

DAVID SUN LECTURE: HELPING YOUR PATIENT BY HELPING YOURSELF: HOW TO IMPROVE THE PATIENT-PHYSICIAN RELATIONSHIP

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We have all heard the statements starting with William Osler (“90% of the diagnosis comes from the history”) and from our patients (“My doctor doesn’t have time for me,” “my doctor doesn’t listen to me, all s/he does are tests,” etc.). We also know that the health care system is imploding because of spiraling costs for care and dissatisfied patients. Is there a solution?

There is growing evidenced that the key to success in patient care is a good patient-doctor relationship. In this era, it doesn’t bring in more money but it may help reduce costs for care. The value of good communication skills and the building of an effective relationship with the patient is supported by several medical studies that show that these skills can lead to improved patient and physician satisfaction, better disclosure of important information, greater adherence to treatment, reduced emotional distress, improved physiological parameters and overall better clinical outcomes.¹⁻⁶ Conversely, ineffective communication skills and a poor patient provider relationship are associated with low patient satisfaction and even an increase in malpractice claims.⁷

What Do Patients Tell Us?

From what patients tell us in practice or through reading internet websites, we are getting a good view of the patient experience in health care (which may be supported when we go to a physician as a patient). The quotations below are actual comments that I’ve been told when seeing my patients with complex functional GI and motility problems.

“Why aren’t I being treated like other patients....I feel so alone.” Many patients do not believe they are receiving proper care and feel isolated from their health care.

“Doctors don’t believe me....I know it’s real....There must be something wrong....They really don’t know what I’m going through....sometimes I feel like I’m going crazy.” Patients also feel that their providers do not understand or believe their symptoms and they desperately want to be believed. They have fears that it’s all “in the mind” and feel isolated almost as “medical orphans.”⁸ While it is unlikely that providers have directly communicated such perspectives, there are sufficient patient commentaries to suggest that this is occurring indirectly either by faulty communication through non-verbal behaviors, or by dialog that communicates mixed messages or provider uncertainty.⁹

“My doctor doesn’t treat me like a person.” Patients do not feel that their providers fully consider the whole person or explore their life experience. They would like them to understand the impact of their symptoms on work, social and family life, the patient’s expectations and beliefs, and the influence of ethnic or sociocultural mores.

“My doctor doesn’t listen to what I have to say....He doesn’t believe me.” There are often discrepancies between the beliefs of patients and their peers (e.g., on the internet) compared to their providers relating to the cause and possible treatments for their conditions, e.g., they may focus on diet and lifestyle while their doctors do not see this as relevant.

“I’m getting much better treatment from a holistic doctor.” Many patients are seeking alternative treatments because they are dissatisfied with the type of care received from their health care providers. Many practitioners of CAM have learned the ways to engage patients effectively.

“She just tells me what to do.” Patients want to participate in the decision-making regarding the options for treatment. Those that do not need to be encouraged to do so.

Family members are also impacted with chronic illness and need to be involved in the patient’s education and in care decisions. However, the patient is primarily responsible.

Finally, patients who feel uncertain about their illness and are involved negatively with their health problems (i.e., worried, depressed, helpless and hopeless) tend to be dissatisfied with their care.⁶ However, patients are more satisfied with providers who are trained in good communication skills.⁶ This further highlights the value of learning these techniques.

Factors Relating to Good Patient-Provider Interactions

There are guidelines developed by expert clinicians and educators which are used to teach clinicians good communication techniques.^{3,10-13} Here are some basic observations:³

Patient satisfaction relates to the patient’s perception of the provider’s humaneness, technical competence, interest in psychosocial factors and his/her provision of relevant medical information. However, too much focus on biomedical issues can have a negative effect.^{14,15}

Table 1: Behaviors Influencing Accurate Data Collection

BEHAVIOR	FACILITATES	INHIBITS
Nonverbal		
Clinical environment	Private, comfortable	Noisy, physical barriers
Eye contact	Frequent	Infrequent or constant
Body posture	Direct, open, relaxed	Body turned, arms folded
Head nodding	Helpful if well timed	Infrequent, excessive
Body proximity	Close enough to touch	Too close or too distant
Facial expression	Interest, empathy, understanding	Preoccupation, boredom disapproval
Touching	Helpful when used to communicate empathy	Insincere if not appropriate or properly timed
Verbal		
Question forms	Open ended to generate hypotheses	Rigid or stereotyped style
	Closed ended to test hypotheses	Multiple choice or leading questions ("You didn't...?")
	Use of patient's words	Use of unfamiliar words
	Fewer questions and interruptions	More
Question style	Nonjudgmental	Judgmental
	Follows lead of patient's earlier responses	Follows preset agenda or style
	Use a narrative thread	Unorganized questioning
	Appropriate use of silence	Frequent interruptions
	Appropriate reassurance	Premature or unwarranted reassurance
	Elicits pertinent psychosocial data in a sensitive and skillful manner	Ignores psychosocial data or uses "probes"

Methods that engage the patient, improve clinical outcome, treatment adherence, reduce symptoms and need for pain medication, and which shortened hospital stay include: good eye contact, affirmative nods and gestures, a partner like relationship, closer interpersonal distance and a gentle tone of voice.^{16,17}

Providers who engage in good communication skills are more likely to like their patients and their work, and their patients are more satisfied.¹⁸

Recommendations to Improve the Patient Provider Relationship

What Not To Do

If clinicians work from their own agenda and don't consider where the patient is, well meaning statements may be misunderstood and have negative effects. For example: "Don't worry, it's nothing serious" will likely have negative consequences for patients who feel not believed or even stigmatized with their disorder. "Your problem is due to stress" can be viewed by patients as stigmatizing and diminishing what they see as "real." It is best to respond to what the patient perceives as the factors contributing to the symptoms. Importantly, the provider needs to accept the reality of the patient's perception as serious and clarify that the symptoms are not due to a psychiatric disorder; rather it is a medical condition which can be psychologically distressing. Also, a comment: "I'd like

to order a few tests to be sure there is nothing wrong, but I believe they'll be normal" is not reassuring. It communicates a mixed message that can be viewed as placating to the patient or that the provider is practicing defensive medicine.

Tips and Strategies

The basis for an effective patient-provider relationship occurs through proper interview technique. It is patient centered, i.e., based on creating the proper environment that encourages the patient to give personal high quality information, both medical and psychosocial. This occurs through both verbal statements, the behavioral context within which it is said and in relation to facilitative non-verbal behaviors that create a comfortable environment and help create a partnership of care:

Listen Actively – The clinical data is obtained through an active process of listening, observing and facilitating. Questions should evolve from what the patient says rather than strictly from a predetermined agenda. If uncertain of the patient's response, it helps to restate the information asking for clarification, and this reaffirms to the patient the provider's commitment to understand.

Accept the Reality of the Disorder – Many providers may have difficulty accepting functional GI or other somatic syndromes as bona fide since there is no biomarker or specific

diagnostic test. It drives behaviors such as frequently ordering of tests or communicating uncertainty. These are patients who desperately want to be believed. The solution here is to accept the diagnosis as real and focus on the commitment to work with the patient and his/her illness by listening, communicating interest and concern, and offering support.

Stay Attuned to Questioning Style and Non-verbal Messages – Often, it's not what you say, but how you say it that makes the difference. Table 1 gives examples of several behaviors that either facilitate or inhibit the acquisition of data from the patient. In general, the physician wants to communicate nonjudgmental interest in an environment of comfort, support and security.

Elicit the Patient's Illness Schema – To properly negotiate treatment, the provider must identify how the patient understands the illness. In doing so, a dialogue can begin that will lead to a mutually specified set of goals. For example, even with years of symptoms, patients may expect the physician to diagnose a different, structural disease and affect a cure. But the provider sees this as a chronic disorder requiring ongoing management. Thus, these differences must be reconciled in order for the patient to accept treatment and cope with the disorder.

Several questions can be routinely asked to understand better the patient's illness schema:

"What brought you here today?" With chronic illness, a patient may choose to be seen for many possible reasons at this time: symptoms are worse, major psychological stress occurring, insurance issues, being urged by family, etc. Knowing the reason can help gauge the direction of the visit.

"What do you think you have?" Patients have certain concepts or "schema" that are personal, familial or cultural. They need to be understood and acknowledged before any reeducation, if needed, can be done.

"What worries or concerns do you have?" Patients may not say they are afraid of cancer or that a close family member died of the same disease. By offering the opportunity to express their concerns, the patient is more receptive to hear your thoughts on the matter.

"What are your thoughts of what I can do to help?" It's not uncommon for patients to be dissatisfied after a few months of care because their expectations were not being met. A patient may come in expecting a cure and the doctor sees this as a chronic management issue. However, if the differences in expectations are discussed on the first visit, some resolution can be achieved through mutual planning on the goals of care.

Offer Empathy – The physician provides empathy by demonstrating an understanding of the patient's pain and distress, while maintaining an objective and observant stance. An empathic statement would be: "I can see how difficult it has been for you to manage with all these symptoms." or "I can see how much this has affected your life." Providing empathy improves patient satisfaction and adherence to treatment.

Validate the Patient's Feelings – When patients disclose personally meaningful information, they may experience shame or embarrassment. So the physician needs to validate the patients' feelings, rather than make personal judgments or close the communication by a quick reassurance or solution.³ A validating statement to a patient who is feeling stigmatized by others saying the problem is stress related: "I can see you are frustrated when people say this is due to stress and you know it's real." This not only validates the feelings but can open the door to further dialogue about how the condition can itself be stressful.

Be Aware of Personal Thoughts and Feelings – Patients may interact in ways that are perceived as overly cautious and "resistant" to recommendations, or even demanding or adversarial. This may relate to earlier negative experiences with their health care. The providers may in turn respond defensively by getting angry, doing unneeded studies or over-medicating. The provider needs to understand such patient behaviors as responses to deficits in the health care system rather than as patient problems. The provider must also "tune in" to personal thoughts and feelings (e.g., "What is it about this patient's behavior that makes me feel frustrated?") in order to prevent counter therapeutic responses.

Educate – Education should be an iterative process. It involves several steps: 1) eliciting the patient's understanding, 2) addressing misunderstandings, 3) providing information that is consistent with the patient's frame of reference or knowledge base, and 4) checking the patient's understanding of what was discussed. It is important to provide clear explanations for symptoms and treatments within the context of explanatory models that are understandable, relate to treatment and consistent with the patient's beliefs. For example, the provider can explain that IBS relates to an oversensitivity of the nerves in the gut and/or in the brain's failure to "turn down" the pain signals. This plausible hypothesis can open the door, to further discussion about testing and treatment options.

Reassure – Patients fear serious disease and have negative thoughts and feelings about their condition – a lack of control and helplessness. Yet reassurance needs to be realistic since a clear understanding of CMI is not yet established. The approach is to: 1) Identify the patient's worries and concerns, 2) acknowledge or validate them, 3) respond to their

specific concerns, and 4) Avoid “false” reassurances (e.g., “Don’t worry, everything’s fine”) particularly before an initial medical evaluation is done.

Negotiate – The patient and physician must mutually agree on diagnostic and treatment options. The provider should then ask about the patient’s personal experience, understanding and interests in various treatments, and then provide choices (rather than directives) that are consistent with the patient’s beliefs. Negotiation is particularly important in certain situations such as recommending an antidepressant (which may be viewed as a “psychiatric” drug rather than a centrally acting analgesic), or when referring to a psychologist for PTSD or treatment of other psychological symptoms.

Help the Patient Take Responsibility – Patients need to actively participate in their health care, and this can be communicated in several ways. For example, rather than asking the patient: “How are your symptoms today?” one might say: “How are you managing with your symptoms?” The former question tends to leave the responsibility for dealing with the pain with the physician, while the latter acknowledges the patient’s role. Another method includes offering any of several treatment approaches with a discussion of their risks and benefits, so the patient can make the choice.

Establish Boundaries – In the care of some patients, maintaining “boundaries” in terms of frequent phone calls, unexpected visits, a tendency toward lengthy visits, or unrealistic expectations for care need to be addressed. The task is to present the provider’s needs in a way that is not perceived as rejecting or belittling to the patient. For example, setting limits on time can be accomplished by scheduling brief but regular appointments of a fixed duration, rather than attempting to extend the time of a particular visit.

Provide Continuity of Care – Many patients with CMI feel isolated from the health care system and even from other peers who have easier to understand medical conditions. It is valuable to make it clear from the outset that the commitment to care is long term in order to manage what may be a chronic condition. Making the commitment to work with the patient obviates patient fears of abandonment.

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