact with the patient instead of looking at the computer or in the patient's medical record. These signals showed that the patient and the consultation are important to the physician. Each focus contained different explanations to the themes above, which are specified below.

1. Focus to Cure (FtC)

This focus centres the disease and the overall purpose of the consultation, which is to make the patient well. The "solution" the physicians bring to the consultation is therefore the ability to cure. Some physicians may feel a huge personal responsibility to cure the patient and look upon themselves as the patient's "last hope".

To be able to cure the patient, the physicians must *understand* the disease and use their medical knowledge to treat the condition. In FtC the physicians considered it their task to diagnose the patient, to offer evidence-based treatment and to inform the patients about their disease and treatment and further to answer the patients' medical questions. Hence, the physicians would focus on mapping out the disease, the patient's thoughts about it and the

expectations on the treatment during the consultation. The patients are an important source of information. Consequently, ph-GC in FtC is partially used by the physician to get as much medical information as possible from the patient. The physicians pointed out that if they show interest in the patient's narrative about the disease, the patients feel genuinely relaxed and want to open up to their physician; more information is shared and the curing ideal is more easily achieved.

The individual consultation should be prepared by physicians reading the medical record with a strict focus on the details of the disease. This medical history can be used to quickly define the patient's current problems, diagnose the disease, guide the conversation to a higher extent and possibly confront the patient if the patient's own story would be different from medical record entries. One of the physicians also believed that a thorough preparation means that the physician easier can answer the patient's questions about the course of the disease and the treatment. Therefore the FtC's overall *preparation* involves the acquisition of new medical knowledge, e.g. through research.

The physicians thought that they, as physicians, have knowledge and understanding of the disease and treatment that the patients cannot have. Their task is therefore to inform the patient in an understandable way. The extent of the information may vary from printed information about the disease and treatment, to drawings or direct admonitions. This means that they are able to inform and answer the patient's questions in an accurate and understandable manner.

When the physicians with this focus talked about *presence* in the conversation, it meant to actively focus on the patient's medical history instead of letting their thoughts run on. Some physicians believed that the presence makes the patient feel important and taken seriously in their medical problem; others argued that it is impossible to cure unless they have understood the extent of the disease first.

2. Focus to Comfort (FtCo)

This focus centres the patient in the conversation and one of the overall aims in the consultation is to understand, to "reach" the patient and to respond to the patient's emotional experience about the disease. The "solution" the physicians bring to the consultation is the ability to comfort the patient. This means to *understand* the problem and the patient's feelings and thoughts about it and to confirm the patient in this. The physicians immerse themselves

and identify the patient's conscious thoughts and feelings about their experience of the disease.

The patient's role is to contribute to the conversation with this information i.e. to be open about their feelings. Irrespective of focus, the physicians believed that the patients may have an agenda which is "hidden" from the physician e.g. other problems, more or less conscious, than the problems they originally sought medical care for. The physicians with FtCo believed that it is their task to draw attention to the patient's hidden agenda, their concerns and expectations. This means that they are able to better understand the patient. Many of the physicians also believed that negative feelings about the disease can make the patient feel worse. By identifying those negative feelings the physicians can respond to and relieve the patient's problems. The physicians therefore meant that it is their duty to somehow confirm the patients in their emotional experiences; "I understand your concern". One physician thought that physicians can "use themselves as a drug" and make the patient feel better just by confirming the patient's experiences. In this way physicians can make a big difference to their patients, "much bigger than we think".

To understand the extent of the problem, it seemed important that the patients feel "safe" in the conversation to be able to open up and in an honest way talk about their experiences and feelings. The understanding of the patient is facilitated if the physician is *prepared* for the individual consultation having read the patient's medical record. Some physicians expressed that they can "see various difficulties 'between the lines'"; during the actual consultation that can help the physician to be more attentive to the signals that the patient sends out. The physician can also actively help the patient to talk about these difficulties. One physician emphasized the importance of the general preparation for the consultations. This physician videotaped some consultations and discussed cases in so-called Balint groups. Both optioned an opportunity to reflect on the physician's work and thus develop a more professional approach.

Additional ways to understand the patients' problems were a range from straight questions about the patient's concerns to *presence* in the consultation through active listening to what the patient conveyed "between the lines". Finally, the physician would confirm the patients in their emotional experience of the disease, both verbally and non-verbally. This may involve to compliment the patient e.g. for their clothing or to acknowledge that the patient had a difficult time. All this, was done to show that the patient is more than a "walking disease."

3. Focus to Heal (FtH)

This focus centres the human being in the consultation and one of its overall purposes is that "something happens in the patient", that the patients feel deeply looked after and existentially seen as human beings. The "solution" that the physicians bring to the consultation is the ability to heal the patient in an existential meaning. The process of healing contains two steps: the understanding and the coping. Patients who have been healed leave a medical appointment with a sense of hope or thoughts about how they can improve their lives in a wider extent than in the purely medical way.

That means that the physicians have to understand or get a sense of who the persons they meet are, how these persons relate to themselves and their existential thoughts. In FtH the physicians meant that their role is to *understand* who the patient is, to see the "big picture", whether the patients are receptive to a discussion and lastly help the patients to relate to themselves in a different way; including that the physician can get involved in problems that for the physician as a professional may be impossible to change and may not be related to the patient's disease or to the emotional experience of the disease. The physician and patient "meet in earnest", as human beings beyond the professional role and disease. This required that the physician was mentally present during the consultation. The physicians believed that the *presence* partly depended on how the physician perceived the patient's signals or expressions, details in the body language which were unconsciously detected or consciously noted in the other person, including spontaneous smiles and eye contact. These signals and the patient's story and questions contributed to a different kind of listening. One physician called it a "dynamic listening" in which the physician is ideally capable of understanding and empathically enter the patient's world.

The patient's role is therefore to set the agenda of the consultation and decide which problems to deal with. Some physicians thought that one of the most important roles of the patient is to serve as its own cure; the patients may very well find approaches and solutions to problems within themselves. Thus the physicians find by themselves or together with the patient an existential solution and a way to deal with the patient's thoughts. Since both patients and physicians relate differently to themselves and their existential thoughts, the consultation will have a unique character. Some physicians believed that time can be seen through a qualitative perspective, that the presence alone makes the consultation effective, while others believe that

presence can be time consuming “those in need of more time will get it” and therefore may be running late in their consulting hours, “the others will have to wait”.

To fully understand the patients, one of the physicians stressed that structured interviews according to a given template are not working. The path towards the healing focus is a long and on-going process that requires mental *preparation*. For this particular physician, the process had led to multiple professional crises, which ultimately had changed the physician’s approach to the role as a physician and to the patients. The mental preparation for this type of consultation may include therapy, meditation or reading books that gives the physician a personal insight. Patients may evoke feelings within the physician that the physicians do not want to feel inside, as anxiety, anger or discomfort. These feelings can make the physicians judge the patients as inferior and push them away. If the physicians already have confronted themselves with these feelings through mental preparation, it is easier to focus on the other person and remain open to the patient. Thus, the physician’s insight is required in order not to project the physician’s own problems to the patient.

The common Good Communication (cGC)

To conclude, the analysis showed: common themes, the patient’s request and physician’s service. When the patient’s request meets the physician’s service there might be a match, an alliance, or a mismatch, a break. Further, the analysis showed that in order for an alliance to arise, the “problem” that the patient brings to the consultation, has to match the “solution” that the physician brings (Figure 1). Consequently, alliance arises when Focus on Disease (FoD) meets Focus to Cure (FtC), when Focus on Emotional Experience (FoEE) meets Focus to Comfort (FtCo), when Focus on Existential Meaning (FoEM) meets Focus to Heal (FtH). The alliance makes cGC possible. A break arises when the patient brings a “problem” that the physician cannot “solve”. One physician described a consultation where the patient sought medical care because of high blood pressure. The physician measured the blood pressure and assured the patient that it was fine. However the patient experienced a mortal dread (FoEM) and therefore was not satisfied with the “solution” that the physician brought (FtC).

In summary, cGC is made possible when the respective themes correspond or when there is an alliance between the physician and the patient. This alliance develops when the patient’s focus of request corresponds with the physician’s focus of service.

DISCUSSION

Our results demonstrated different aspects of Good Communication (GC), where the main findings are presented below.

The results presented common themes within the medical consultation for patients and physicians, respectively. The common Good Communication (cGC) is made possible when these common themes correspond. The patients and physicians describe what happens in cGC with the words “chemistry” and “connection”. Both parties mean that in cGC the physician is respectful and takes the patient seriously, e.g. by asking questions, by listening to the patient’s story, and by letting the patient ask questions. In cGC the patient is important, opens up and shares information with the physician, they reach shared understanding. Finally, cGC evokes positive feelings and both physicians and patients feel satisfaction and well-being after the consultation.

Another interesting finding is that the consultation can be described with the patient’s request, what the patients bring to the consultation as their “problem” and the physician’s service, what the physicians bring to the consultation as their “solution”. The patient’s request contains three different focuses: 1. disease, 2. emotional experience, 3. existential meaning. The physician’s service contained three corresponding focuses: 1. to cure, 2. to comfort, 3. to heal. These three focuses can be seen as parts of the individual consultation and co-exist in various extents. Thus in the individual consultation both parties can bring up more than one focus and there might be room for all three focuses, however one of the focuses can dominate and make the consultation take a certain path. The consultation might concentrate on one of these focuses due to a certain situation, the physician’s preferred way of working or the patient’s expectations. These focuses also show that certain common themes differ in meaning depending on focus; this gives the consultation a complexity, which is not evident at first.

A third finding is that an alliance arises when the patient’s focus meets the corresponding focus of the physician. Thus, the “problem” that the patient brings to the consultation, has to match the “solution” that the physician brings. This alliance makes cGC possible. If the patient’s focus of request does not correspond to the physician’s focus of service, the “problem” cannot be “solved” and a break arises. Therefore neither the alliance, nor cGC arises within the consultation.

Several findings are noteworthy and have important implications for future research and clinical practice. First, the physicians and patients show common themes for GC. These findings are consistent with other studies indicating the importance of listening to the patient and making the patients more active through their questions (21, 49, 51, 52) and shared understanding (31, 53).

A second important finding in this study is the importance of a shared focus for the consultation, the alliance. The alliance has been reported in other studies (42, 54-56), however, this study contributes with an expanding of the meaning of this alliance, by introducing the different focuses of request and service that contributes to the shared task and goal of the consultation.

This study has several limitations. First, the used method originates from humanistic science while this article is written in a medical format with a limited ability to demonstrate the qualitative results; by a maximum of words favourable of a result that can be represented by quantitative science through statistical numbers. The limited space therefore makes the clarification of the human experience and understanding of a phenomenon less dynamic and weakens the qualitative approach of this study. The qualitative ambition to contribute with a new way of understanding the phenomenon of GC is therefore limited. The interviews were held and transcribed in Swedish, while the article is written in English. The article is faithful to the transcribed material; however, when material is translated there is an unavoidable decline in information.

Secondly, the authors are schooled within a medical paradigm where a concept of GC to some extent is established already. Therefore, the authors have looked upon the patients and the physicians as two separated groups, with separated experiences and understandings of GC; implicitly, that the experiences of GC are shared within the respective groups. The aim of the study is formulated as to explore the meaning of GC to physician and patient, respectively. The results demonstrate common themes, but in addition and contrary to expectations, three different focuses within the respective groups are presented (disease/cure, emotional experience/comfort, existential meaning/heal).

As a consequence of this medical paradigm the physicians primarily participated in the interview as professionals; with a theoretical understanding of the concept of GC. To avoid this problem with the physicians sharing a theoretical framework, and to get a deeper

understanding of their actual experiences of GC, they were encouraged to exemplify their experiences and share their feelings about GC. The patients participated as persons with an experience of their medical condition and the medical health care system. They shared their experiences and feelings easier; however the patients did not look upon GC as a separate phenomenon, but rather as an integrated part of the whole health care system. As a consequence of this the patients might have looked upon the interviewers as a part of the established medical system. To make sure that the patients fully shared their experiences, the written consent declared the interviewers impartial position as medical students and researchers. Future research should include patients' experiences of healthcare and to what extent their experiences of healthcare as a system affect the communication with their physician.

A strategic selection has been made to ensure the variability of the data, although the inclusion of cultural background, "country of birth" was narrow and did not include all the aspects of cultural differences. Therefore the variability of this aspect could be questioned and preferably be taken into consideration in future research.

One strength of this study is the methodological consistency. This generates high scientific quality. Further, the results are more dynamic and informative because of two authors interviewing, transcribing and analysing the material.

This study has shown a new way of looking upon the phenomena GC, quantitative studies should investigate the generalizability of this model. Future research could also include the questions concerning whether the different focuses of request and service correspond to a certain group of patients or physicians considering gender, age, cultural background and diagnosis or specialty. In addition, it could focus on to what degree the patient and the physician are responsible for the alliance to arise.

Conclusion

The Good Communication (GC) can be described through common themes for patients and physicians, respectively, and when these coincide the common Good Communication (cGC) can arise. This entailed the patient's request and the physician's service, which had to correspond in order for an alliance and cGC to arise. The different focuses use the same terms to describe GC; however these terms differ in meaning. To conclude, communication and meaning of words are complex. This complexity is important to bring out when talking about

communication either in professional or in educational contexts. Hence, it is desirable that physicians avoid a given and simple template of communication; and instead understand the complexity of GC and the whole spectrum of meaning of the terms that describe it. Only then, the physicians can begin to fully understand the patients with their different focuses of requests. The physicians can additionally adopt a meta-perspective, which embraces strategies from all three of the physicians' focus of service. This enables the physicians to meet the individual patients in their requests and establish the cGC in every day practice.

If the practicing physician accomplishes cGC in the individual medical encounter, this will contribute to what has been shown in previous studies: the patients' increased adherence and improved health, as well as the well-being and satisfaction of both parties. It could also help the medical care system to be more effective through shorter consultations, fewer re-visits and unnecessary prescriptions.

Our research has shown a new way of understanding the phenomenon GC within the medical encounter. This not only has implications for professional development and medical education, but also for academic research. Since society and the concept of GC are ever evolving processes, it is important with continuous research and incorporation of new research into the education and profession.

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TABLES AND FIGURE

Tables

Table 1. Demography of Participants.

Variables	Physicians	Patients
Gender		
Male	5	4
Female	5	5
Age		
20- 40	3	4
40-60	3	3
60-80	4	2
Birth location		
Sweden	8	8
Denmark	1	-
Iceland	1	-
Bosnia	-	1
Highest level of education		
Upper secondary	-	2
College/University	10	7
Speciality		
Surgery	3	2
Medicine	3	3
General Practitioner	2	2
Gynaecologist	1	1
Dermatologist	1	1

Table 2. Systematic text condensation- the method of analysis.

The analysing steps of Systematic text condensation	Description of the process
Step 1 Overall impression – from chaos to themes	The transcribed material is read to intuitively find themes that represent the material. This should be done with the attempt to put aside the theoretical framework and the understanding of the phenomenon.
Step 2 Units of meaning – from themes to codes	The material is coded by: 1. A systematic perusal of the material to distinguish relevant material from irrelevant according to the aim of the actual study. 2. Finding quotations, units of meaning that correspond to the themes found in step 1. The themes are now referred to as codes. 3. Systematically decontextualize the material by putting the units into a matrix.
Step 3 Condensation – from codes to essence	The coded material is sorted into different subgroups and artificial quotations are constructed to illustrate the given subgroup.
Step 4 Summation – from condensation to descriptions and concepts	Each code and subgroup are summarized to come up with a description of what the material conveys about the objective. Finally quotations that can elucidate this description are found in the material.

Table 3. "Focus of the Patient's Request"

Quotations taken from the interviews, presented in Swedish in order to better preserve the meaning of the content.

Focus	Summation	Quotation
Focus on Disease	Centres the disease and the patient's hope for the physician to come up with a medical answer and potentially cure them. The patient's role is to contribute with information about the disease and further to accept the physician's medical advices. The physician's role is to gather information about the patient's medical condition and to come up with a medical solution to cure the patient.	”Då har jag förväntningen att Försöka få Svar på vad det är för något som är Fel. Lite problemlösning /.../ ifall man då upptäcker ngt annat problem, att man upprättar en åtgärdsplan för det, i form av kanske att läkaren skriver ut ett recept. Och så äter man ngt så blir man frisk! (skratt) eller Dylikt! /…/ eller iallafall ett Steg i en lösning. Det kan ju vara så att man ska gå vidare till en annan instans eller så... Men då är det ju ändå att det är Förklaringen på någonting. 'jamen då är det så att vi måste gå vidare på si och så sätt' att man slussas vidare till andra ställen.” *Patientinformant 3*
Focus on Emotional Experience	Centres the emotional experience of being ill, and the patient's hope for the physician to listen to their thought and worries about their condition. The patient's role is to open up and share the emotional experience of being ill. The physician's role is to confirm the patients in their experiences of being ill and confirm them in their feelings about their conditions.	”Man för en dialog. Man för ett samtal kring... (harkling) Och att man kanske också speglar patienten igen och att man… Om det är något annat som man undrar över, eller tänker på, eller är bekymrad över. /…/ Vad är det då som gör att jag är så orolig för min dotter? Även om hon uppenbarligen inte har feber enligt bokens rätta mening. /…/ då kanske man kan lösa det, då kanske man kan säga 'nej, men det finns, det här, och det här, och det här också som gör att det inte finns någon anledning till oro just nu.'” *Patientinformant 5*
Focus on Existential Meaning	Centres the Existential Meaning in the patients' lives and the patients' hope for the physician to help the patient to find new perspectives on themselves and their lives. The patients' role is to contribute to the consultation with their unique understanding of what it means to them to be a person living with a disease. The physicians' role is to see their patient as a person and contribute to a dialog were the patients can look upon themselves and their lives from a new perspective.	I bästa fall så kan jag få ngn förståelse för min situation./.../ ngn 'aha'-upplevelse kring min sjukdom./.../ I de bästa stunderna så känner jag att det är Det som händer. Jag är där som människa, men min sjukdom Det är ngt annat. /.../ Den kan jag lite få skjuta ifr... Titta på utifrån. /.../ det känns som om det finns mycket Förtroende i rummet. /.../ [hon] Hjälper mig att se på mig själv utifrån. /.../ det känns Skönt. Lite befriande för en stund. /.../ hon hjälpa mig att förstå att det Här är ett sjukdomstillstånd. Och det du Gör och så... (gråter) /…/ Det är Sjukdomen. /…/ Då kan det kännas lite befriande ett tag. (gråter) /.../ Ja men slippa gå och betrakta sig själv som en sjukdom. Det är jätteskönt och det kan jag göra där när det blir bra! *Patientinformant 2*

Table 4. "Focus of the Physician's Service"

Quotations taken from the interviews, presented in Swedish in order to better preserve the meaning of the content.

Focus	Summation	Quotation
Focus to Cure	Centres the disease and the ways to a curative solution. The patient's role is to contribute with information about the disease. The physicians' role is to be a medical resource to achieve the goal, to cure.	"Det bästa är ju om man kan få Allting löst under Det korta mötet, det är ju sällan det händer, det är ju oftast så att man får utreda vidare, återkomma, kolla upp något. Men drömmen är ju att man kunde möta varje patient och bli Klara, så att säga, och gå vidare till nästa /.../ i bästa fall har jag ju Botat dem, det är ju tyvärr sällan det händer, men patienten har fått information, vet att det finns en behandling eller vet att det Inte finns en behandling. Eller förstår att det som hon eller han upplever som ett Stort problem kanske tom är något normalt förekommande, och inte ens är någon sjukdom. Och då kan man bemöta eller förklara. Det är ju jättemycket information." *Läkinformant 8*
Focus to Comfort	Centres the patient, the emotional experience of being ill, and a comforting solution. The patient's role is to contribute with information about their feelings and thoughts about the disease. The physician's role is to listen to and confirm the patient's emotional thoughts and feelings of being ill, to achieve the goal, to comfort.	"Jag minns speciellt en gammal tant när jag gav ett tråkigt besked där jag egentligen satt och lyssnade i 30 minuter. Och sa den medicinska faktan i två minuter. Och när hon gick därifrån så sa hon att det här var det Bästa samtalet hon hade haft med en doktor någonsin. Och det är ju en fantastisk erfarenhet. Trots att jag då kanske inte hade sagt någonting, men den situationen var sån att hon ville berätta om sin sorg över att behöva konfrontera att dö osv. Och vi fann varandra. Jag i den lyssnande och hon /.../ i sin monolog. Så att hon fick ösa ur sig, ur sin ryggsäck. Och sen så blev det ett fantastiskt bra samtal." *Läkinformant 7*
Focus to Heal	Centres the human being, the existential dimension of meaning and the healing solution. The patient's role is to set the agenda for the consultation and realize that parts of the solution lie within the patient. The physicians' role is to understand the patient as a human being and to find new strategies for the patients to relate to themselves in a new way.	"Helheten. Alltid helheten. /…/ för att här har jag ju en chans att hjälpa dem genom att säga rätt ord på rätt plats. Så att jag får dem att börja fundera själva. Att ge dem ett bollplank. Reflektera lite om sin egen situation och vad de kan göra, eller visa på vad de Kan göra. För att må bättre. Eller visa dem på ett annat tänk. Hur de kan tänka om sin missbildning. Att leva och avvika är svårt. Men då kan man försöka lära dem att se på det, på ett annat sätt. Eller tänka på det de har. Och inte på det de inte har. /…/ Vi måste alltid ge dem hopp. Får aldrig ta bort hoppet." *Läkinformant 10*

Table 5. The meaning of the themes in pt-GC.

Themes	Common meaning	Focus on Disease	Focus on Emotional Experience	Focus on Existential Meaning
Trust	The patients feel "safe" enough to share their story with the physician. Trust is created by a well-prepared physician and continuity in the relationship between the physician and the patient.	Created when the patients feel that the physician has enough medical knowledge to come up with an understandable answer to their medical condition.	Is created when the patients feel that they have been understood and confirmed in their experience of being ill.	Arises when physicians look upon their patients as individuals and not as diseases or biological phenomena.
To be listened to	The patient feels that the physician listens attentively to what the patient has to say.	The patients feel that their story counts as a reliable source of information, the physicians take their medical story into account when making their medical decision.	The patients feel that the physician makes room in the consultation for the patients' experiences and feelings and additionally listens carefully and with respect to the story.	The patients feel that the physician listens to them as human beings, not only in the context of their medical condition but in their "whole" context as individuals.
To be seen as equal	Balance in power between physicians and patients. The physician makes room in the consultation for the patient to take part and uses a manner of speaking that is understood by the patient.	The difference in medical knowledge between the patient and physician is evened when the patients prepare themselves with research about their condition and when the physicians answer the patients' questions.	The difference in emotional level between the patient and physician (e.g. patient's anxiety) is evened by the physicians showing interest in the patient and by listening to what the patient has to say and by the patients sharing their feelings.	The difference in existential experiences between the patient and physician is evened by their sharing of knowledge and experience. They almost act as colleagues during the consultation.

Table 6. The meaning of the themes in ph-GC.

Themes	Common meaning	Focus to Cure	Focus to Comfort	Focus to Heal
Preparation	The physician is well prepared for the consultation due to preparation before the individual consultation and the overall preparation.	The individual consultation is prepared by reading the medical record with a strict focus on the details of the disease. The overall preparation involves the acquisition of new medical knowledge, e.g. through research.	The individual consultation is prepared by reading the patient's medical record with a focus on details of the patient's feelings. The overall preparation involves videotaped consultations, discussions and reflections of the physician's professionalism.	The consultations are prepared by requiring personal insight. This involves therapy, meditation, reading books and handling professional crises.
Understanding	An understanding within the consultation arises when the physician understands the patient.	The physicians understand the disease by mapping out the disease, the patient's thoughts about it and the expectations on the treatment. The	The physicians understand the patients through mapping out their conscious thoughts and feelings about their experiences of the disease and also by drawing attention to the patient's "hidden" agenda.	The physicians understand the patients as human beings, how the patients relate to themselves and their existential thoughts.
Presence	The physicians show presence in the consultation by not allowing interruptions by a phone call or by other people or things in the room. They turn on the "red light", ask not to be disturbed and switch off the telephone. They keep eye-contact with the patient instead of looking at the computer or in the patient's medical record.	The physicians actively focus on the patient's medical history and the extent of the disease, instead of letting their thoughts run on.	The physicians actively focus on the signals the patient is sending out, the feelings and thoughts that the patient conveys 'between the lines'.	The physicians actively focus on the patient as a human being, through the patient's signals or expressions, details in the body language and story, called a "dynamic listening" in which the physician empathically enters the patient's world.

Figure

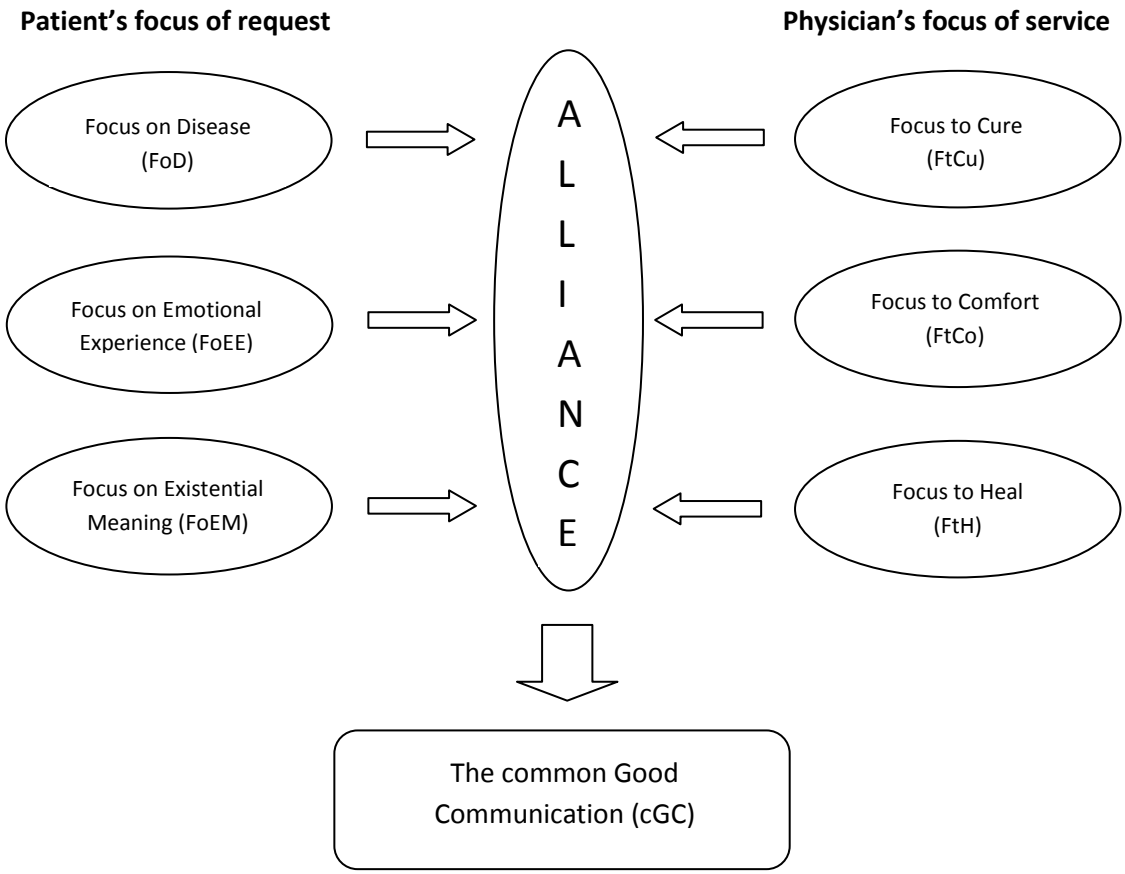

Figure 1. The common good communication

APPENDIX

Interview guides for physician and patients in Swedish

Intervjuguide läkare

1. Information om forskningsprojektet + samtyckeslapp x 2
2. Intro: Vårt projekt handlar ju om hur läkare och patienter ser på ett gott samtal...
    1. Vad anser du är ett gott samtal?
    2. Hur märker du att det blir ett gott samtal?
    3. Hur känner du efter du haft ett gott samtal?
    4. I vårt mejl till dig bad vi dig tänka på ett exempel på ett gott samtal du haft med en av dina patienter. Kan du beskriva det?
3. Övergång: En del av samtalet utgörs av patientens och läkarens förväntningar på samtalet…
    1. Vad förväntar du dig av ett samtal med din patient?
    2. Vad tror du patienten förväntar sig av ett samtal med dig som doktor?
    3. I exemplet innan /.../. Hur tror du patienten upplevde dig i det samtalet? Hur tror du patienten upplever dig i dina patientsamtal?
    4. Vad tror du patienten tycker är ett gott samtal?
4. Övergång… Det finns en massa teorier om vad som krävs för att ett gott samtal ska kunna uppstå.
    1. Vad tror du krävs för att ett samtal ska bli gott?
    2. Vad hos dig bidrar till ett gott samtal?
    3. Finns det ngt hos dig som kan försvårar ett gott samtal?
    4. På vilket sätt bidrar patienten till ett gott samtal?

Hjälpfrågor: Vad hände? / Vad gjorde du då? Hur reagerade du då? / Hur kände du då? Varför blev just det samtalet bra? Exemplifiera! Hur menar du då? Vad innebär /.../? Du säger /.../ vad menar du med det? Menar du så här/.../? Har jag förstått dig rätt om /.../? Sammanfatta: /.../, ngt mer?

5. Nu har vi inga fler frågor. Är det ngt som du vill tillägga innan vi avslutar intervjun? Inspelningen avbryts.
6. Hur tycker du det här kändes?

Intervjuguide patienter

1. Information om forskningsprojektet + samtyckeslapp x 2
2. Intro: Vårt projekt handlar ju om hur läkare och patienter ser på ett gott samtal...
    1. Har du upplevt ett gott samtal med en läkare?
    2. Kan du beskriva det?
    3. Vad anser du rent generellt är ett gott samtal?
    4. Hur märker du att det blir ett gott samtal?
    5. Hur känner du efter ett gott samtal?
3. Övergång: En del av samtalet utgörs av patientens och läkarens förväntningar på samtalet…
    1. Vad förväntar du dig i ett läkarsamtal?
    2. Vad tror du läkaren förväntar sig av ett patientsamtal?
       Vad vill de få ut av samtalet?
    3. I exemplet innan /.../. Hur tror du läkaren upplevde dig i det samtalet?
       Vad är din roll i ett läkarsamtal?
    4. Vad tror du läkare tycker är ett gott samtal?
4. Övergång… Det finns en massa teorier om vad som krävs för att ett gott samtal ska kunna uppstå.
    1. Vad tror du krävs för att ett samtal ska bli gott?
    2. Vad hos dig bidrar till ett gott samtal?
    3. Finns det ngt hos dig som kan försvårar ett gott samtal?
    4. På vilket sätt kan läkaren bidra till ett gott samtal?

Hjälpfrågor: Vad hände? / Vad gjorde det så bra? Vad gjorde läkaren för att det skulle bli bra? Hur reagerade du då? / Hur kände du då? Exemplifiera Hur menar du då? Vad innebär /.../? Du säger /.../ vad menar du med det? Menar du så här/.../? Har jag förstått dig rätt om /.../? Sammanfatta: /.../, ngt mer?

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