

# Can Some Clinicians Read Their Patients' Minds? Or Do They Just Really Like People? A Communication and Relationship Study

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## Introduction

A clinician's skill in interpersonal communication and relationships is a component of health care so important that patients may both seek and select health care practitioners on the basis of this skill.

Findings published in the medical literature illustrate the importance of good communication and interpersonal skills for achieving effective, satisfying health care encounters and episodes of care. Humaneness is the first patient priority for general practice care,<sup>1</sup> and patients rated communication in the top three out of seven aspects of patient care.<sup>2</sup> Patients' rates of adherence to recommended treatments were increased 2.6-fold when a physician's knowledge of a patient "as a whole person" was strongest.<sup>3</sup> The trust level between patient and physician predicted self-reported adherence at six months.<sup>4</sup> In addition, higher patient satisfaction occurred when patients received any one of three nontechnical interventions—education, stress counseling, or negotiation—as part of the medical care.<sup>5</sup> Meeting patient expectations for diagnostic tests did not have an important effect on satisfaction. A patient's perception of a clinician's humanity did correlate with satisfaction.<sup>6</sup> Of five distinct communication patterns in primary care practice, patients were most

satisfied with the psychosocial pattern (inclusion of psychologic, social, and personal questions and information).<sup>7</sup> A review article on communication and health outcomes concluded that "most of the studies ... demonstrated a correlation between effective physician-patient communication and improved patient health outcomes."<sup>8</sup>abstract The outcomes most affected were patients' emotional health, symptom resolution, functional status, physiologic measures, and pain control.<sup>8</sup>

## Methods: Patient Satisfaction Survey and Database "Art of Medicine Survey" of Patient Satisfaction

Routinely since 1992, Kaiser Permanente Northwest (KPNW) has evaluated the communication and interpersonal relationship skills of physicians and affiliated clinicians by using the Art of Medicine Survey (AOM), a data collection tool developed in 1992 by Karl Weiss, President, HealthCare Research, Inc (HCR).<sup>9</sup> The survey, routinely distributed in a single mailing to KPNW Health Plan members who recently visited a health care clinician, asks patients about their satisfaction with their care as delivered by a specific clinician. The mailing achieves about a 35% response rate, and differences in response rate are not related to survey score. More than

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| 1. How COURTEOUS and RESPECTFUL was the clinician?                                  |
| 2. How well did the clinician UNDERSTAND your problem?                              |
| 3. How well did the clinician EXPLAIN to you what he or she was doing and why?      |
| 4. How well did the clinician LISTEN to your concerns and questions?                |
| 5. Did the clinician SPEND ENOUGH TIME with you?                                    |
| 6. How much CONFIDENCE do you have in the clinician's ability or competence?        |
| 7. OVERALL, how satisfied are you with the service you received from the clinician? |

a million AOM surveys received from patients in multiple KP Regions have been analyzed, and both validity and reliability of the survey have remained constant.<sup>9</sup> The number of surveys mailed in the NW has been large enough to obtain 75 completed questionnaires for each clinician every six months. The survey was administered in six-month cycles (during 1995 and 1996) and in 12-month cycles (in 1997 and 1998), thus producing six data sets spanning four years.

The AOM Survey asks patients seven questions to assess positive attributes of clinicians' communication skills<sup>9</sup> (Table 1).

Between 1992 and 1999, Northwest Permanente Medical Group (NWPMG) has administered the AOM survey to patients seen by 400 physicians and 200 affiliated clinicians over seven years. In spring of 1999, survey data collected at KPNW from

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1995 through 1998 were comprehensively analyzed.

**Highest Rated Clinicians: Cohort Selection**

In 2000-2001, clinicians who consistently scored in the top 10% in the AOM Survey—specifically, the “overall satisfaction” question—were interviewed to learn what they say, how they behave, and what they believe are the reasons why patients rate them so highly. From the six data sets collected from 1995 through 1998, this high rating was achieved by 35 clinicians.

**Pilot Study of Clinicians**

A pilot study was conducted in fall 1999 after a recognition dinner held for the 35 clinicians. Twenty-one clinicians attended, and after the dinner, the clinicians were asked, “Why do you feel that your patients rate their interactions with you so highly?” The clinicians responded with the following kinds of comments:

*“I introduce myself; I shake their hand; I acknowledge their presence.”*

*“I talk to them as a person.”*

*“I explain things, and involve them in decisions.”*

**“I am with them when they are with me.”**

*“I’m conscious of what it takes to please people.”*

*“Meet the patient where they are.”*

*“I am with them when they are with me.”*

**Methods: Qualitative Research Study**

Research study participants included all those physicians and affiliated clinicians in the highest rated group who responded to a request for an individual interview about their patient interactions. Twenty-six clinicians (74%) of the highest rated group agreed to participate (Tables 2, 3).

**Interview Approach**

The qualitative method used in the interviews is sometimes called “conversation with a purpose.” Data were collected on specific, research-defined topics by means of a conversational interview in which participant’s responses influenced the sequence of questions as well as the probes used to explore issues more deeply. The study used an interview guide (Table 4).

Interviews were conducted by one of the authors (NV) and by three other interviewers trained in qualitative methods. Interviews were conducted in the clinician’s office and lasted between 30 and 60 minutes. With the clinician’s permission, all interviews were both audiotaped and transcribed for analysis.

Analysis focused on features of good practice identified by clinicians and on perceptions of the role of intuition in their practice. The interviewers and Dr Vuckovic read a sample of the transcripts and developed coding based on the interview questions and themes that emerged in the transcripts.

**The Coding Elements**

Ten coding elements were included: reason for high rating; what patients value; connection to patient; finding

meaning at work; intuition; listening; time; respect; nonverbal communication; caring about the patient. These codes were applied to the remaining transcripts using *Atlas ti (Scolari/Sage)*, a software program for text-based data analysis. This software enables electronic labeling of sections of text with codes and retrieval of coded segments.

**Results**

**Interpersonal Communication**

Clinicians’ statements were recorded verbatim because these personal narratives most specifically convey the main themes highlighted by the coding. From clinicians’ stated beliefs about what patients value, four common themes emerged:

1. Being respected as a person and an individual.
2. Being listened to and heard by the clinicians.
3. Full presence and undivided attention of the clinician.
4. Being cared about and cared for.

**1. Respect for Patient**

Participants uniformly reported that respect for the patient as a person and an individual was both a fundamental aspect of their interactional style and an aspect of their practice of medicine that patients valued. Individual clinicians’ ways of demonstrating that respect varied but had in common a desire to both recognize the patient as a person and minimize social distance between patient and clinician.

*“I try to treat people like I’d want to be treated.”*

*“Patients value that I treat them with respect.”*

*“When I come in the room ... I always try to shake their hand, just to establish a touch contact.”*

*“It’s such an imbalance of power for one person to be naked and the other to be wearing an extra lab coat over their clothing.”*

*“Even just a two-second personal*

|                           |                                  |
|---------------------------|----------------------------------|
| 21 Physicians             | 5 Affiliated Clinicians          |
| 12 Men                    | 14 Women                         |
| 17 Specialty Care         | 9 Primary Care                   |
| 7-27 KP years             | Average 15 years                 |
| 12 Full time/14 Part time | Part time range .5-.91 (.76 ave) |

| Physicians            |   | Affiliated Clinicians |   |
|-----------------------|---|-----------------------|---|
| <b>Specialists</b>    |   |                       |   |
| General Surgery       | 4 | General Surgery       | 1 |
| Oncology              | 2 | Psychology            | 1 |
| Ophthalmology         | 1 | Cert. Nurse Midwife   | 1 |
| Urology               | 1 |                       |   |
| <b>Primary Care</b>   |   |                       |   |
| Family Practice       | 3 | Family Practice       | 1 |
| Internal Medicine     | 3 | Pediatrics            | 1 |
| Pediatrics            | 3 |                       |   |
| Obstetrics/Gynecology | 4 |                       |   |

*interjection: I'm sorry. I'm running late. Just acknowledging that yeah, their time is not going unnoticed either. It's a big deal for them. It translates into showing some mutual respect."*

## 2. Listening

Another aspect of their practice that participants believed patients valued was the attempt to listen to patients' concerns. Some participants described nonverbal strategies they used to communicate to patients that they were attentive to what the patient had to say.

*"What they tell me they value the most is when I take the time to listen to them."*

*"I give them time to address whatever problems they have. I don't start by telling them things. What I say is, 'How are you doing?'"*

*"And most times they say 'You know, you're the only person who listens,' or 'You're the only person who cared,' or 'I feel like you're going to get to the bottom of it.' That type of thing."*

*"When I go into a patient's room, I always sit down to talk with them .... People just get this sense that you're listening to them longer, or something, if you're seated than if you're standing by the door."*

*"You need to look directly at them when you talk to them. If you're typing on the computer, then you're not really listening, at least in their perception."*

## 3. Presence

Several participants also described a style of focused attention—which we have termed “presence”—that contributed to patients' sense of ease and satisfaction. The essence of this practice was to let go of events or thoughts that have preceded or that will follow an encounter and to focus on the moment and on the person in the exam room.

*"And even if it's not very long,*

*you've given them a sense that you're just there for them, to listen to them .... And even if I'm really, really rushed, when I walk in the patient's room I really try hard that they never know that's going on."*

*"When I'm talking to them, I'm talking to them, and everybody else is out of the picture for the time being."*

*"I don't appear rushed. Even when I am. So when I go in that room, that is their sacred time."*

## 4. Caring About Patients

For most participants, the behaviors described above were motivated by a sincere liking for patients, not merely techniques applied to improve satisfaction scores. For some clinicians, their enjoyment of patients as people was the most meaningful part or their work.

*"I pretty much like all my patients. I think it's important that you find something to like about them."*

*"I really care about my patients and I think that probably comes through in the conversation and I think they realize it then."*

*"They know, first and foremost, that I actually, really do care about them, and I will help them in any way I can."*

*"I enjoy my patients. I wouldn't keep doing this if I didn't enjoy them."*

*"They're wonderful. In fact, that's the most rewarding part of it."*

## Intuition: A Transpersonal Communication Process

We were interested in the phenomenon of intuition as it relates to clinician-patient interaction. This interest arose from our familiarity with the anthropology and transpersonal psychology literature. In these disciplines, intuition, as a part of the communication process has been explored more explicitly and deeply and is recognized as a potent and effective way to gain information without sensory input.

**Table 4. Interview guide**

- Why do you think your patients rate you so highly?
- What would you say your patients value most about the way you practice medicine?
- How would you describe your philosophy of caring for your patients?
- What about your work is most meaningful to you?
- Tell me about what you do to connect with your patients?
- Some practitioners describe a “gut instinct” or intuition as a part of practice. Have you had this experience?

When posed to participants, our question about use of intuition in medical practice elicited responses that classified intuition into three categories:

1. knowledge that comes from experience;
2. knowledge that comes from being open to information from multiple sources,
3. information from other (spiritual, paranormal) sources.

### 1. Knowledge That Comes From Experience

Some participants described intuition, or “gut instinct,” as the result of years of experience in medical practice. A clinician might sense that something is wrong with a patient because the clinician has lived through other, similar situations.

*"I think a lot of what seems like intuition is actually observation, a lot of training, and a lot of just repetition and judgment that you've learned from making mistakes before."*

*"I don't know that it's really intuition. I think a lot of it is experience and it's training. You learn to interpret and observe people very carefully."*

*"It's something that I didn't just have off the bat. It's something that came after a few years."*

### 2. Being Open to Information

For other participants, intuition about how to act resulted from being aware of and open to sensory information beyond clinical tests and standard diagnostic procedures. This information could be visual (eg, how

a patient looks or acts) or embedded in information given by the patient.

*"Everybody knows that there's an instinct thing and that some people are good at it and some people aren't. I don't know if certain people are just more open. You go in and you just get a feeling of how that person looks and is moving around and acting. You know, I'll come up and say 'I just didn't get a good feeling.' It's hard to quantify."*

*"You know, when a car goes by and you just know it's a Chevy. You just know. It's hard to put into words."*

### 3 Information from Other (Spiritual, Paranormal) Sources

This experience of intuition was identified by only a few participants. For these clinicians, intuition came from a source outside the individual and was not seen as a cognitive process. This form of intuition was not the result of clinician experience, skill, or being open to other sensory information; the clinician only needed to be receptive to it.

*"This sounds really crazy, but sometimes I do feel it's more spiritual where you almost feel like at some point, somehow, something tells you to do something .... You don't know why you did the right thing at the right time, but you did."*

*"The closest thing I can even relate it to is almost like a psychic phenomenon. You know, something just enters your mind as if another voice was telling you information."*

*"It has nothing to do with you."*

#### Hindrances

Time constraints were the most frequently named hindrance to practicing medicine in a caring, attentive way. Clinicians said that they often chose to ignore appointment time limits to give patients the

time they needed and that patients were willing to wait to receive this kind of attention:

*"I'm way behind a lot of the time, but mostly they'll say 'It's worth waiting for. I know you're going to spend the time that I need with me, so it's ok to wait.'"*

Clinicians acknowledged that providing extra time for patients extracted a personal cost from clinicians who chose to do so:

*"It is a challenge, though, with our schedule, to provide that time. I think it's a big issue that if you do provide the time, it's usually your own time and not company time. That has a lot of problems, because what I've found is that a number of the really good doctors—who have provided that time—end up burning out and then they're not there."*

## Discussion

### Interpersonal Communication

Our results indicate that, as perceived by clinicians, qualities that patients find important in interpersonal health care encounters are consistent regardless of medical specialty, gender, years with Kaiser Permanente, practicing as a physician or affiliated clinician, or schedule (ie, whether seeing patients part-time or full-time).

Although physicians and clinicians would naturally be keyed to what patients think is important by focusing on the questions of the AOM survey, these attributes were initially chosen as important characteristics of overall patient satisfaction. HRC has validated that these six attributes individually show high correlation with overall satisfaction.<sup>9</sup> Clinicians' results on the "overall satisfaction" question were used to determine the most highly rated cohort.

Clinicians believe that what they do to satisfy their patients so highly and so consistently is about interpersonal relations, not simply about ordering

the right test. Fundamentally, it is about listening, whether passively (ie, by being quiet) or more actively (ie, by hearing patients' words as well as by divining the meaning behind the words). The interpersonal relationship skills necessary for patient satisfaction also include being so attentive as to hear the person within the patient, being a person within the professional, and being present in the moment enough to share a personal moment. An ultimate demonstration of personal regard is listening deeply and being present fully, as if the world is only this moment.

Are these communication skills transferable, or do they just represent innate ability that only a few elite professions possess? Observations made in a Seattle public fish market confirm our belief that many people can, with practice, learn to communicate in this effective way.<sup>10</sup> How employees of the fish market interact with customers demonstrates that people can learn presence. Paying attention and being present in the moment have "street value," so to speak. These concepts are illustrated by sample quotes from fish market employees:

*"You have to always be there. I mean, being aware of what the customers are saying. Actually dealing with them face to face."*

*"You are being with them. You are, like, just with them. Things are going on all around, but you are taking care of just them."*

*"Be with the people from moment to moment."*

*"We are 95% of the time present from moment to moment. You have to keep bringing yourself back to being present now and do what you have to do."*

If this full presence is important to customer satisfaction in a commercial encounter, how much more important it must be in situations where health care is the purpose of the encounter! The

**"I just didn't get a good feeling. It's hard to quantify."**

health care encounter should provide an enhanced opportunity for the clinician to be attentive and present. The encounter is a private, personally important, and meaningful moment for patients because it relates to their health, their body, their emotional well-being, and sometimes their survival.

The basic elements of what clinicians think is most important about satisfying patients in interactions are well-known and are taught in communication courses. Clinicians with high patient ratings have not necessarily taken these basic elements to a level of social sophistication or high intelligence but have deepened the communication experience between two people to create a highly respectful, personally meaningful, highly important moment.

Qualitative studies such as ours often identify new hypotheses for future exploration and may confirm or explain hypotheses on the basis of previous work. One such hypothesis is that clinician awareness of, and reliance on, intuition in medical practice can influence both the process and outcome of care. Further controlled studies will be necessary to understand this phenomenon and its implications for education and practice.

### **Transpersonal Communication: Intuition and Intention**

The anthropology and transpersonal psychology literature demonstrate that information flows between people in both sensory and non-sensory ways. "Intuition" is a term used commonly to describe the knowledge a person gains through this process. "Intention" is a conscious and compassionate act of mentation intended to benefit the physical and/or emotional state of another.<sup>11-13</sup>

A secondary hypothesis for this study was that in the highest-scoring clinicians, intuition and intention were factors in creating patient satisfaction. Patients were consis-

tently highly satisfied because the clinicians better knew what the patients needs were (intuition), and patients' felt more cared about and cared for (intention).

Intuition and intention can have powerful therapeutic effects, especially in the context of the clinician-patient interaction. These processes can result in a therapeutic moment—an intuitive moment in which patient and clinician share knowledge of need or concern. A caring act of intention may initiate the treatment process before the first pill is swallowed; or this caring act may become the treatment itself (for example, validation of a self-care approach that could work in place of a prescribed pill).

Clinicians' responses given during interviews group intuition according to one of three themes:

- knowledge that comes from experience;
- knowledge that comes from being open to information from multiple sources;
- information from other (spiritual, paranormal) sources.

Clinicians are trained mainly from a physical science perspective and from scientific belief systems where knowledge is derived three ways: from collecting and analyzing quantifiable, tangible, sensory data; from use of physical techniques; and from applying physical agents and procedures. Clinicians are taught that with time and clinical experience, they will develop "clinical judgment," which is part of the art of medicine. Given this orientation, the comments of this first group may be expected. The clinical encounter is a vehicle for gathering historical and physical examination information from a patient; for presenting therapeutic options; and, more recently, for implementing a shared-decision process. However, only a mental health therapist would view the encounter as

primarily a "therapeutic encounter."

The second group of clinicians, either because of their personality, holistic belief system, or both, understands that the clinical practice of medicine requires a broader perspective than physical science alone. These clinicians are open to other information, value this information, and use it. They admit that "non-scientific" (ie, subjective) knowledge is not publicly acceptable to the medical community and do not discuss this knowledge with colleagues or patients.

The third group of clinicians is willing to admit (at least confidentially in an interview) to having a belief system that includes existence of "another source" of information or to admit that people can know things in ways that extend beyond usual sensory processes, even though these ways are not understood. These clinicians state a belief that this way of knowing could represent spiritual or psychic phenomena.

What is important to us as investigators is not to advocate for replacing current interpersonal communication processes with intuitive and intentional processes. Instead, we believe that creating awareness and some understanding of processes that may be at work in the clinician-patient interaction could benefit both patients and clinicians.

### **Study Limitations**

Although the sample size for this study was small, it represents 74% of the cohort. However, other questions remain that were not addressed by this study. First, the participants were not interviewed by a clinician; might clinicians have solicited different responses or prompted deeper exploration of some areas? Or would clinicians, acting as interviewers, have introduced bias?

**... create a highly respectful, personally meaningful, highly important moment.**

**Table 5. The Four Habits Model**

|  |
|--|
| Invest in the beginning  |
| <ul style="list-style-type: none"> <li>• create rapport quickly, elicit patient's concerns, plan the visit with the patient</li> </ul>                                       |
| Elicit the patient's perspective   |
| <ul style="list-style-type: none"> <li>• ask for patient's ideas, elicit specific requests, explore impact on the patient's life</li> </ul>                                  |
| Demonstrate empathy  |
| <ul style="list-style-type: none"> <li>• be open to patient's emotions, make at least one empathetic statement, convey empathy nonverbally, be aware of reactions</li> </ul> |
| Invest in the end  |
| <ul style="list-style-type: none"> <li>• deliver diagnostic information, provide education, involve patient in decision-making, complete the visit</li> </ul>                |

A second question merits additional research: On a scale of overall patient satisfaction, what is the natural point of differentiation between competent and superior patient communication during clinical interactions? The study does not answer this question.

In addition, the main data is second or third derivative: 1) clinician intent and attitude; 2) clinician behavior; 3) high KP patient satisfaction; 4) clinician (self-perception) recall and description of clinician attitudes and behavior. Something these clinicians do makes patients satisfied, but it is not clear the clinicians themselves best know what that is. Neither can we characterize structural or environmental factors at play.

Finally, we relied on face-to-face interviews with clinicians only.

We are now conducting research now in which we videotape the physician-patient interaction and then interview patients and physicians about this interaction. This research will deepen our understanding of highly successful interactions, communication, and relationships.

## Conclusions

In our health care delivery system, we must not only find ways to guide low-performing clinicians toward greater competence. To substantially improve clinician-patient interactions, we must elevate competent performance to high performance. The

learnings from this study give us guidance and tools for developing this competence. The fish market employee's communication and service behaviors are one example of how these skills are broadly transferable and not just the purview of a select few.

Other successful tools for improving communication skills include CME courses, tutorials, and coaching sessions, in addition to the "Four Habits Model" (Table 5) the importance of which is confirmed by this study.<sup>13</sup> Of particular note, a new video training tool is now available from The Permanente Medical Group Physician Health Department, "Mindfulness Practice for Busy Doctors and Healthcare Professionals," featuring Jon Kabat-Zinn.<sup>14</sup> With practice clinicians can integrate mindfulness (being fully present in the moment) into their patient interactions and into interactions with their care teams.

Excellent service and commitment to the highest medical quality, are what we and patients both want; patients view medical quality through their perception of service quality. We must therefore enhance the work environment, while providing sufficient time to be fully attentive to patients and meet their highest expectations. We must also be willing to provide the leadership direction, resources, and training to promote these goals. Excellent communication is an aspect of excellent service that distinguishes practitioners in the health care marketplace and can become a hallmark of Permanente Medicine, thereby producing a sustainable competitive advantage to enhance the health and well-being of our patients and our community. ♦

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