**LECTURE #4** *(Course – Psychology of Communication, Lutsenko, O. L., 2018)*

**Topic: Contacts with patient: Fostering the relationship and gathering information**

Topic 6. Contacts with patient: Fostering the relationship:

Expressed interest in the patient as a person. Treated the patient with respect. Listened and paid attention to the patient. The role of patient’s personality and individuality.

Topic 7. Contacts with patient: Gathering information:

Encouraging the patient to tell his/her story. Coping with time limit. Sociocultural aspects of communication. Exploring the patient’s reaction to the illness or problem.

Among inter-personal relationships, the doctor-patient relation is one of the most complex ones. It involves interaction between individuals in non-equal positions, is often non-voluntary, concerns issues of vital importance, is therefore emotionally laden, and requires close cooperation

**Contacts with patient: Fostering the relationship**

Main aspects of fostering the relationship:

Expressed interest in the patient as a person

Treated the patient with respect

Listened and paid attention to the patient personality and individuality

Dominick Frosch, *(PhD, an associate investigator at the Palo Alto Medical Foundation's Research Institute and associate professor at the University of California, Los Angeles)*, and colleagues held focus groups in San Francisco to explore how patients discuss health-care issues with their physicians *(Health Affairs, 2012)*. They found that even well-educated patients feel intimidated in the physician's office.

"In the context of a medical consultation, people feel uniquely vulnerable," Frosch says. "Asserting their views might require disagreeing. Patients fear that will lead to negative consequences that might impact their care in the future."

The result? Patients often hold back from asking questions or sharing opinions, and end up less involved than they could be in making their own medical decisions (<https://www.apa.org/monitor/2012/11/patient-physician>).

People often don’t give important information to the doctor by such reasons:

1) they misinterpret and underestimate the significance of their problems;

2) they worry about how they look if the symptoms turn out to be nothing;

3) they are concerned about too much troubling their physicians;

4) they don’t want to change their social plans by long or complex examination and treatment.

**The role of patient’s personality and individuality**

Personality is made up of the characteristic patterns of thoughts, feelings, and behaviors that make a person unique. Personality arises from within the individual and remains fairly consistent throughout life.

Some of the fundamental characteristics of personality include:

1. *Consistency*. There is generally a recognizable order and regularity to behaviors. Essentially, people act in the same ways or similar ways in a variety of situations.

2. *Psychological and physiological*. Personality is a psychological construct, but it is based on biological processes and needs.

3. *It impacts behaviors and actions*. Personality influence how we respond in our environment; it causes us to act in certain ways.

4. *Multiple expressions*. Personality is displayed more widely than only in just behavior. It can also be seen in our thoughts, feelings, close relationships and other social interactions.

What is known about communication and behavior in medical environment of people with different personality peculiarities?

Studies have shown that people who are relatively high in anxiety tend to report more symptoms of illness then others do.

People who are high in neuroticism experience higher levels of anxiety and tend to be “high-strung”. This characteristic often translates into oversensitivity to symptoms and to more complaining about ill health.

A thorough review of the personality and health literature suggested that people with chronic negative affect show a disease-prone personality.

People who monitor their symptoms to an extreme may be hypochondriacs. If person have hypochondriac personality tendency or disorder, he/she have excessive preoccupation with one’s health and constant worry about developing physical illness. Hypochondriacs believe that any minor change in their condition could be a sign of a major problem. They are constantly going to their physicians to be checked. Even they are told they are all right, they don’t believe the diagnosis and may change doctors (“doctors shopping”). Among patients with different psychological problems, hypochondriacs reported suffering more often from abdominal pain, and they reported a higher intolerance of bodily complaints.

Munchausen syndrome or Munchausen syndrome by proxy. They relate to Factitious disorder that is a serious mental disorder in which someone deceives others by appearing sick, by purposely getting sick or by self-injury. Factitious disorder also can happen when family members or caregivers falsely present others, such as children, as being ill, injured or impaired (Munchausen syndrome by proxy). Factitious disorders are described in the literature as having a broad spectrum of physical and/or psychological symptoms and signs which are invented and produced by the patient, who has the intention of acting out the role of a sick patient.

When such patients arrive at a general hospital with a dramatic presentation and extreme complaints, a prolonged admission often follows. Their clinicians quickly become frustrated by the patients’ demanding interpersonal styles, their deception and manipulation. These difficulties can lead to poor outcomes for patients and staff alike.

Factitious disorder is challenging to identify. These people involve mimicking or producing illness or injury or exaggerating symptoms or impairment to deceive others. People with the disorder go to great lengths to hide their deception. They continue with the deception, even without receiving any visible benefit or reward or when faced with objective evidence that doesn't support their claims.

How those with factitious disorder fake illness?

* *Exaggerating existing symptoms.* Even when an actual medical or psychological condition exists, they may exaggerate symptoms to appear sicker or more impaired than is true.
* *Making up histories*. They may give loved ones, health care professionals or support groups a false medical history, such as claiming to have had cancer or ulcer. Or they may falsify medical records to indicate an illness.
* *Faking symptoms*. They may fake symptoms, such as stomach pain, seizures or passing out.
* *Causing self-harm* *or harm to their child*. They may make themselves sick, for example, by injecting themselves with bacteria, milk, gasoline or feces. They may injure, cut or burn themselves. They may take medications, such as blood thinners or drugs for diabetes, to mimic diseases. They may also interfere with wound healing, such as reopening or infecting cuts.
* *Tampering*. They may manipulate medical instruments to skew results, such as heating up thermometers. Or they may tamper with lab tests, such as contaminating their urine samples with blood or other substances.

These conditions generate high costs and unnecessary procedures in health care facilities, and their underdiagnose might be for lack of health professional’s knowledge about them, and difficulty to differentiate these patients from others, who really have high morbidity and mortality.

Other personality trait such as optimism and self-esteem normally buffer us against stress and illness but may delay us from seeking treatment. E.g. people with high self-esteem believe that they are very healthy and are optimistic in their outlook. They may also believe that their bodies can fight off infections or heal without any specific medical treatment. These people may wait to see if they get better. Low self-esteem individuals have been found to report more health problems.

Other specific individual difference refers to how patients involving in the health care process. Patients vary in how much they want to be involved in their treatment and how much information they want. Behavioral involvement includes the patient’s attitude toward self-care, specifically an active involvement in treatment. Informational involvement measures how much the patient wants to know about his or her illness and specific details of its treatment. It may be important to match a patient with a certain preference for information (high in information involvement) with a practitioner who is accepting of such a preference. A lot of studies showed that preference-match strategies in physician-patient communication lead to positive effects on treatment outcomes.

Age and gender role

Women and elderly persons use health services and report their symptoms to the doctors at a significantly higher rate than do men and younger individuals. Part of this difference is because these two groups have more specific issues that need care such as pregnancy and childbirth for women, and chronic and terminal illnesses among elderly persons. Women have been shown to be more sensitive to changes in their bodies than men are and may find it more socially acceptable to report symptoms than men. Men may not report symptoms or pains as much so as not to appear weak (“boys don’t cry”).

So men need more encouragement from doctor to tell full story about their health condition.

Role of patients training/informing. Researcher Ho has explored the feasibility and effectiveness of training patients to communicate more effectively with their physicians. In one project, she and her colleagues trained patients to talk with their physicians about their use of complementary and alternative medicine (CAM). Studies show most patients don't tend to talk about their CAM usage at medical appointments — a problem since some alternative therapies could interfere with conventional medicines. Ho and her team conducted a workshop to help patients build four skills: *preparing a list of questions before the appointment; being proactive by initiating the CAM conversation; disclosing all CAM use; and asking relevant questions*. After the workshop, more than half of patients mentioned their CAM use within the next two physician visits. Follow-up surveys also indicated that more than 80 percent of participants demonstrated the "be proactive" skill while meeting with their physicians *(Patient Education and Counseling, 2012).* In the case of CAM, good communication is more than simply knowing which herbs a patient takes. It's about fully understanding each patient's health-care preferences and habits.

**Gathering information**

Main aspects:

Encouraged the patient to tell his/her story

Explored the patient’s reaction to the illness or problem

**Ability to conduct patient’s interview**

The first goal for both practitioner and student is the accurate and complete diagnosis of the patient’s condition, while the second goal for the practitioner is appropriate treatment planning with which the patient will comply *(Pendleton, Schofield, Tate and Havelock, 1984).*

Critics and researchers have suggested that students trained using this traditional history-taking format do develop diagnostic skills, at the same time, show a progressive tendency to focus only on patients’ pathophysiological complaints *(Barbee and Feldman, 1970; Helfer, 1970).* This focus on physiological aspects of medicine is usually accompanied by a marked unwillingness or inability to explore patients’ psychological and social worlds *(Poole and Sanson-Fisher, 1979; Maguire, 1984; Flaherty, 1985).* Researchers have argued that many students’ interactional skills appear to become poorer rather than better over the course of their medical education.

Early in their clinical experience, students display a keen interest in, and concern for, patients and their problems. As medical knowledge increases, their approach to patients changes. They begin to focus on illness symptoms, underlying aetiology and functional enquiry, perhaps ignoring what patients say about themselves and their struggle to cope with illness *(Poole and Sanson-Fisher, 1979; Preven, Kachur, Kupfer and Waters, 1986).* Thus, to patients, students appear less caring, conducting interrogations rather than conversations *(Nichols, 1984; Preven et af., 1986).*

These changes to students’ interviewing styles have been further highlighted in research studies which have contrasted the traditional format for training in medical interviewing with specialised consulting skills training programmes.

Verby et al. (1979) developed a 17 item scale (later transformed into16 item) with which to measure the consulting skills of general practice trainees.

**Table 1 Communication skills of students’ history-taking consultations**

|  |  |
| --- | --- |
| 1. Beginning interview | Greeting of patient and clarity of purpose for interview. |
| 2. Seating arrangement | Open, facilitative arrangement which helps communication. |
| 3. Body posture | Open posture. Use of unconscious mannerisms. |
| 4. Eye contact | Maintenance of appropriate eye contact to regulate communication flow. |
| 5. Interruptions | Speaking over patient. Use of non-verbal cues to interrupt. |
| 6. Use of facilitation | Student’s techniques for helping patient to express ideas, e.g. minimal encouragers, reflection. |
| 7. Maintaining relevance | How effectively the student keeps the patient “on-the-track.” |
| 8. Psychosocial concerns related to diagnosis | The student’s attempts to include relevant psychological and social factors in the discussion. |
| 9. Empathy | The student’s expressed understanding of what the patient is feeling and communicating. |
| 10. Use of silence | Use by student to encourage patient to talk. |
| 11. Personal and social issues | Student’s willingness to discuss emotional or highly personal issues raised by patient. |
| 12. Verbal or non-verbal leads | Student’s ability to pick up leads from what the patient says or does. |
| 13. Warmth | Student’s expressed acceptance of patient as a person. |
| 14. Question style | Sequencing of open and closed questions.Use of simple questions and avoidance of leading and multiple questions. |
| 15. Clarity | Clear communication between the two people. Avoidance of unexplained medical terms. |
| 16. End of interview | Summary by student. Communication of appreciation. Effective and clear closure of interview. |

Two student groups showed similar interview effectiveness prior to training given to the trained group, with no significant differences between the two groups.

The interview ratings given by the two observers have reported that untrained medical students display many poor interviewing behaviours *(Maguire and Rutter, 1976; Maguire, 1984; Irwin et al. 1989).*

Students generally failed to open interviews effectively, they neglected to introduce themselves and/or failed to state the purpose of the interview. Few displayed the skill to be able to control their interview and some passively sat back when faced with a talkative patient and tried few, if any, techniques to regain control.

There was a general lack of responsiveness to cues given by patients and a failure to give appropriate feedback as to whether or not the information being given by patients was appropriate. The observers were particularly unimpressed by students’ failure to show interpersonal warmth or concern to patients. Interview closures were similarly ineffective, with some students seemingly anxious to leave as soon as they had collected their data, without asking for patients’ questions or comments. Several failed to thank patients for their time.

In marked contrast, trained group students achieved higher mean scores on most scale items across the three interview times.

Trained students were rated significantly better at showing appropriate interview commencement and closure behaviours (“structural” aspects of interviewing), and showed greater skill in questioning and general communication clarity. They were more effective in their use of silence and showed greater willingness and ability in discussing patients’ psychosocial concerns, they showed greater ability at eliciting relevant psychosocial data from patients and their questioning style and communication clarity was also significantly better than control students.

This study has confirmed the finding of previous researchers that medical students can be taught basic interpersonal skills which enable them to more effectively relate to patients in the context of hospital-based history-taking interviews. That interview behaviours are discrete microskills are relatively independent and can be learned one at a time.

**How to cope with doctor’s time limit?**

Doctors can give as usual from 10 to 20 minutes to each patient. Alas, physicians aren't likely to discover extra hours in their days. The short time of encounter with a doctor is one of the major causes of dissatisfaction of patients. Fortunately, research suggests some ways to improve communication even in short interactions with patients.

The duration of 3 interviews conducted by trained group students (in doctor-patient interview conducting techniques) did not differ from those conducted by control group students at any of the three interview times. Even though their interviews were rated to be more interpersonallly effective by the two observers, trained students’ mean interview times were no different to the mean interview times of control students (Evans, B. J. et al., 1992).

Paul Arnold, (MD, at the University of Kansas Medical Center), and colleagues found that when physicians sat at a patient's bedside, the patients perceived the visit as lasting longer than they did when physicians stood, even though the visits lasted the same number of minutes (Patient Education and Counseling, 2012). Simply pulling up a chair can leave a patient feeling more satisfied, leading to better patient compliance and stronger patient-physician relationships.

Study of L. Aubree Shay, (a doctoral candidate at Virginia Commonwealth University), and colleagues found that patients rate physician communication more positively when the physicians take relatively simple steps, such as inviting patients to express their concerns, or extending the interaction outside of the exam room with a chat or referral exchanged in the hallway or reception area (Patient Education and Counseling, 2012).

**SUMMARY**

• Two primary steps of creating good doctor-patient contact are fostering the relationship and gathering information.

• Interview training can help students and practitioners to be more effective in gathering information from patients.