

Davis Observation Code
Operational Definitions for Direct Observation Coding

CH: *Chatting* Physicians or patient discussing topics not related to current.... e.g. small talk or humor which might be used to build rapport.

SI: *Structuring Interaction* Physician or patient discussing what is to be accomplished in current interaction: or physician asks patient for any questions. Excludes request by physician for patient to do anything which is part of the physical exam or is done to prepare for physical exam. Excludes planning treatment. Can include statement describing what will be done in physical exam.

CO: *Counseling* Physician discusses interpersonal relations or current emotional state of patient or patient's family, provides reassurance, advice, or support, or uses self-disclosure to reassure patient. Excludes "advice" taking for health behavior change (see Health Promotion). Physician restates what patient has said (in regards to above) or reflects on the patient's nonverbal behavior.

HT: *History Taking* Physician inquiring about or patient describing in details related to the current chief complaint or to prior illnesses or treatment. Includes physician reading medical record. Excludes patient response to current treatment: see Treatment Effects or TE. Includes physician asking if physical exam maneuver produces pain or feeling described in chief complaint history.

FI: *Family Information* Physician inquires about or discusses family medical or social history or about current functioning of family. (Family can include unrelated significant others from social or work groups.)

TE: *Treatment Effects* Physician inquires about or patient describes results of ongoing therapeutic intervention for current episode of problem.

HK: *Health Knowledge* Physician asks or patient spontaneously offers what patient knows or believes about health or disease (as opposed to patient's own treatment history which is coded History Taking).

EF: *Evaluation Feedback* Physician tells patient about results of history, lab work, etc. (includes telling that lab tests are incomplete, inconclusive, etc.). Results can be preliminary or speculative.

PE: *Physical Examination* Physician conducts any aspect of physical examination of patient including taking samples for lab test or diagnostic procedures; also includes asking patient to prepare for physical exam, telling patient to do something in physical exam, or asking if maneuver hurts or is tender.

PQ: *Patient Question* Patient asks question of physician about diagnosis, treatment, side effects, history or disease.

CM: *Compliance* Physician inquiring about or discussing what patient is currently doing or has done recently regarding previously requested behavior around taking medication, changing nutrition, or doing exercise or other behavior change.

PS: *Preventive Services* Physician discusses plans or performs any screening task associated with disease prevention. For example: Pap smear, breast exam, vaccination, hip click exam, testicular exam, rectal exam, thyroid exam, or scoliosis exam. (See Preventive Services sheet.)

HE: *Health Education* Physician presents information regarding health to patient. This may include information regarding diagnosis, etiology, drug effects and treatment, or accident prevention. May also include statements about health attitudes and motivation.

HP: *Health Promotion* Physician asks for a change in patient's behavior in order to increase or promote patient's health (including accident prevention). This excludes changing behavior around taking medication. Any explanation of the procedure itself, its side effects, drug interactions, or contradiction should be coded HE. Excludes asking patient to take medication.

PT: *Planning Treatment* Physician prescribes a medication, diagnostic, or treatment plan to be followed other than behavior change (see Health Promotion). Includes physician asking if prescription refill is needed.

EX: *Exercise* Any question about or discussion of exercise.

SM: *Smoking Behavior* Any question about or discussion of smoking or other use of tobacco.

NU: *Nutrition* Any question about or discussion of nutrition. Includes discussion of diet and/or food intake (excludes questions regarding only appetite, which is coded as history).

SU: *Substance Use* Any question about or discussion of drinking alcohol or use of other substance.

PR: *Procedure Any* Any treatment or diagnostic procedure done in office, e.g. removing skin tags, warts, drawing blood, casting, dressing, debriding, etc. Excludes preventive services such as Pap smear.

Note: From "Callahan EJ, Bertakis KD. Development and validation of the Davis Observation Code. *Fam Med.* 1991;23:19-24." Reprinted with permission from the Society of Teachers of Family Medicine, www.stfm.org.