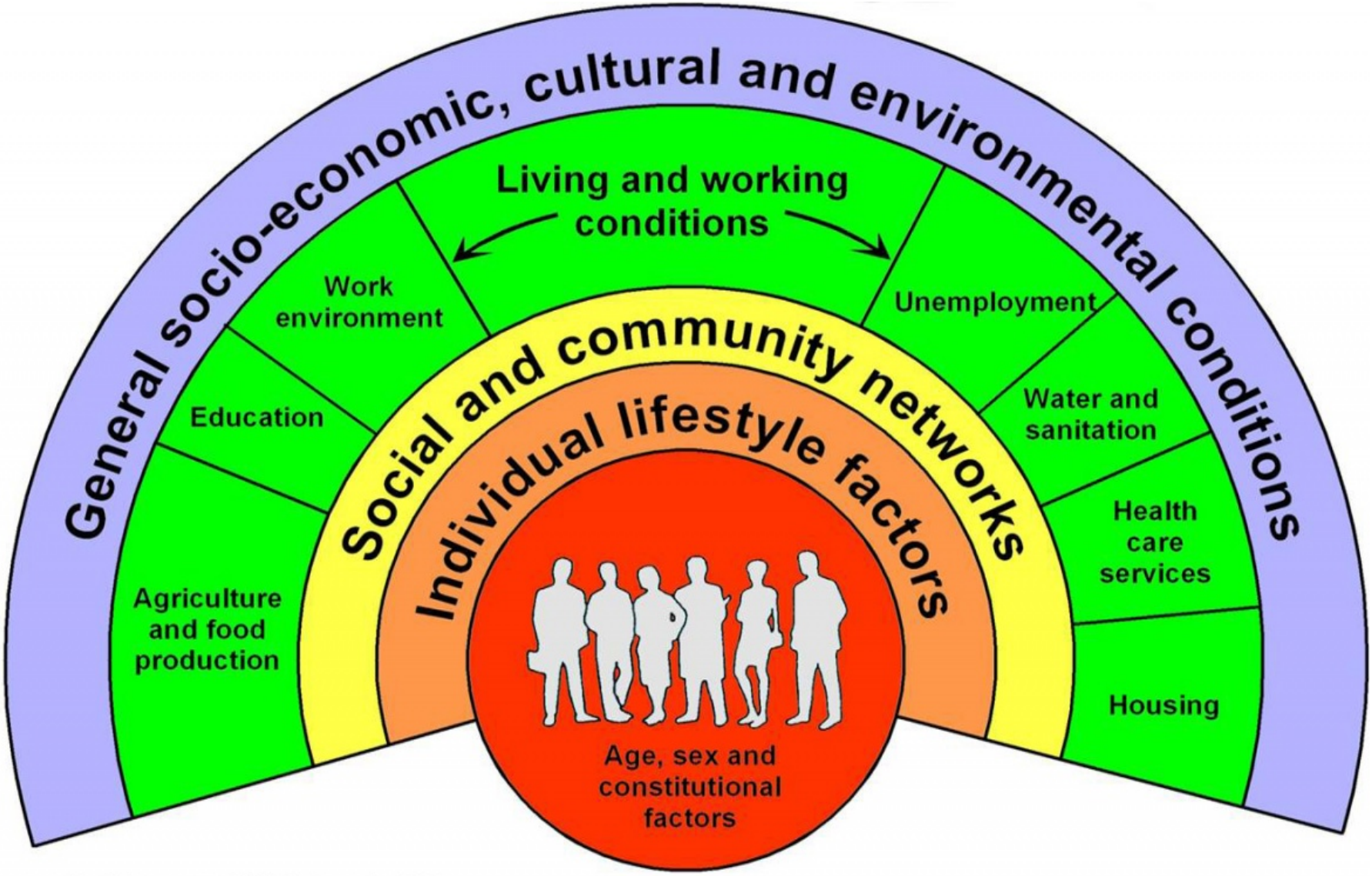
When the doctor says…	He/she *really* means…	What the patient *hears*…
Sorry, I'm running late. There was an emergency.	I was checking Facebook.	I think my time is more important than yours.
Lesion, mass, growth, abnormality, or irregularity	Possibly cancer.	Definitely cancer.
This won't hurt a bit.	You are not getting any Valium.	This is going to hurt a lot.
This might be a bit uncomfortable.	You can have some Valium.	Holy sh*t, this is going to feel like getting stabbed in the face 1000 times.
The lab lost your specimen.	I forgot to order it.	We need to stick you again.
We need to run a few more tests.	Everything is probably OK, but I don't want to get sued because I missed something.	You are probably dying from some rare, incurable disease.
I will call you with the results in the next few days.	I will call when I get a free millisecond between my patients scheduled every 10 minutes, all my paperwork/charting, and a billion committee meetings. Or after the kids are in bed.	I will call you 1st thing tomorrow morning, otherwise it's terrible news.
There's an incidental finding….	Dang it, I never should have ordered that unnecessary test!	Thank goodness we ran this important test!
It's just a virus.	I have no idea what that is, but it doesn't look serious.	Perhaps you should eliminate gluten from your diet.
This is an unusual presentation.	I have no idea what that is, but it looks serious.	Perhaps you should go home and google your symptoms.
I don't know.	I don't know but I will work my tail off trying to figure it out.	I don't know because I'm _____ (insert appropriate adjective: too old and out-of-touch with modern medicine, too young and lack enough experience).
Yes, I'd be happy to read those 15 articles you printed from the internet.	Yeah right, I'm not reading this crap.	Thanks for providing me with the most up-to-date info…what would I do without you?
Take this medication three times daily for 10 days.	I know you're really going to take it twice daily for 5 days.	Take this medication when you feel like it. Or not.
This medication is completely safe.	The foul-smelling diarrhea it will cause isn't too bad.	I am prescribing this medication because I get a kick-back and sold my soul to big pharma.
Everything is going to be fine.	I hope everything is going to be fine.	Everything is *not* going to be fine.
We will find a treatment for you.	We will find a phase 1 clinical trial, designed only to look at safety.	We will find you a cure.
There is nothing more we can do for you.	Please stop asking us for more horrible, quality-of-life-squashing treatments.	But you might be able to see someone else, and they will find you a cure.

Doctor – Patient Communication

Assoc. prof. Rima Viliūnienė
Clinic of Psychiatry

2018

The main determinants of health



Source: Dahlgren and Whitehead, 1991

What is the goal of doctor’s job?

The interview

The task in medicine a practitioner will do the most often and spend the most time on from now until he or she retires .

An average primary care practitioner may do between as many as 250,000 interviews in a professional lifetime of 40 years;

Therefore it is worth doing expertly, cogently, and efficiently.

- Why?
- Does?
- How?

The good clinician treats the disease, but the great clinician treats the patient.

William Osler

Clients rating their clinicians

Not knowledge based

Not skills based

Based on communication and subtle cues.

They might be wrong . . . but their perception is everything

People don’t care how much you know,

until they know how much you care.

Lewis Barnett, MD

Clinical Competence

ABILITY TO INTEGRATE

- knowledge base
- communication skills
- examination skills
- problem-solving ability

- Clinical skill does not make up for communication lacking
- Communication does not replace clinical skills
- Getting it right worthwhile

- **How** we do things is just as important as **what** we do
- Communication skills turn theory into practice

- 90% of info comes from taking a history
- 10% (or less) from case files and records

- Communication is a core clinical skill
- **How** we do things is just as important as **what** we do
- Communication skills turn theory into practice
- The average GP undertakes 200,000 consultations in a professional lifetime!

?

Can it be learned?

or

Is it just inborn talent?

COMMUNICATION IS A CLINICAL SKILL

- it is a series of learnt skills
- experience is a poor teacher
- there is conclusive evidence that:

✓ communication skills can be taught

✓ communication skills teaching is retained

Experience alone is a poor teacher: need observation, well-intentioned feedback and rehearsal

COMMUNICATION SKILL SETS

- content skills – *what you say*
- process skills – *how you say it*
- Self-perception skills – *awareness of your own feelings and biases*

The interview

The task in medicine a practitioner will do the most often and spend the most time on from now until he or she retires .

An average primary care practitioner may do between as many as 250,000 interviews in a professional lifetime of 40 years;

Therefore it is worth doing expertly, cogently, and efficiently.

How might good doctor-patient communication further your goals?

Time saving

Best predictor of resolution

Shorter care *needed* *(coronary care patients with emotional support - 2 days less bed time)*

Fewer malpractice suits

Clients more satisfied

Greater physician satisfaction

Reduces Stress & Burnout

Better patients adherence

A study focusing on the first 90 seconds of the medical visit found that the patient's response to the physician's opening question was completed in only 23% of the visits studied. In 69% of the visits, the physician interrupted the patient's opening statement, after an average of only 15 seconds, to follow up on a stated problem. In only one of these visits was the patient given the opportunity to return to, and complete, the opening statement. **For those 30% of patients who were allowed to continue, none of their statements took more than 2.5 minutes.**

Beckman, H. B., & Frankel, R. M. (1984). The effect of physician behavior on the collection of data. Annals of Internal Medicine, 101, 692–696.

A replication of this study some 15 years later found little had changed in physicians' attention to their patients' agenda; patients' initial statements of concern were completed in only 28% of interviews, and their opening statements were redirected after an average of 23 seconds.

Marvel, M. K., Epstein, R. M., Flowers, K., & Beckman, H. B. (1999). Soliciting the patient's agenda: Have we improved? Journal of the American Medical Association, 281, 283–287.

Although approximately 20% of medical patients suffer from significant psychiatric disorders *(primarily anxiety, depression, and substance abuse)*, studies indicate that, in general, their primary care physicians do not recognize half of these disorders.

Mant, A. Is it depression? Missed diagnosis: the most frequent issue . Aust Fam Physician. 1999; 28(8): 820.

Health care providers who have been trained in interviewing skills have been shown to be better able to detect and manage emotional distress in their patients who in turn report better emotional outcomes.

Roter, DL, et al . Improving physicians' interviewing skills and reducing patients' emotional distress. A randomized clinical trial. Arch Intern Med. 1995; 155(17): 1877– 1884.

Good doctor-patient communication improves medical outcomes:

- quicker resolution of chronic headaches
- reduced blood sugar values in diabetics
- improved blood pressure readings in hypertensive patients
- reduced pain in cancer patients
- better functional capacity in heart disease and asthma patients.
- lower stress hormones in radiology patients
- more realistic assumptions in patients making decisions whether or not to engage in life extending therapies

Patient centeredness on the part of the physician, partnership, and participatory decision making between the physician and the patient have been shown to lead to improved physical outcome in hypertension, diabetes, and arthritis.

Stewart, MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995; 152(9): 1423– 1433.

Patients sue doctors… Why?

- "People just don't sue doctors they like"[1]
- The surgeons who had never been sued spent more than three minutes longer with each patient than those who had been sued did (18.3 minutes versus 15 minutes)[2]
- They were more likely to make "orienting" comments, such as "*First I'll examine you, and then we will talk the problem over*" or "*I will leave time for your questions" or "Go on, tell me more about that*"[2]

1. Jeffrey Allen and Alice Burkin by Berkeley Rice: "How Plaintiffs' Lawyers Pick Their Targets," Medical Economics (April 24, 2000);
2. Wendy Levinson et al., "Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons," Journal of the American Medical Association 277, no. 7 (1997): 553-559

Clinicians with good relationship skills will have patients who are much less likely to sue them when unexpected bad outcomes occur or even when mistakes are made.

Cole, S. Reducing malpractice risk through more effective communication. Am J Manag Care. 1997; 485– 489.

Frank, GW. Malpractice claims and physicians' communication patterns. JAMA. 1997; 277(21): 1682.

Beckman, H. Communication and malpractice: why patients sue their physicians. Cleve Clin J Med. 1995; 62(2): 84– 85.

Research indicates that physicians who are better able to respond to patients' emotional distress report higher satisfaction of their own.

Suchman, AL, et al. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. Med Care. 1993; 31(12): 1083–1092.

Your sense of satisfaction with medicine

When a group of physicians was asked what enhances their work satisfaction the most, the most frequently named factor was "*relationships with patients*".

The practitioner with good relationship skills will cope with emotionally troubling situations more easily and will, in general, find the clinical practice of medicine more enjoyable.

Such a physician will be able to give more to patients emotionally and will, in turn, get more satisfying responses from them.

Suchman, AL, et al. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. Med Care. 1993; 31(12): 1083–1092.

Suchman AL, Hinton-Walker P, Botelho RJ, eds. Partnerships in healthcare: transforming relational process. Rochester: University of Rochester Press, 1998.

272 doctors and 117 in 6 hospitals and 3 outpatient clinics throughout Lithuania.

Results. High levels of burnout syndrome in MBI scales of emotional exhaustion, depersonalisation and personal accomplishments were determined for respectively 30.1%, 44.2%, 27.2% ($p<0.05$) of respondents.

Other studies indicate that patients who are more satisfied with their physicians are more likely to adhere to treatment recommendations and that physicians who are more skilled in the emotional domain of patient interaction are likely to have more satisfied patients.

Suchman, AL, et al. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. Med Care. 1993; 31(12): 1083–1092.

Roter, DL, Hall, JA. Communication and adherence: moving from prediction to understanding. Med Care. 2009; 47(8): 823– 825.

Clinicians with good relationship skills will have patients who are more satisfied and who will be more likely to adhere to treatment recommendations.

Roter, DL, Hall, JA. Communication and adherence: moving from prediction to understanding. Med Care. 2009; 47(8): 823– 825.

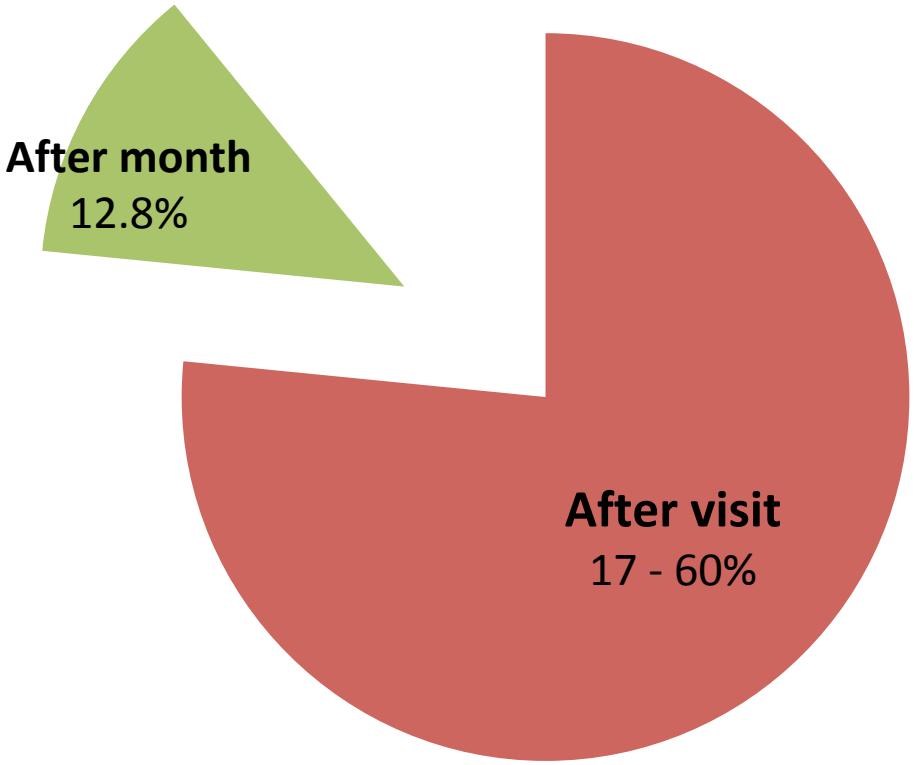
Patients who were asked to discuss their illness and its treatment (even immediately after leaving their physicians' offices) could correctly identify only about 50% of critical information. *(1)*

Additional research demonstrates that about 50% of patients do not know the medications they are supposed to take. *(2)*

(1) Stewart, M. Patient recall and comprehension after the medical visit. In: Lipkin M, Jr., eds. The medical interview: clinical care, education, and research. NY. P: Springer; 1995: 525– 529.

(2) Kravitz, RL, et al. Recall of recommendations and adherence to advice among patients with chronic medical conditions. Arch Intern Med. 1993; 153(16): 1869– 1878.

Patients remember



- Mcguire, L. C., Morian, A., Codding, R. and Smyer, M. A. Older adults' memory for medical information: Influence of elders peak and note taking. International Journal of Rehabilitation and Health, 2000. 5 (2), pp. 117—128.

Compliance, adherence, and persistence

All terms are to describe medication-taking behaviors.

- Adherence to, or compliance with, a medication regimen is generally defined as the extent to which a person takes medications as prescribed by their health care providers.
- *Adherence* has become the preferred term, defined by the World Health Organization as "the extent to which a person's behavior [in] taking medication <...> corresponds with agreed recommendations from a health care provider" (World Health Organization, 2003).
- Adherence, on the other hand, requires the person's agreement to the recommendations for therapy.

Compliance, adherence, and persistence

All terms are to describe medication-taking behaviors.

- *Compliance* has come into disfavor because it suggests that a person is passively following a doctor's orders, rather than actively collaborating in the treatment process.
- *Persistence* is defined as the ability of a person to continue taking medications for the intended course of therapy.

Patient nonadherence

Hundreds of studies indicate that between 22% and 72% of patients do not follow their doctors' recommendations.

The percentage of nonadherent patients varies according to illness category (e.g., 23% nonadherence in medications for acute illness vs. 45% for illness prevention) and outcome measured (e.g., 54% nonadherence to appointments for prevention and 72% nonadherence to diets).

It is worth noting, however, that these numbers, in general, do not vary according to the educational level or socioeconomic status of the patient.

Noncompliance with prescribed medication regimens has been shown to be a significant cause of hospital admissions (Ley, 1988).

Additional studies have revealed that patient compliance with prescribed medication falls to around 50% by the second visit to the physician and continues to fall to about 30% by the fifth visit (Phillips, 1988).

It has been reported that as many as 50% of patients leave a physician's office or clinic with little or no idea of what to do to care for themselves. They don't have even a rudimentary understanding of their medical problem, and they can't describe the treatment that is prescribed for them (Svarstad, 1976).

Medication nonadherence

either willful or inadvertent, can include:

- Failing to initially fill a prescription
- Failing to refill a prescription as directed
- Omitting a dose or doses
- Taking more of a medication than prescribed
- Prematurely discontinuing medication
- Taking a dose at the wrong time
- Taking a medication prescribed for someone else
- Taking a dose with prohibited foods, liquids, and other medications
- Taking outdated medications
- Taking damaged medications
- Storing medications improperly
- Improperly using medication administration devices (e.g., inhalers).

What happens after a prescription is written?

Consider these statistics (American Heart Association):

- 12% of Americans don't fill their prescription at all
- 12% of Americans don't take medication at all after they fill the prescription
- Almost 29% of Americans stop taking their medication before it runs out
- 22% of Americans take less of the medication than is prescribed on the label

- Persistence rates, especially among those with newly diagnosed disease, also decrease over time, and in persons with newly diagnosed high blood pressure have been reported to be as low as 78% after 12 months and 46% after 54 months (Caro et al., 1999).

Main reason for not filling prescriptions, americans age 50 and older

- Cost of the drug 40%
- Side effects of drug 11%
- Thought drug wouldn't help much 11%
- Didn't think I needed it 8%
- Drug did not help 6%
- Don't like taking prescription drugs 5%
- Condition improved 4%
- Already taking too many prescriptions 3%

Source: AARP, 2004

Surveys of older adults indicate that 55% do not follow, in some way, their medication regimens (Amaral, 1986). In an AARP survey of Americans aged 50 and older (AARP, 2004), 25% said they did not fill a prescription written by their doctor in the past two years; cost was cited as the main deterrent.

A 2002 study of 325 older persons (average age of 78 years) reported that 39% were unable to read the prescription labels, 67% did not fully understand the information given to them, and as a result 45% were nonadherent.

These problems were especially prevalent in men and in people older than 85 years (Moisan et al., 2002).

It is likely that the incidence of medication nonadherence is actually higher than published reports show, as methodological difficulties associated with conducting medication adherence studies may lead to an underestimation of the extent of the problem (Haynes et al., 1979).

Adherence requires that a person:

- Show interest in his or her health and understand the diagnosis
- Understand the potential impact of the diagnosis
- Believe that the prescribed treatment will help
- Know exactly how to take the medication and the duration of therapy
- Find ways to fit the medication regimen into his or her daily routine
- Value the outcome of treatment more than the cost of treatment
- Believe that he or she can carry out the treatment plan
- Believe that the health care practitioners involved in the treatment process truly care about him or her as a person rather than as a disease to be treated

To increase adherence:

- Assessing the person's understanding about the disease and the treatment regimen and then providing information where knowledge gaps exist
- Tying the medication-taking process to other daily routines
- Using adherence aids, such as medication organizers or charts
- Simplifying medication regimens
- Providing human support within the health care team
- Recognizing difficulty in coping and other socio-behavioral issues that may affect the person's ability to follow the treatment regimen

Communication should facilitate recognition of the link between a patient's mental state and the physical experience of illness.

Communication should go beyond biomedicine to reflect and respect the patient's experience of life.

The patient should be considered an “expert” in his or her own right and therefore to have unique perspectives and valuable insights into his or her physical state, functional status, and quality of life.

A Meeting of Experts

Any clinical consultation is a meeting of two experts

Clinician - Skills & Knowledge

Client - Their body & Experience

But sometimes, people just want to be told what to do . . .

Physicians have the duty to share their medical expertise with patients in such a way that this information is **clear, relevant, and useful** to patients.

Bioethicists suggest that **power relations** in medical visits are expressed through several key elements, including

(1) who sets the agenda and goals of the visit (the physician, the physician and patient in negotiation, or the patient);

(2) the role of the patient's values (assumed by the physician to be consistent with his or her own, jointly explored by the patient and the physician, or unexamined); and

(3) the functional role assumed by the physician (guardian, advisor, or consultant).

Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. Journal of the American Medical Association, 267, 2221–2226.

DiMatteo describes three basic models of the physician-patient relationship:

(1) the active-passive model, where the patient is unable to participate in his or her own care;

(2) the guidance-cooperation model, where the physician takes the bulk of responsibility for diagnosis and treatment;

(3) the mutual participation model, which involves physician and patient making joint decisions about every aspect of care, from the planning of diagnostic studies to the choice and implementation of treatment (DiMatteo, 1991).

TYPES OF DOCTOR-PATIENT RELATIONSHIPS

Patient Control		Physician Control
	Low	*High*
Low	**Default**	**Paternalism**
High	**Consumerism**	**Mutuality**

BASIC ELEMENTS IN IDEAL RELATIONSHIPS WITH PATIENTS

- Patients as active participants
- Interdependence
- Joint decision making
- Empowerment of patients in their health
- Two-way communication.

OTHER TERMS FOR RELATIONSHIPS WITH PATIENTS

- Mutual problem-solving relationships
- Patient-centered vs. physician-centered relationships
- Open relationships
- Two-way relationships
- Mutually interdependent relationships.

THE RELATIONSHIP IDEALLY SHOULD BE

* Person focus as opposed to problem focus
- Commitment to patients
- Humanistic professional as opposed to technological soldier
- Better bedside manner
- Style of the old family doctor
- Patient-centered as opposed to physician-centered
- More concern for patients
- Caring as well as curing
- More empathy with patients
- Treating patients with respect
- Fostering more patient involvement
- Compassion for patients
- Bonding with patients
- Unconditional, positive regard for patients
- Seeing patients as persons
- Listening more to patients
- Being a teacher to patients.

TERM “COLLABORATIVE RELATIONSHIP”

In the collaborative approach the client is an active participant in the diagnosis.

Collaborative practitioners view their patients more holistically and are more person-focused than problem-focused.

They have a goal of empowering their patients in an ongoing process of self-diagnosis.

As a result, patients are more likely to feel satisfied through developing more "fate control" and less likely to feel dependent on the expert.

Cole, Steven A.; Bird, Julian

The Medical Interview:

The Three Function Approach

Elsevier Health Sciences

THE THREE FUNCTIONS

The skilled clinician strives to accomplish the three core objectives of the clinician-patient communication process:

(1) build the relationship;

(2) assess and understand the patient's problems; and

(3) collaborate for management of these problems.

To build an effective relationship

Concerns the relationship and employs skills focused on the emotional domain of the interview, including engagement, rapport, mutual respect, trust, expression of empathy, and development of the affective connection for a working alliance.

To assess and understand the patient's problems

Uses inductive and deductive information-gathering techniques to diagnose, assess, and understand patient problems as well as the patient as a person who is experiencing those problems;

Collaboratively manage problems

Relies primarily on education, patient activation, shared decision making, self-management support, and motivational skills to facilitate collaboration for management of patient problems.

F1 Build an effective relationship

Concerns the relationship and employs skills focused on the emotional domain of the interview, including engagement, rapport, mutual respect, trust, expression of empathy, and development of the affective connection for a working alliance.

F2 Assess and understand the patient's problems

Inductive and deductive information-gathering techniques to diagnose, assess, and understand patient problems as well as the patient as a person who is experiencing those problems;

F2 Goal

Collection of accurate, sufficient, and relevant data, as efficiently as possible. Understanding the patient's "explanatory model" of his or her symptoms , realizing the impact of illness on the patient's quality of life, and appreciating the patient's expectations and preferences for the encounter all contribute to achieving optimal outcomes through the collaborative management process (F3).

- Suchman, AL, Hinton-Walker, P, Botelho, RJ. Partnerships in healthcare: transforming relational process. Rochester: University of Rochester Press; 1998.
- Yedidia, MJ, et al. Effect of communications training on medical student performance. JAMA. 2003; 290(9): 1157– 1165.
- Eisenthal, S, et al . "Adherence" and the negotiated approach to patienthood. Arch Gen Psychiatry. 1979; 36(4): 393– 398.
- Kleinman, A, Eisenberg, L, Good, B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978; 88(2): 251– 258.

F3 Collaboratively manage problems

Education, patient activation, shared decision making, self-management support, and motivational skills to facilitate collaboration for management of patient problems.

F 3: Collaborate for Management

Educate patients for shared decision making,

Support patient self-management,

Motivate patients for adaptive health behaviors.

addresses all of these separate but related objectives, it is clearly the most complex of the three functions of the interview

F1 Build the Relationship

- Clinicians with good relationship skills will have patients who are more satisfied and who will be more likely to adhere to treatment recommendations.
- Roter, DL, Hall, JA. Communication and adherence: moving from prediction to understanding. Med Care. 2009; 47(8): 823– 825.

Group of basic skills that help build the clinician-patient relationship:

(1) nonverbal skills;

(2) reflection;

(3) legitimation;

(4) support;

(5) partnership; and

(6) respect.

Nonverbal Skills

- The nonverbal behavior of the physician contributes significantly to the overall quality of the doctor-patient relationship.
- Roter, DL, et al. The expression of emotion through nonverbal behavior in medical visits. Mechanisms and outcomes. J Gen intern Med. 2006; 21(Suppl 1): S28– S34.
- Quiet, attentive listening conveys interest and builds rapport more powerfully than virtually any other action or utterance the physician can make.
- Roter, DL, et al. The expression of emotion through nonverbal behavior in medical visits. Mechanisms and outcomes. J Gen intern Med. 2006; 21(Suppl 1): S28– S34.
- Hall, JA , et al. Nonverbal sensitivity in medical students: implications for clinical interactions. J Gen Intern Med. 2009; 24(11): 1217– 1222.

- Doctors who establish appropriate eye contact are more likely to detect emotional distress in their patients.

- Goldberg, DP, et al. Training family doctors to recognize psychiatric illness with increased accuracy. Lancet. 1980; 2(8193): 521– 523.

- Doctors who lean forward and have an open body posture also have more satisfied patients.

- Roter, DL, et al. The expression of emotion through nonverbal behavior in medical visits. Mechanisms and outcomes. J Gen intern Med. 2006; 21(Suppl 1): S28– S34.
- Hall, JA , et al. Nonverbal sensitivity in medical students: implications for clinical interactions. J Gen Intern Med. 2009; 24(11): 1217– 1222.
- Halpern, J. What is clinical empathy? J Gen Intern Med. 2003; 18(8): 670– 674.

Empathy

- Empathy starts with an individual's appreciation, understanding, and acceptance of someone else's life situation.
- The communication of this understanding and acceptance completes the empathic process and becomes, in virtually every situation, the most helpful, meaningful, and comforting intervention one person can have with another.

Reflection

Refers to the physician recognizing and naming the emotional or cognitive response of the patient; statement of an observed feeling or thought of the patient.

This type of reflective comment usually helps the provider communicate empathic concern for the patient's emotional situation.
In actual practice, such comments function as facilitators and usually give patients “permission” to talk more about the feelings or thoughts they experience.

physician: You look sad right now.

or

physician: I can see this is upsetting to you.

or

physician: This is hard to talk about.

It is generally helpful and supportive to allow patients the opportunity to express verbally the feelings that are near the surface of awareness.

- Such interventions help develop rapport and actually contribute to the overall efficiency of the interview.

Roter, D, Hall, JA. Doctors talking with patients/ patients talking with doctors: improving communication in medical visits, ed 2. Westport, Conn.: Praeger; 2006.

- Gerrity, MS, et al. Improving the recognition and management of depression: is there a role for physician education? J Fam Pract. 1999; 48(12): 949– 957.
- Roter, DL, et al . Improving physicians' interviewing skills and reducing patients' emotional distress. A randomized clinical trial. Arch Intern Med. 1995; 155(17): 1877– 1884.

Furthermore, despite the belief that such attention to the emotional domain of patient care increases interview time, research indicates the contrary:

after training, empathic communication by primary care physicians improved numerous outcomes of importance (*e.g., recognition of emotional disorders, patient satisfaction, disclosure of information, and decreased emotional distress*) **without increasing overall interview time**.

- Roter, D, Hall, JA. Doctors talking with patients/ patients talking with doctors: improving communication in medical visits, ed 2. Westport, Conn.: Praeger; 2006.
- Gerrity, MS, et al. Improving the recognition and management of depression: is there a role for physician education? J Fam Pract. 1999; 48(12): 949– 957.
- Roter, DL, et al . Improving physicians' interviewing skills and reducing patients' emotional distress. A randomized clinical trial. Arch Intern Med. 1995; 155(17): 1877– 1884.

Rule #1

Respond to patient's feelings as soon as they appear.

Legitimation

or validation, refers to the physician's confirming that the response is understandable and acceptable.

Is closely related to reflection but indicates an intervention that specifically communicates acceptance of and respect for the patient's emotional experience.

After a physician has carefully listened to the patient's discussion of an emotional reaction, the physician should let the patient know that the feelings are understandable and make sense to the physician.

ph: I can certainly understand why you'd be upset under the circumstances. or
ph: Anyone would find this very difficult. or
ph: Your reactions are perfectly normal. or
ph: This would be anxiety provoking for anyone. or
ph: Of course you're angry. Anyone would be.

With respect to validating the feelings of someone who is angry, it is important to realize that the physician does not have to agree with the reasons for the anger.

It is important to first try to understand this anger from the patient's point of view and then communicate this realization to him or her.

Personal Support

Statements of personal support enhance rapport.

The physician should make explicit efforts to reassure the patient that he or she is there and wants to help.

Limited self-disclosure is also appropriate.

- *physician: I want to help in any way I can.*

or

- *physician: Please let me know what I can do to help.*

Partnership

Patients are more satisfied with physicians and are more likely to adhere to treatment recommendations when they feel a sense of partnership with their physicians.

Dye, NE, DiMateo, MR. Enhancing cooperation with the medical regime. In: Lipkin M, Jr., eds. The medical interview: clinical care, education, and research. NY. P: Springer; 1995: 134– 136.

Increasing the participation of a patient in his or her treatment improves coping skills and increases the likelihood of a good outcome .

Roter, DL, Hall, JA. Communication and adherence: moving from prediction to understanding. Med Care. 2009; 47(8): 823– 825.

physician: *Once I have reviewed our options, I'd like us to work together to develop a treatment plan that works for you.*

Or

physician*: After we've talked more about your problems, I'm confident we can work together to find some solutions.*

Respect (Affirmation)

The physician's respect for patients and their problems is implied by attentive listening, specific nonverbal signals, eye contact, and genuine concern.

However explicit, respectful comments also help build rapport, improve relationships, and help patients cope with complex situations.

- *physician: I'm impressed by how well you're coping.*

or

- *physician: You're doing a good job handling the uncertainty.*

or

- *physician: Despite your feeling so bad, you're still able to carry on at home and at work. That is quite an accomplishment.*

Like all discussed interventions, statements of affirmation must be honest or they will be more destructive than helpful.

P(E) ARLS

Five skills to build the relationship:

- Partnership
- (Empathy), expressed through reflection and legitimation
- Affirmation (respect)
- Reflection
- Legitimation
- Support

THE RELATIONSHIP IDEALLY SHOULD BE

* Person focus as opposed to problem focus
- Commitment to patients
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- Seeing patients as persons
- Listening more to patients
- Being a teacher to patients.

F2: Assess and Understand

1. Nonverbal listening behavior
2. Questioning style: open-ended questions and the open-to-closed cone
3. Rule #2: Let the patient complete the opening statement.
4. Facilitation
5. Clarification and direction
6. Checking/ summarizing
7. Rule #3: When in doubt, check.
8. Survey problems: What else?
9. Avoid leading questions.
10. Elicit the P's perspective: "**ICE**".
11. Explore the impact of the illness on the P's quality of L.

Patients will usually continue speaking when they feel their physician is listening. Physicians who look at their patients and maintain an attentive and interested body posture will be more likely to instill confidence and trust than doctors who

retreat behind a desk,
slouch in a chair,
drink coffee while talking, or

try to read or write in the chart while also trying to listen.

A considerable body of literature supports the use of open-ended questioning as the most efficient and effective vehicle to gain an accurate and complete understanding of patients' problems.

Headache 1

- *physician: What can I do for you today?*
- *patient: I've been having terrible headaches.*
- *physician: I'm sorry. Where is the pain?*
- *patient: The pain is all over.*
- *physician: Is the pain sharp or dull?*
- *patient: Dull.*
- *physician: Does the pain come and go, or is it there all the time?*
- *patient: It comes and goes. But when the headache comes, it may be there for several days.*

Headache 2

- *physician: What can I do for you today?*
- *patient: I've been having terrible headaches.*
- *physician: Can you tell me some more about these headaches?*
- *patient: Well, they come on slowly and get worse and worse over several days. They seem to come only in the hay fever season when my allergies get worse.*

Headache 3

- *physician: Can you tell me some more about your headaches?*
- *patient: Well, they only started about 3 weeks ago and seem to come on when I'm in the library late at night studying for exams.*

Rule #2

Let the Patient Complete the Opening Statement!

Checking (or summarizing)

Checking feels reassuring to the patient because he or she realizes the doctor is interested in gaining an accurate understanding of the problem, and this promotes trust as well as the patient's experience of the physician as caring.

It also allows the patient the opportunity to correct any misinformation that is presented.

Anxiety in communication

There are so many different questions that medical students need to learn that they commonly “freeze” and find it hard to know in which direction they should go. They find it hard to remember what they have just heard as they think about what they must ask next.

Beginning interviewers, in particular, find **checking** useful to help manage their own anxiety while trying to conduct an efficient interview.

Rule #3

When in Doubt, Check

Survey Problems: “What Else?”

- “What else is bothering you?” to be the most important question he asks his patients.
- Sometimes, if the physician directs the interview too strongly, patients may be too anxious to remember to discuss all their concerns, or there are simply too many to get to.
- *“Oh, by the way, doctor … is this chest pain important?”*

“What Else?”

Late questions create difficulties for physicians because they are unpredictable, add anxiety, and require time and attention that may not already have been allocated for this patient. Such situations are common . Studies indicate they occur in up to 20 % to 35% of interviews. Use of surveying techniques can decrease these problems significantly.

It is recommended that the physician begin surveying problems shortly after eliciting and briefly exploring the patient's chief complaint. (The chief complaint is defined as the patient's response to the clinician's first open-ended question: “What problem brought you here today?”).

physician: *Now that I've heard a little about your headache, your allergies, and some of your recent stresses, I'd like to make sure I know something about all your other problems before we get back to them one at a time.* ***What else is bothering you?***

“What else is bothering you? ” vs.

“Is there anything else bothering you?”.

“You don't have any other problems, do you?”

The clinician should continue asking, “What else is bothering you?” until the patient indicates that all the problems have been mentioned.

Leading questions can result in significant and sometimes dangerous misinformation:

physician: The pain doesn't go down your arm, does it?

patient: No, not really.

Patients tend to be strongly influenced by the wording of a clinician's question, especially if the wording implies that a certain kind of answer is expected.

Because the patient usually wants to please the clinician, a leading question will usually elicit the answer the clinician expects.

physician: The pain doesn't go down your arm, does it?

patient: No, not really.

"How helpful was the medication I gave you?"

What effects, good and bad, did the medication have?

Patient's Perspective - ICE

- Explore the Patient's **Ideas** about the Meaning of the Illness
- Elicit the Patient's **Concerns** about the Problems
- Elicit the Patient's **Expectations**

- Eisenthal, S, Lazare, A. Evaluation of the initial interview in a walk-in clinic. The clinician's perspective on a "negotiated approach.". J Nerv Ment Dis. 1977; 164(1): 30– 35.
- Eisenthal, S, Koopman, C, Lazare, A. Process analysis of two dimensions of the negotiated approach in relation to satisfaction in the initial interview . J Nerv Ment Dis. 1983; 171(1): 49– 54.
- Eisenthal, S, et al . "Adherence" and the negotiated approach to patienthood. Arch Gen Psychiatry. 1979; 36(4): 393– 398.

Impact of the Illness on the Patient's Quality of Life

This includes the impact on

(1) interpersonal relationships (*especially spouse, significant other, and family*),

(2) work,

(3) sexual relationships, and

(4) emotional stability.

Social stress and social support

- For example, among patients experiencing their first heart attacks, those patients with low support and high stress were four times more likely to die of a repeat heart attack in the subsequent year.

- Rozanski, A, et al. The epidemiology , pathophysiology, and management of psychosocial risk factors in cardiac practice: the emerging field of behavioral cardiology. J Am Coll Cardiol. 2005; 45(5): 637– 651.

The CAGE interview

Helpful in eliciting information suggestive of alcohol abuse. Ewing, JA. Detecting alcoholism: the CAGE questionnaire. JAMA. 1984; 252: 1905.

- C Have you ever felt the need to **cut down** on your drinking?
- A Do you ever get **annoyed** when people tell you to cut down on your drinking?
- G Do you ever feel **guilty** about drinking too much?
- E Have you ever needed an "**eye-opener**" in the mornings?

If the patient answers yes to any of the four questions of the CAGE model, the possibility of alcohol abuse or risky drinking is present and must be explored in more detail.

F3 COLLABORATE FOR MANAGEMENT

1. Education about illness
2. Self-management support tool ≈ Brief Action Planning (BAP) ↔ Motivational interviewing (MI).

Education about illness

Use (e) TACCT:

elicit patient's baseline understanding of the problem.

Tell the patient the core message.

Ask the patient for his or her understanding of the condition and his or her reaction.

Care by responding to the emotional impact (using Function One skills).

Counsel the patient about the details of the educational message.

Tell-back: Ask the patient to “T ell-back” the core details of the message.

Brief Action Planning

1. Elicit patient ideas for change
2. Offer a behavioral menu when needed or helpful
3. SMART behavioral planning
4. Elicit the commitment statement
5. Question Two: Scale for confidence
6. Problem solving to increase confidence level when necessary
7. Arrange accountability
8. Follow-up

Motivational Interviewing

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Motivational Interviewing

- Is an effective way of talking with people about change.
- Effective → evidence based.

Addictions; physical activity; dieting/weight loss; smoking; study habits; exercise

When change is hard to realize

often it is NOT because of

Lack of info; Laziness; Oppositional personality; Denial

Ambivalence!

uncomfortable → anxiety →procrastination

Not a resistance

MI can help resolve ambivalence and help elicit a person's own motivation to change.

The Spirit of MI

Partnership

Acceptance

Compassion

Evocation

Core Skills

Open Questions

Affirmations → awards, attempts; achievements; accomplishments;

Reflections → understanding what the client is thinking and feeling then saying it back to the client;

Summaries → a long reflection of more than one client statement

4 Processess

Engaging – the process of establishing a trusting and mutually respectfull relationship

Focusing – an ongoing process of seeking and maintaining direction

Evoking – eliciting a patient's own motivation for change; eliciting change talk

Planning

Engaging

The process of establishing a trusting and mutually respectfull relationship

Focusing

An ongoing process of seeking and maintaining direction

Evoking

Eliciting a patient's own motivation for change;

Eliciting change talk

Planning

Developing a specific change plan that the patient agrees to and is willing to implement

Specific

Measurable

Achievable

Relevant

Timed

BREAKING THE BAD NEWS
for the patient

Bad news

Any information which adversely and seriously affects an individual's view of his or her future.

Bad news is always, however, in the “eye of the beholder,” such that one cannot estimate the impact of the bad news until one has first determined the recipient's expectations or understanding.

Breaking bad news

- Prepare *yourself (*to feel badly)
- Set the context.
- Prepare patient
- Deliver the bad news clearly and unequivocally
- Express your commitment of support
- Make a plan
- Finally, follow up

6-STEP STRATEGY FOR BREAKING BAD NEWS

SPIKES

S—SETTING UP the interview

P—ASSESSING THE PATIENT'S PERCEPTION

I—OBTAINING THE PATIENT'S INVITATION

K—GIVING KNOWLEDGE AND INFORMATION TO THE PATIENT

E—ADDRESSING THE PATIENT'S EMOTIONS WITH EMPATHIC RESPONSES

S—STRATEGY AND SUMMARY